I. Request Information

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

B. Waiver Title (*optional*): ARChoices in Homecare

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

D. Amendment Number (*Assigned by CMS***):**

E.1 Proposed Effective Date: 01-01-2019

E.2 Approved Effective Date *(CMS Use):*

II. Purpose(s) of Amendment

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

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

1. Section 1.F is amended to clarify that the State does not enroll individuals who need a skilled level of nursing care. Conforms to current State administrative rules.

2. For assessments and re-assessments, replacement of (a) independent assessments performed by DHS registered nurses (RNs) using the ArPath assessment instrument with (b) independent assessments performed by RNs of the DHS Independent Assessment Contractor using the new Arkansas Independent Assessment (ARIA) instrument.

3. For Attendant Care Services and Respite Care Services, policy reforms and clarifications to limit the amount, frequency, and duration based on Task and Hour Standards; reduce overuse, misuse, and potential abuse of services; and revise scope of services descriptions.

4. For Attendant Care Services, three Instrumental Activity of Daily Living (IADL) tasks are eliminated (managing basic personal finances; communication with others; and traveling) to align with State Plan personal care services and self-directed personal assistance services (Independent Choices), reduce risk of duplication, and improve program integrity; and (for waiver participants) synchronize the prior authorization/prior approval of State Plan personal care services and waiver Attendant Care Services.

5. The deletion of Adult Family Home Services, an obsolete service not used by enrollees;

6. The addition of a new service, Prevocational Services, for persons with physical disabilities.

7. To ensure cost effectiveness and fiscal sustainability of waiver services, the maximum dollar amount of waiver services authorized for each specific participant is limited by a prospectively determined Individual Services Budget (ISB).

8. Various technical revisions are made to reflect responsibilities of new DHS Division of Provider Services and Quality Assurance (DPSQA) (a new operating agency), new name of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (formerly Division of Aging and Adult Services, an operating agency), and location of Office of Long-Term Care (OLTC) in DPSQA.

9. To accommodate past and projected growth in participation in ARChoices, the limitations on the maximum number of participants served at any point in time are increased to 9,071 for Waiver Year 4; and 9,434 for Waiver Year 5.

III. Nature of the Amendment

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

Component of the Approved Waiver		Subsection(s)
X	Waiver Application	1.F
X	Appendix A – Waiver Administration and Operation	A-1 A-2-b A-3 A-5 A-6 A-7
X	Appendix B – Participant Access and Eligibility	B-3-b B-6-c, d, e, f, i, and j B-7-a B-8
X	Appendix C – Participant Services	C-1/C-3 C-1-c C-2: 1 of 3-a, b, C-2: 3 of 3-e, f C-4-a Quality Improvement
X	Appendix D – Participant Centered Service Planning and Delivery	D-1: 3 of 8, 4 of 8, 5 of 8, 6 of 8, 7 of 8, 8 of 8 D-2-a, b Quality Improvement

	Component of the Approved Waiver	Subsection(s)
☐	Appendix E – Participant Direction of Services	
X	Appendix F – Participant Rights	F-1 F-3-b, c
X	Appendix G – Participant Safeguards	G-1-b, c, d, e G-2 Quality Improvement G-3: 1 of 2
X	Appendix H – Quality Improvement Strategy	H-1-a, b
X	Appendix I – Financial Accountability	I-1 Quality Improvement I-2-a, d I-5-b
X	Appendix J – Cost-Neutrality Demonstration	J-1 J-2: 1 of 9 (a.), 4 of 9, 5 of 9 (d.ii.), 6 of 9 (d.ii.), 7 of 9 (d.ii.), 8 of 9 (d.ii.), 9 of 9 (d.ii.)

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

☐	Modify target group(s)
X	Modify Medicaid eligibility
X	Add/delete services
X	Revise service specifications
☐	Revise provider qualifications
☐	Increase/decrease number of participants
☐	Revise cost neutrality demonstration
☐	Add participant-direction of services
X	Other (specify): 1. Transition independent assessment process from (a) DHS RNs using the ArPath instrument to (b) RNs of independent assessment contractor using the Arkansas Independent Assessment (ARIA) instrument. DHS RNs will gather additional information from individuals in connection with developing the person-centered service plan (PCSP). 2. Add limit on the maximum dollar amount of waiver services authorized for each specific participant by the prospectively determined Individual Services Budget (ISB). 3. To accommodate past and projected growth in participation in ARChoices, the limitations on the maximum number of participants served at any point in time are increased to 9,071 for Waiver Year 4; and 9,434 for Waiver Year 5.

	4. Technical edits to reflect changes in operating divisions (names, responsibilities).

IV. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Tami
Last Name	Harlan
Title:	Director
Agency:	Arkansas Department of Human Services, Division of Medical Services
Address 1:	P. O. Box 1437, Slot S-295
City	Little Rock
State	AR
Zip Code	72203-1437
Telephone:	(501) 682-8292
E-mail	tami.harlan@dhs.arkansas.gov
Fax Number	(501) 682-1197

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

First Name:	Stephenie
Last Name	Blocker
Title:	Assistant Director
Agency:	Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services
Address 1:	P. O. Box 1437, Slot S-530
City	Little Rock
State	AR
Zip Code	72203-1437
Telephone:	(501) 320-6569
E-mail	stephenie.blocker@dhs.arkansas.gov
Fax Number	(501) 682-8155

V. Authorizing Signature

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

Signature:

_____

State Medicaid Director or Designee

Date:	

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

REQUESTED AMENDMENT TO WAIVER INFORMATION

1. Request Information
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):

X Nursing Facility

X Nursing Facility as defined in 42 CFR 440.40 and 42 CFR 440.155

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

Individuals requiring a skilled level of care are not eligible for the ARChoices program.

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 purpose of the ARChoices in Homecare (ARChoices) waiver is to offer cost-effective, person-centered home and community-based services as an alternative to nursing home placement to persons aged 21 to 64 years of age with a physical disability or 65 and older who require an intermediate level of care in a nursing facility. Through person-centered service plans managed by State-employed registered nurses (RN), the waiver maintains Medicaid-eligible participants at home, promotes dignity, autonomy, privacy, and safety, fosters community inclusion, and precludes or postpones institutionalization of the participant.

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

Functional eligibility for the waiver is determined using assessments and reassessments performed by the State's Independent Assessment Contractor using a new electronic instrument, the Arkansas Independent Assessment (ARIA) system and the contractor's team of registered nurses. The assessment is sent to the

Office of Long-Term Care (OLTC) in the Division of Provider Services and Quality Assurance (DPSQA) to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and functionally eligible, the DHS county office approves the application.

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

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

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

Attachment #1: Changes from Previous Approved Waiver That May Require a Transition Plan.

Instructions: If applicable, check the box next to any of the following changes from the current approved waiver that you are making with this application. Check all of the boxes that apply. If you check any of the boxes, you will be prompted to complete a transition plan.

	Replacing an approved waiver with this waiver.
	Combining waivers.
	Splitting one waiver into two waivers.
X	Eliminating a service.
	Adding or decreasing an individual cost limit pertaining to eligibility
X	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.
X	Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
X	Making any changes that could result in reduced services to participants.

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

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

1. The amended waiver adds a new Prevocational Services benefit for persons with physical disabilities who wish who wish to join the general workforce. Prevocational Services are a range of learning and experiential type activities to help prepare a participant for paid employment or self-employment in the community.

2. The amended waiver eliminates Adult Family Home Services, which is not used by any waiver participants and obsolete.

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

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

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

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

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

1. **Program Integrity Reforms:** The service definitions and service limitations to the amount, duration, and frequency of Attendant Care Services and Respite Care Services are clarified and improved to reduce overuse, misuse, and duplication of services; ensure only medically necessary services are covered; and better ensure waiver services do not inappropriately supplant other services available to the participant (such as family supports, Medicare covered services, and targeted or supplemental services offered by a participant's Medicare Advantage plan).

2. **Prospective Individual Services Budget:** The Individual Services Budget (ISB), a prospectively determined dollar limit on the amount of all waiver services that may be authorized in a service plan over and above any limits on amount, duration, and frequency that apply to individual waiver services. (Please note that the Individual Services Budget applies post-eligibility and is not an "individual cost limit pertaining to eligibility" as defined in CMS guidance.)

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

1. The registered nurses who develop the person-centered service plans have a reasonable degree of professional discretion to adjust the amount, duration, and frequency of Attendant Care Services and Respite Care Services to meet individual needs and circumstances. The amended waiver itself covers other services that may be adjusted, as appropriate.

2. Waiver eligibility also provides participants with access to a broad mix of services covered under the Arkansas Medicaid State Plan, including personal care, durable medical equipment, and targeted case management.

3. After considering the participant's assessed needs, priorities, preferences, goals, and risk factors, if services authorized in the individual's person-centered service plan are not sufficient to meet their needs, the registered nurse will make referrals to appropriate services available through the Medicaid State Plan or another waiver program, Medicare, the participant's Medicare Advantage plan or Medicare prescription drug plan, and other federal, state, or community programs.

4. In the event the waiver services authorized for the participant within the limit of the applicable Individual Services Budget amount, Medicaid State Plan services, other waiver services, Medicare-covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DAABHS registered nurse will counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The nurse may also order a re-assessment of the participant.

5. In the event that a participant's Individual Services Budget (ISB) amount requires limitations to waiver services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, the participant will be given the opportunity during the person-centered service plan process to choose a different mix, type, or amount of waiver covered services. (For example, the participant could decide to forego a day of adult day health services to have additional attendant care hours.)

6. As detailed in the amended waiver (appendix C-4), the prospective Individual Services Budget amounts are determined using population-based factors.

7. Participants may request an exception to their Individual Services Budget amount. A panel of registered nurses will review exception requests to determine if an adjustment is necessary due to unusual, exceptional circumstances. Approved exceptions will be in the form of a temporary increase in the participant's Individual Services Budget amount for a period not to exceed one year.

8. Further, the revised service definitions and service limitations for Attendant Care Services and Respite Care Services are written to ensure that services authorized and received are reasonable and medically necessary, consistent with the participant's needs and risks as determined through the independent assessment, not duplicative, and exclude coverage of services unrelated or contrary to the participant's health and welfare. This includes nurse review and approval of the number of service hours for tasks according to published medical necessity guidelines (Task and Hour Standards). The overuse, misuse, abuse, or duplication of a covered service do not support a person's health and welfare. The receipt of medically unnecessary services does not serve the health and welfare of participants and in fact may adversely affect a beneficiary's health and welfare. Therefore, by design, the application of these new policies will serve to further protect participant health and welfare by ensuring that service scopes and amounts, durations, and frequencies of services under the amended waiver are sufficient, reasonably flexible to meet differences in participants' assessed needs, and exclude medically unnecessary activities and quantities.

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

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

Further, starting in CY 2019, Medicare Advantage (MA) health plans (including MA Special Needs Plans for dual eligibles) may offer supplemental services not otherwise covered under regular Medicare Part A or Part B benefits and at no additional cost to plan enrollees. These targeted or supplemental benefits may include a wide range of non-medical, in-home services or supports. They must be designed to improve or maintain the health or overall functioning of beneficiaries with chronic conditions. This new supplemental benefit option in Medicare Advantage (Medicare Part C) is through the Medicare Advantage Value-Based Insurance Design demonstration (expanding nationwide as required under BBA 2018 section 50321), the new expanded benefit option for chronically ill enrollees created by BBA 2018 section 50322 (42 U.S.C.

1395w–22(a)(3)(D)), and CMS final rules promulgated on April 2, 2018 (CMS-4182-F). Medicare Advantage plans will vary is how they choose to use this increased flexibility and Medicare Part C enrollment is voluntary. However, many waiver participants may have access to "Medicaid-like" supportive services offered through their MA plan or one or more of the competing MA plans available to them in Arkansas.

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

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

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

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

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

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

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

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

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

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

No participants use the adult family home service proposed for elimination. We expect no requests for it before the effective date of the amended waiver. Therefore, no transition is needed for this service elimination.

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

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

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

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

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

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

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

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

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

Relevant beneficiary materials will be updated to describe policy changes.

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

REQUESTED AMENDMENTS TO APPENDIX A

Appendix A: Waiver Administration and Operation

A-1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver:

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

- Department of Human Services (DHS), Division of Aging, Adult, and Behavioral Health Services (DAABHS) (an operating agency).
- Department of Human Services (DHS), Division of Provider Services and Quality Assurance (DPSQA) (an operating agency).

Appendix A: Waiver Administration and Operation

A-2. Oversight of Performance.

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

The Arkansas Department of Human Services (DHS) uses an Interagency Agreement to define the responsibilities of the three DHS divisions – Division of Medical Services (DMS, the Medicaid agency) DAABHS, and DPSQA – charged with responsibility for administering both the ARChoices in Homecare (ARChoices) and Living Choices in Assisted Living (Living Choices) HCBS waiver programs. This

agreement is reviewed annually and updated as needed. DMS, as the Medicaid agency, monitors this agreement on a continuous basis to assure that the provisions specified are executed.

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

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

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

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

A-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)

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

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

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

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

As described in the Interagency Agreement between the Division of Medical Services (DMS, the Medicaid agency), the Division of Aging, Adult, and Behavioral Health Services (DAABHS), and the Division of Provider Services and Quality Assurance (DPSQA), DAABHS, and DPSQA will jointly share

responsibility for oversight of the performance of the Independent Assessment Contractor, with DMS being ultimately accountable. The contract provides for performance measures the Independent Assessment Contractor is required to meet.

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

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

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

The monthly reports include the following:

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

The annual report includes the following:

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

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

performance measures, requiring development and execution of corrective action plans, reallocation of staff resources, data and systems improvements, consultation with stakeholders, and/or sanctions under the contract.

Appendix A: Waiver Administration and Operation
Quality Improvement: Administration Authority of the Single State Medicaid Agency

a. Methods for Discovery: Administrative Authority

i. Performance Measures

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

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.
Medicaid Quarterly QA Report (Chart Reviews)
Case Record Review
Sampling Approach *(check each that applies*)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Performance Measure:
Number and percent of participant service plans completed by DAABHS in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of service plans completed by DAABHS in time frame; Denominator: Number of service plans reviewed.
Case Record Review
Sampling Approach *(check each that applies*)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Performance Measure:
Number and percent of LOC assessments completed by Optum in the time specified in the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by Optum in time frame; Denominator: Number of LOC assessments reviewed.
Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Performance Measure:
Number and percent of LOC assessments completed by an Optum-qualified evaluator according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by an Optum-qualified evaluator; Denominator: Number of LOC assessments reviewed.
Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

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.
Case Record Review
Sampling Approach *(check each that applies)*
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Appendix B: Evaluation/Reevaluation of Level of Care
Quality Improvement: Level of Care

a. Methods for Discovery: Level of Care Assurances/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 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.
Case Record Review
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***
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.
Case Record Review
Sampling Approach (check each that applies)
X **Representative Sample**

Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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:

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.

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.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

b. Methods for Remediation/Fixing Individual Problems

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 Provider Services and Quality Assurance (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. DPSQA and DMS have an Interagency Agreement that includes measures related to level of care determinations for the waiver.

Appendix B: Participant Access and Eligibility
B-5. Post-Eligibility Treatment of Income (2 of 7)

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*):

X Other

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

Appendix B: Participant Access and Eligibility
B-3. Number of Individuals Served (1 of 4)

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.

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

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

Table: B-3-b

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

B-6. Evaluation/Reevaluation of Level of Care

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

Directly by the Medicaid agency

X By the operating agency specified in Appendix A

Specify the entity:

Currently, independent assessments and reassessments for the waiver are performed by DHS registered nurses using the ArPath instrument. Upon implementation of the new independent assessment program for the waiver program, an Independent Assessment Contractor under contract with the Department of Human Services (DHS) will perform independent assessments and reassessments using the Arkansas Independent Assessment (ARIA) instrument and the contractor's team of registered nurses. The Office of Long Term Care (OLTC), now part of the DHS Division of Provider Services and Quality Assurance (DPSQA) (an operating agency), continues to be responsible for reviewing results of independent assessment and reassessments, establishing the level of care, and determining eligibility. (Registered nurses in the Division of Aging, Adult, and Behavioral Health Services [DAABHS], an operating agency, remain responsible for the development and approval of person-centered service plans.)

Appendix B: Participant Access and Eligibility

B-6. Evaluation/Reevaluation of Level of Care

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

Level of Care Criteria:

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

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

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

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

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

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

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

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

2. Not require a skilled level of care, as defined in the State rule.

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

Instrument/Tool Used:

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

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

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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.

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

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

Level of Care Instrument for Institutional Care:

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

Level of Care Instrument for Waiver Program:

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

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level 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 new process for evaluating waiver applicants and re-evaluation of waiver program participants for their respective needs for the level of care under the waiver is described below.

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

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

Re-evaluations will continue to be performed on at least an annual basis, with the level of care re-affirmed or revised and a written determination issued by the Office of Long Term Care. Re-evaluations (re-assessments) will continue to be performed on at least an annual basis, with the level of care re-affirmed

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

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

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

In summary:

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

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

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

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

(Note that ARIA-based assessments are also used to help determine whether Medicaid enrollees meet the minimum ADL needs-based criteria for State Plan coverage of Medicaid personal care services and self-directed personal assistance services. Tier 1 (one) and Tier 2 (two) each indicate that the Medicaid

enrollee meets the minimum criteria for personal care or self-directed personal assistance service coverage. Coverage of these State Plan services for Medicaid enrollees is further subject to a medical necessity determination and prior authorization.)

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

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

Specifically, DAABHS registered nurses (RNs) and RN supervisors use a "tickler" file system approach to monitor upcoming review data and service plan expirations. The process of reassessment begins two months prior to the expiration date of the current person-centered service plan or two months prior to the annual anniversary date of the last independent assessment, whichever is earlier. The case is added to the assessment schedule. Once the re-assessment is completed and the level of care revised as appropriate, the DHS RN begins development of the new person-centered service plan.

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

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

Records of evaluations and reevaluations of level of care are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS), the primary authority for the daily operation of the waiver program, and the Office of Long Term Care (OLTC) in the Division of Provider Services and Quality Assurance (DPSQA), which is responsible for the level of care evaluations and reevaluations.

DAABHS maintains records for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations, or court cases are resolved for a participant, whichever is longer.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

a. Methods for Discovery: Level of Care Assurances/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 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.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

e. ***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:

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.

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.

Case Record Review

Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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

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

Appendix B: Participant Access and Eligibility
B-7: Freedom of Choice

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

At the time of assessment and re-assessment of the waiver participant, the DHS RN explains the services available through the ARChoices waiver, discusses the qualified ARChoices providers in the state, and develops an appropriate person-centered service plan. As part of the service plan development process, the participant (or representative) documents their choice to have services

provided in the community setting through the HCBS waiver as opposed to receiving services in an institutional setting. In addition, freedom of choice is explained through a Freedom of Choice form and the applicable qualified provider listing; both are signed by the waiver participant or their representative. This is documented on the service plan, which includes the signature of the waiver participant (or representative) and the DHS RN, and included in the participant's electronic record. NOTE: For reassessments, the Freedom of Choice form is utilized showing if changes are requested by the participant. If no changes are requested, no signatures are required on the provider listing; however, the Freedom of Choice form is signed and dated by the participant or representative. The participant's signature on the service plan, as entered by the participant or representative, documents that the participant (or representative) has made an informed decision to receive HCBS rather than services in an institutional setting and that HCBS are based on the participant's assessment of needs. Freedom of Choice documentation is tracked through the record review process, all staff performance evaluations and monthly reporting.

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

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.
Copies of the waiver participant's service plan are maintained with the DAABHS (operating agency) and with the providers chosen by the participant and included on the service plan. Freedom of Choice forms and person-centered service plans are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

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

REQUESTED AMENDMENTS TO APPENDIX C

Appendix C: Participant Services
C-1: Summary of Services Covered

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

Service Type	Service		
Statutory Service	**Adult Day Health**		
Statutory Service	**Respite**		
Other Service	**Adult Day Services**		
Other Service	**~~Adult Family Home~~ [delete from table]** **Prevocational Services [add to table]**		
Other Service	**Attendant Care Services**		
Other Service	**Environmental Accessibility Adaptations/Adaptive Equipment**		
Other Service	**Home-Delivered Meals**		
Other Service	**Personal Emergency Response System (PERS)**		

Appendix C: Participant Services

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Attendant Care Services
HCBS Taxonomy: (no change)

Service Definition (Scope):

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

1. Reasonable and medically necessary, supported by the individual's latest independent assessment, and consistent with the individual's Level of Care;

2. Not available from another source (including without limitation family members, a member of the participant's household, or other unpaid caregivers; a Medicaid State Plan covered service; the Medicare program; the participant's Medicare Advantage plan [including targeted or other supplemental benefits offered by the plan]; the participant's Medicare prescription drug plan; and private long-term care, disability, or supplemental insurance coverage);

3. Expressly authorized in the individual's person-centered service plan;

4. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services specified in the Task and Hour Standards;

5. Provided by qualified, Medicaid-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and

6. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

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

1. Activities of Daily Living (ADLs):

    a. Eating (i.e., feeding assistance during meal times and encouraging fluids, excluding tube feeding and total parenteral nutrition and meal preparation);

    b. Toileting;

    c. Personal hygiene and grooming (i.e., face shaving; nail trimming; shampooing, brushing, or combing of hair; and menstrual hygiene);

    d. Dressing;

e. Bathing or showering; and/or

f. Mobility/ambulating (i.e., functional mobility, moving from seated to standing, getting in and out of bed).

2. Instrumental Activities of Daily Living (IADLs):

a. Meal planning and preparation for meals consumed only by the participant;

b. Laundry for the participant or incidental to the participant's care;

c. Shopping for food, clothing, and other essential items required specifically for the health and maintenance of the participant;

d. Housekeeping (i.e., cleaning of areas directly used by the participant); and

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

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

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

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

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

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

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

b. Any such health-related tasks performed:

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

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

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

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

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

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

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

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

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

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

5. Cleaning of any spaces of a home or place of residence (including without limitation the kitchen, bathroom, living room, dining room, family room, and utility or storage rooms, and the floors, furnishings, and appliances therein) shared by the participant with one or more adults who are, together or separately, physically able to perform housekeeping of these areas; and

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

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

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

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

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

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

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

1. The amount, frequency, and duration of attendant care services must be consistent with the amounts, frequencies, and durations specified in the Arkansas Medicaid Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at

the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, or month. Any amounts, frequencies, or durations in excess of the THS specifications are not covered.

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

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

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

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

   d. When attendant care services delivered through a home health agency or private care agency are provided by any person who (i) resides (permanently, seasonally, or occasionally) in the same premises as the participant; (ii) has a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's guardian or legal representative; or (iii) is related to the participant by blood (i.e., a consanguinity relationship) or by marriage or adoption (i.e., an affinity relationship) to the fourth degree; and/or.

   e. On dates of service when the participant:

      i. Receives personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan for the same tasks;

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

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

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Adult Family Home
HCBS Taxonomy:

[Delete Adult Family Home service]

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Environmental Accessibility Adaptations/Adaptive Equipment
HCBS Taxonomy: (no change)

Service Definition (Scope):

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

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

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment provided by:

1. Any person related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree;
2. A resident of the participant's home or place of residence (whether permanent, seasonal, or occasional);
3. Any person who has a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or
4. Any provider organization that employs or contracts with any above individual.

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Respite
HCBS Taxonomy: (no change)

Service Definition (Scope):

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

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

1. The participant lives at home and is cared for, without compensation, by their families or other informal support systems;

2. As determined by the independent assessment, the participant has a severe physical, mental, or cognitive impairment(s) that prevents him or her from being left alone safely in the absence or availability of the primary caregiver;

3. The primary caregiver to be relieved is identified and with sufficient documentation that he or she furnishes substantial care of the client comparable to or in excess of services described under the Attendant Care service;

4. No other alternative caregiver (e.g., other member of household, other family member) or source of assistance is available to provide a respite for the primary caregiver(s);

5. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b) supervision necessary to maintain the health and safety of the participant, as supported by the independent assessment and determined medically necessary by the DAABHS registered nurse; and

6. Respite Care solely serves to supplement (not replace) and otherwise facilitate the continued availability of care provided to waiver participants by families and other informal support systems.

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

Respite Care is available in the following locations:

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

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

1. In-home respite may be provided for up to 24 hours per date of service.

2. Facility-based respite care may be provided outside the participant's home on:

   a. A short-term basis (eight (8) hours or less per date of service), or

   b. A long-term (maximum of 24 hours per date of service and used most often when respite needed exceeds the short-term respite amount).

Reimbursement is only permitted for direct care rendered according to the participant's person-centered service plan by trained respite care workers employed and supervised by certified in-home respite providers.

Reimbursement is not permitted for Respite Care services provided by:

1. Any person related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree;
2. A resident of the participant's home or place of residence (whether permanent, seasonal, or occasional);
3. Any of the participant's regular caregiver(s) for whom respite is being provided;
4. Any person who has a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's guardian or legal representative; or
5. Any provider organization that employs or contracts with any above individual.

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

Respite Care is subject to the following limitations:

1. The amount, frequency, and duration of Respite Care must be entirely consistent with and shall be limited to amounts, frequencies, and durations specified in the DAABHS Personal Care Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. Any amounts, frequencies, or durations in excess of the THS specifications are not covered.

2. Respite Care excludes:

   a. Skilled health professional services, including physician, nursing, therapist, and pharmacist services.

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

   c. Services provided for any other person other than the participant;

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

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

3. Participants are limited to no more that 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof.

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

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

[In the current waiver, the box for "Relative" is checked. This check should be removed because relatives will no longer be permitted to provide respite services under amended waiver]

[unchecked] Legally Responsible Person
[uncheck] Relative
[unchecked] Legal Guardian

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Prevocational Services
HCBS Taxonomy:

Service Definition (Scope):

Prevocational services are available to ARChoices waiver participants with physical disabilities who wish to join the general workforce. Prevocational Services comprises a range of learning and experiential type activities that prepare a participant for paid employment or self-employment in the community.

Prevocational services are as follows:

1. Development and teaching of general employability skills (non-job-task-specific strengths and skills) directly relevant to the participant's pre-employment needs and successful participation in individual paid employment. These skills are: ability to communicate effectively with supervisors, coworkers, and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; and skills related to obtaining paid employment. Excluded are services involving development or training of job-specific or job-task oriented skills.

2. Career exploration activities designed to develop an individual career plan and facilitate the participant's experientially based informed choice regarding the goal of individual paid employment. These may include business tours, informational interviews, job shadows, benefits education and financial literacy, assistive technology assessment, and local job exploration events. The expected outcome of career exploration activities is a written, actionable, person-centered career plan designed to lead to community employment or self-employment for the participant.

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the participant interacts with individuals without disabilities, other than those providing services to the participant or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Prevocational services may be provided one-to-one or in a small group format and may be provided as a site-based service or in a community setting, consistent with requirements of the ARChoices provider manual.

All prevocational services must be prior approved in the participant's person-centered service plan, provided through a DPSQA-certified prevocational services provider, and delivered and documented consistent with requirements of the ARChoices provider manual.

Reimbursement is not permitted for Prevocational services provided by:

1. Any person related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree;
2. A resident of the participant's home or place of residence (whether permanent, seasonal, or occasional);
3. Any person who has a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or
4. Any provider organization that employs or contracts with any above individual.

Prevocational services exclude any services otherwise available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 (Rehab Act), the Individuals with Disabilities Education Act (IDEA), or any other federally funded (non-Medicaid) source. Proper documentation shall be maintained in the file of each individual receiving prevocational services under the waiver.

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

The total amount of all prevocational services provided to any participant shall not exceed $2,500 per lifetime.

The amount of career exploration activities provided per participant shall not exceed 30 hours.

Duration of prevocational services provided to any given participant shall be limited to 180 days (six months). Services not completed within this timeframe are not covered.

C-1/C-3 Provider Specifications

Service: Adult Day Health
Provider Type - Adult Day Health

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

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

Service: Respite
Provider Qualifications – Certificate (specify) – Acute General Hospital

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

Provider Type – Licensed Level II Assisted Living Facility

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

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

Provider Type - Licensed Level II Nursing Facility Agency
Provider Qualifications – License (specify)

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

Provider Qualifications - Certificate (specify)

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Medicaid Certified Nursing Facility license at all times.

Provider Type – Licensed Adult Day Health Care Agency

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Health Care license at all times.

Provider Type – Licensed Residential Care Facility

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Residential Care Facility license at all times.

Provider Type – ~~Certified Adult Family Home~~
[Delete provider type]

Provider Qualifications – Certificate (specify)
[Delete current language]

Verification of Provider Qualifications
Entity Responsible for Verification:
[Delete current language]
Frequency of Verification:
[Delete current language]

Provider Type - Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current license at all times.

Service: Adult Day Services
Provider Type – Licensed Adult Day Care

Provider Qualifications - License (specify)
Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et. seq.
Provider Qualifications - Certificate (specify)
Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Services. To be certified, providers must provide a copy of their current adult day care license through the DHS Division of Provider Services and Quality Assurance.

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Care license at all times.

Service: ~~**Adult Family Home**~~

Provider Type – ~~Adult Family Home~~
[Delete Adult Family Home service type and provider type]

Provider Qualifications - Certificate (specify)
[Delete Adult Family Home service type and provider type]

Verification of Provider Qualifications
Entity Responsible for Verification:
[Delete Adult Family Home service type and provider type]
Frequency of Verification:
[Delete Adult Family Home service type and provider type]

Service: Attendant Care Services
Provider Type – Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the provider's current Personal Care Agency license in the provider file at all times.

Provider Type – Licensed Home Health Agency

Provider Qualifications - License (specify)
Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency, as cited in Arkansas Code Annotated section 20-10-809.
Provider Qualifications - Certificate (specify)
Agencies must be certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, to provide ARChoices agency attendant care services.

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the provider's current Home Health Agency license in the provider file at all times.

Service: Environmental Accessibility Adaptations/Adaptive Equipment
Provider Type – Installer (Builder, Tradesman or Contractor)

Provider Qualifications - License (specify)

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually.

Service: Home-Delivered Meals
Provider Type – Provider of Food Services

Provider Qualifications - Certificate (specify)
Food Establishment Permit issued by the Arkansas Board of Health

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Food Establishment Permit at all times.

Service: Personal Emergency Response System (PERS)
Provider Type – Alarm or Security Company

Provider Qualifications - Certificate (specify)
Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually

Service: Prevocational Services
Provider Type – Certified Prevocational Services Vendor

Provider Qualifications - Certificate (specify)
Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Prevocational Services.

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:
Annually

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

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

Each ARChoices waiver participant's person-centered service plan will include Medicaid State Plan targeted case management, unless refused by the waiver participant. Qualified targeted case managers who can deliver targeted case management services are the employees of providers enrolled in the Medicaid State Plan Targeted Case Management Program. A qualified targeted case manager must be licensed in the State of Arkansas as a social worker, a registered nurse or a licensed practical nurse or have a bachelor's degree from an accredited institution or have performed satisfactorily as a case manager for a period of two (2) years.

The targeted case manager is responsible for monitoring the waiver participant's status on a regular basis for changes in his or her service need, and reporting any waiver participant's complaints or changes to the DHS RN immediately upon learning of the change.

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

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):
Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All ARChoices waiver providers employing persons providing direct services (personal assistants, attendants) shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere to any disqualifying criminal offense.

Each ARChoices waiver provider must obtain from each employee and from each applicant for employment a signed authorization permitting disclosures to the ARChoices provider of criminal history information as defined in Ark. Code Ann., Section 12-12-1001.

Each provider receiving payment under the ARChoices program must, as a condition of continued participation in the program, comply with the requirement for criminal history checks for new employees, and periodic criminal history checks for agency operators and all employees at least once every five years. The scope of the criminal background checks is national. This requirement applies to any employee who in the course of employment may have direct contact with an ARChoices participant. At the time of initial certification and re-certification, providers must submit a list of all direct care services staff and the dates of their last criminal background check.

If the results of the criminal history check establish that the applicant was found guilty of, or pled nolo contendere (no contest) to a disqualifying offense under Ark. Code Ann., Section 20-33-205 ("disqualifying offense"), then the ARChoices waiver provider may not employ, or continue to employ, the applicant. Disqualifying offenses do not include misdemeanors that did not involve exploitation of an adult, abuse of a person, neglect of a person, theft, or sexual contact.

According to Arkansas Department of Human Services Policy 1088, DHS shall automatically exclude any provider (or, an employee or subcontractor of that provider) that has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or nolo contendere (no contest), to any crime related to:

1. Obtaining, attempting to obtain, or performing a public or private contract or subcontract,
2. Embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty,
3. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony,
4. Federal antitrust statutes,
5. The submission of bids or proposals, or
6. Any physical or sexual abuse or neglect when the offense is a felony.

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor.

The DPSQA Provider Certification unit sends new applications and a list of providers who are due recertification to the Medicaid Provider Enrollment unit, the Medicaid fiscal agent, which processes all criminal background checks. Certification of new providers and recertification of active providers is contingent upon the completion of the criminal background check. The Medicaid program's fiscal agent submits reports detailing the background checks for new and existing providers to DPSQA.

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

X Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Abuse registry screenings of the direct care of services staff of ARChoices agency providers are monitored at initial certification and re-certification. This is a required part of the certification and re-certification process. In addition, agency providers must submit a list of all direct care of services staff and the dates of their last criminal background checks. Criminal background checks are required for agency providers every five years pursuant to Act 762 of 2009. Providers are required to follow all requirements related to employee criminal background checks discussed in the Medicaid Provider Manual.

The Adult Protective Services unit of the Division of Aging, Adult, and Behavioral Health Services is responsible for maintaining the abuse registry.

As part of the qualified provider review, DPSQA verifies that the provider file contains all required documentation, including information regarding the criminal background checks.

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

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

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

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

The following ARChoices services may be reimbursed if provided by a relative of the participant, subject to the limitations specified below: Adult Day Service, Adult Day Health Service, Home-Delivered Meals, and PERS.

The following ARChoices services are not reimbursable if provided by a relative of the participant, whether provided directly or as an employee or contractor of a provider: Attendant Care Services, Environmental Accessibility Adaptations/Adaptive Equipment, Prevocational Services and Respite Care.

For the purposes of this waiver program, “relative” means any person related to the participant by blood (i.e., a consanguinity relationship) or by marriage or adoption (i.e., an affinity relationship) to the fourth degree.

Individuals who are legally responsible for the participant (i.e., spouse, legal guardian, or attorney-in-fact granted authority to direct the participant’s care) are prohibited from receiving any reimbursement for any ARChoices services provided for the participant.

All providers, including relatives, are required to meet all applicable ARChoices provider certification requirements and Arkansas Medicaid enrollment requirements, comply with all applicable ARChoices provider manual requirements, and provide services according to the participant’s approved service plan and any established benefit limits for that specific service, as identified in Appendix C-1/C-3.

Controls are maintained through the required documentation for all service providers. This documentation must support each service for which billing is made and include a copy of the participant's person-centered service plan, a brief description of the specific services provided, the signature and title of the individual providing the service, and the date and actual time services were provided. DHS RN supervisory staff conducts chart reviews to ensure that services were provided according to the service plan. DPSQA performs audits and quality reviews of providers.

To improve program integrity and meet the new requirements of 42 U.S.C. 1396b(l), Arkansas Medicaid is implementing an Electronic Visit Verification (EVV) requirement, whereby providers of in-home services will be required to use a DHS-approved EVV system to electronically verify and document services as a condition of reimbursement. EVV data will also

be used to help target audit activities and monitor delivery of services according to approved person-centered service plans and prior authorizations. For ARChoices providers, EVV use will be required for Attendant Care Services, Respite Care, and Home-Delivered Meals. EVV will also be required for certain other Medicaid services such as home health services, private duty nursing services, and Independent Choices self-directed personal assistance services. EVV requirements and effective dates will be promulgated through the provider manual process, following stakeholder consultations and completion of the EVV system vendor procurement.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

ARChoices provider enrollment is open and continuous. Those interested in becoming an ARChoices provider can contact DPSQA Provider Enrollment for information and to obtain certification materials. There are no restrictions applicable to requesting this information. The provider certification process is open and available to any interested party.

The Division of Provider Services and Quality Assurance (DPSQA) website lists information for potential ARChoices providers.

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services:

Prospective Individual Budget Amount:

There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

1. Individual Services Budget (ISB):

   a. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.

   b. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by DAABHS for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.

   c. Each participant's Individual Services Budget shall be explained when the DAABHS registered nurse consults with the individual on the person-centered service plan. This may be done through written information.

d. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.

2. Adjustments, Considerations, and Safeguards Regarding Individual Services Budgets:

a. During the development of each person-centered service plan, after considering the participant's assessed needs, priorities, preferences, goals, and risk factors, and to ensure that the cost of all ARChoices services for each participant does not exceed the applicable Individual Services Budget amount, the DAABHS registered nurse shall, as necessary:

i. Limit and modify the type, amount, frequency, and duration of waiver services authorized for the participant (notwithstanding any service-specific limits established in Appendix C: Participant Services); and

ii. Make referrals to appropriate services available through the Medicaid State Plan or another waiver program, Medicare, the participant's Medicare Advantage (MA) plan (including targeted and other supplemental benefits the MA plan may offer), the participant's Medicare prescription drug plan, and other federal, state, or community programs.

b. Should the DAABHS nurse determine that the ARChoices waiver services authorized for the participant within the limit of the applicable Individual Services Budget, other Medicaid or Medicare covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DAABHS nurse shall counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The DAABHS nurse may also order a re-assessment of the participant.

c. In the event that a participant's ISB requires changes or limitations to ARChoices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type, or amount of ARChoices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.) Any such participant-requested changes and substitutions are subject to the following:

i. The services chosen by participant are otherwise covered and reimbursable under ARChoices and do not exceed any applicable service limitations;

ii. The services chosen by participant are necessary and appropriate for the individual and consistent with results of the independent assessment;

iii. The cost of all ARChoices waiver services authorized for or received by the participant, including any participant-requested changes and substitutions, do not exceed the applicable ISB amount;

iv. The DAABHS nurse determines the changes are reasonable and necessary for the individual and reflected in the approved person-centered service plan.

d. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. The exceptions process, including request procedures, documentation, and process for determining exceptions, shall be specified in the ARChoices manual, as promulgated by DHS. This exceptions process is intended as a safeguard to address exceptional, unexpected circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:

i. In the professional opinion of the nurse panel, unique circumstances indicate that additional time is reasonably needed by the participant (or the participant's family on his or her behalf) to (1) adjust waiver service use costs to within the applicable Individual Services Budget (ISB) amount, (2) arrange for the start of or increase in non-Medicaid services (such as informal family supports and Medicare-covered services), and/or (3) arrange for placement in an alternative residential or facility-based setting.

ii. Such unique circumstances must be (1) specific to the individual; (2) supported by documentation provided to the nurse panel; (3) relevant to the individual's assessed needs and risk factors; (4) relevant to the temporary need for additional, medically necessary coverable waiver services in excess of the person's pre-exception ISB amount; and (5) not the result of a need for skilled services or other services not covered under the waiver.

iii. Such unique circumstances may include (1) recent major life events not known at the time the current person-centered service plan was approved, including without limitation death of a spouse or caregiver, and loss of a home or residential placement; and (2) a temporary increase in care needs, for a period not to exceed ninety (90) days after a discharge from inpatient acute treatment or post-acute care.

iv. If the exception request is due to the participant (or participant's family on his or her behalf) encountering delays or difficulties in arranging new care arrangements or an alternative residential or facility-based placement in the state, an exception may be granted if the nurse panel determines reasonable efforts are being made and the delays or difficulties experienced are exceptional or due to rural or remote location of the participant's home.

v. The factors considered by the nurse panel must be reasonably relevant to the necessity for additional waiver services in total cost in excess of the person's pre-exception ISB amount and for a temporary period of time not to exceed one year.

e. If the projected cost of services identified in an individual's person-centered service plan (whether such plan is under development, provisional, or final or renewed, amended, or extended) is less than the applicable Individual Services Budget amount, this shall not be construed to permit, suggest, or justify approval, coverage, or reimbursement of different or additional waiver services (including changes in amount, frequency, or duration); coverage and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or other actions to increase spending to use the remaining "unused" portion of the ISB amount.

f. The Individual Services Budget shall not apply to environmental accessibility adaptations/adaptive equipment

3. Transition Process:

a. The Individual Services Budget limit shall apply to the following:

i. New ARChoices participants, including individuals determined newly eligible for ARChoices following a period of ineligibility for this or another HCBS waiver program, when they are determined waiver eligible, and effective for their first person-centered service plan and thereafter; and

ii. Existing ARChoices participants immediately upon any of the following events, whichever may occur first:

(a) Waiver eligibility is re-evaluated;

(b) The Level of Care is reaffirmed or revised;

(c) A new independent assessment or re-assessment is performed;

(d) Expiration, renewal, extension, or revision of the participant's person-centered service plan occurs; or

(e) Admission to or discharge from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or transfer from a hospice facility occurs.

b. For all other ARChoices participants not otherwise identified above, the Individual Services Budget limit shall apply no later than 60 days after the effective date of this waiver amendment.

c. For the following ARChoices participants, the DAABHS deputy director (or his/her designee) may on a case-by-case basis extend the effective date of the participant's first Individual Services Budget by a maximum of 60 days per participant upon written request of the participant (or legal representative) or the participant's personal physician, if:

i. The specific participant's recent pattern of waiver service expenditures exceeds the average Individual Services Budget amount by an estimated twenty-five (25) percent or more; and/or

ii. DAABHS determines that unique, intervening circumstances indicate that additional time is reasonably needed by the participant and the participant's family and providers. Examples of unique, intervening circumstances include the death of the spouse, loss of home, or unexpected difficulties in accessing or arranging care or placement, among others.

4. Methodology for Determining Individual Services Budgets:

a. The Individual Services Budget amount for a participant is based on that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The three ISB Levels are:

i. Intensive: The participant requires total dependence or extensive assistance from another person in all three areas of mobility, feeding, and toileting.

ii. Intermediate: The participant requires total dependence or extensive assistance from another person in two of the areas of mobility, feeding, or toileting.

iii. Preventative: The participant meets the functional need eligibility requirements for ARChoices in Section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate.

b. The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (c) below, is as follows:

i. For an individual with an assessed ISB Level of Intensive, the Individual Services Budget is $30,000.

ii. For an individual with an assessed ISB Level of Intermediate, the Individual Services Budget is $20,000.

iii. For an individual with an assessed ISB Level of Preventative, the Individual Services Budget is $5,000.

c. For a participant with total waiver expenditures of more than $30,000 in calendar year 2018:

i. The participant will be granted a Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures in calendar year 2018.

ii. In the year following the Transitional Allowance, the participant's maximum Individual Services Budget will be 95% of the participant's total waiver expenditures in calendar year 2019.

iii. For purposes of this subsection (c), "total waiver expenditures" for a calendar year shall be calculated as the sum total of claims submitted and paid by December 31 of that calendar year for all waiver services received by the participant in that calendar year, and then modified by:

1. If the cumulative expenditures are for less than 12 months, annualizing the total to reflect what the expenditures would have been if the participant had received the same monetary amount of services for 12 consecutive months; and

2. Excluding amounts expended for environmental modifications/adaptive equipment.

d. DHS will monitor and update these ISB amounts if circumstances (including without limitation provider rate increases) warrant a change for CY2020.

e. For purposes of determining the projected cost of all waiver services in an individual's person-centered service plan, DAABHS shall assume that:

i. The individual will receive or otherwise use all services identified in the service plan and in their respective maximum authorized amounts, frequencies, and durations; and

ii. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.

f. Determination of ISB Amounts

i. The maximum ISB amount, $30,000, which is also the threshold for the Transitional Allowance, is based on the average annual state and federal cost of nursing home care, excluding the average resident share, the average revenue from the state-imposed Quality Assurance Fee (QAF), and the average FMAP revenue associated with the QAF. For FY2018, the average amount of state general revenue paid for a nursing home stay was $24.04 per day; the average amount of the FMAP on that state general revenue was $57.67, for an average daily total of $81.71, multiplied by 365 days to produce an annual total average cost of $29,824.15. This amount is then rounded up to the nearest thousand to produce the $30,000 ISB amount.

ii. The ISB amounts for the Preventative and Intermediate levels are based on a DHS review of actual waiver service expenditures during FY2018 by a set of 6,810 ARChoices participants who received an assessment or reassessment during FY2018. The expenditures for each participant were adjusted to produce a projected annual total expenditure amount, and participants were divided into the Preventative, Intermediate, and Intensive ISB levels based on the results of the ArPath assessment or reassessment recorded in FY2018. DHS then reviewed the distribution of projected annual total expenditure amounts by ISB level to determine an appropriate ISB amount.

Appendix C: Quality Improvement

Quality Improvement: Qualified Providers

a. Methods for Discovery: Level of Care Assurances/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: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measure: Number and percentage of providers, by provider type, which obtain re-certification in accordance with state law and waiver provider qualifications. Numerator: Number of providers with re-certification; Denominator: Total number of providers
Data source (Select one)**:**
Other: Provider Certification Unit (DPSQA) Provider Database
Performance Measure: Number and percentage of providers, by provider type, which obtained the appropriate license/certification in accordance with state law and waiver provider qualifications prior to delivering services. Numerator: number of providers with appropriate license/certification prior to delivery of services; Denominator: Number of new providers
Data source (Select one)**:**
Other: Provider Certification Unit (DPSQA) Provider Database

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***
Performance Measure: Number and percent of agency providers meeting waiver provider training requirement as evidenced by in-service attendance documentation. Numerator: Number of agency providers indicating training by in-service documentation; Denominator: Total number of agency providers
Data source (Select one)**:**
Other: Provider Certification Unit (DPSQA) Provider Database

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

The state identifies and rectifies situations where providers do not meet requirements. This is accomplished by monitoring certification/license expiration dates within MMIS and continuing communication with the Medicaid fiscal agent responsible for provider enrollment functions, and reviewing monthly reports that identify providers whose participation is terminated for inactivity or violations. Participation in provider training is documented and monitored through monthly activity reports.

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

Each month the DHS RN receives a provider list for each county included in their geographical area. This provider list may be used at each assessment and reassessment to give the participant a choice of providers for each service included on the service plan. In addition, this list is used to identify the providers who are new or who have been reinstated in the program.

Providers are required to follow all guidelines in the Medicaid Provider Manual related to provider training of employees and staff orientation, including documentation requirements, provider participation requirements, and any penalties or sanctions applicable for noncompliance.

Provider training consists of program policy, including documentation requirements, reporting, claims processing and billing, the Medicaid Provider Manual and other areas. This training is scheduled, at a minimum, two times per year based on training needs.

Training requirements are explained in the provider manual. In addition, DPSQA is responsible for contacting new providers according to program policy. These contacts provide information regarding proper referrals, eligibility criteria, forms, reporting change of status, general information about the program, etc. Within three months of appearing on the provider list, the DHS RNs must meet with each new provider face-to-face to discuss all of the above.

Evaluations from in-services are used to address strengths and weaknesses in the training process, topics for future in-services, and policy enhancements. As a result of in-services, policy clarifications have been issued; forms have been revised; training topics have been chosen; documentation requirements have been revised; training sessions have been redesigned.

The Medicaid fiscal agent provides DPSQA access to Provider License/Certification Status. If needed, this provides a second monitoring tool for monitoring licensure and certification compliance.

The mandatory Medicaid contract, signed by each waiver provider, states compliance with required enrollment criteria. Failure to maintain required certification and/or licensure results in loss of their Medicaid provider enrollment. Each provider is notified in writing at least two months prior to the certification/licensure expiration date that renewal is due and failure to maintain proper certification will result in loss of Medicaid enrollment.

All waiver providers are responsible for all provider requirements, penalties and sanctions as detailed in the Medicaid provider manual.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

To continue Medicaid enrollment, a waiver provider must maintain certification by DPSQA. In cases where providers do not maintain certification, DPSQA's remediation may include requesting termination of the provider's Arkansas Medicaid enrollment, recouping payment for services provided after certification/licensure has expired, and allowing the participant to choose another provider.

D-1: Service Plan Development

As indicated in Appendix B-6-d above, Arkansas plans to follow a transition process, that will be detailed in a transition plan submitted to CMS for review, in implementing the independent assessment.

D-1: Service Plan Development (3 of 8)- Supporting the Participant in Service Plan Development

When scheduling the person-centered service plan development visit, the DHS Division of Aging, Adult, and Behavioral Health Services (DAABHS) RN explains to the participant or authorized representative the process and informs the participant that they may invite anyone they choose to participate in the service plan development process. Involved in this assessment visit is the participant and anyone they choose to have attend, such as their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment process or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting.

During the service plan development, the DHS RN explains to the participant the services available through the ARChoices waiver.

When developing the person-centered service plan, all services and any applicable benefit limits are reviewed, as well as the comprehensive goals, objectives and appropriateness of the services. The participant and their representatives participate in all decisions regarding the type of services, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services. This information is recorded on the service plan, which is signed by the participant.

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

a) DHS RNs will develop initial person-centered service plans for ARChoices in Homecare participants based on the Independent Assessment Contractor's assessment of the participant's needs and information gathered during the service plan development meeting with the participant. The DHS RN will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development

meeting. The DHS RN will assist in notifying interested parties if requested by the participant or the representative.

The development of the person-centered service plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor within 10 working days of the Independent Assessment Contractor receiving a referral from the DHS county office. Following the assessment and assignment of a tier level by the Independent Assessment Contractor, a DHS RN will schedule a meeting with the participant to develop the service plan. Reassessments, which will be conducted by the Independent Assessment Contractor, will be completed annually or more often, if deemed appropriate by the DHS RN. Following the reassessment by the Independent Assessment Contractor, the DHS RN will develop a person-centered service plan. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans are developed and sent to all providers before services may begin.

(b) The Independent Assessment Contractor will assess the participant's needs. The DHS RN will assess the participant's comprehensive goals and objectives related to the participant's care and reviews the appropriateness of ARChoices services. If necessary, the DHS RN will read any of the information provided during the assessment to the participant. If this is done, it is documented in the participant's record. All forms and information will be provided in an alternate format upon request. If an alternate format is requested and/or provided, the DHS RN will document in the participant's record the format requested and/or provided.

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

The results of the Independent Assessment Contractor's functional assessment using the ARIA assessment tool will be used by the Office of Long Term Care to evaluate the level of care and by the DHS RN to develop the person-centered service plan. Information collected for the Independent Assessment Contractor's functional assessment using the ARIA tool will include demographic information and information on the waiver participant's ability to perform the activities of daily living; transferring and ambulation; continence status; nutritional status; hearing, vision, speech and language; skin condition; behavior and attitude; orientation level; other medical conditions; psychosocial and cognitive status; and, medications/treatments.

The assessment is a complete functional assessment and includes a medical history. The Independent Assessment Contractor will evaluate the participant's physical, functional, mental, emotional and social status, and will obtain a medical history to ensure that the service plan addresses the participant's strengths, capacities, health care, and other needs. The DHS RN will assess the participant's preferences, goals, desired outcomes, and risk factors. Support systems available to the participant are identified and documented, along with services currently in place. Based on this assessment information, the DHS RN will discuss the service delivery plan with the participant.

When the service plan development process results in an individual being denied the services or the providers of their choice, the state must afford the individual the opportunity to request a Fair Hearing.

Provisional (Temporary Interim) Service Plan Policy: A provisional person-centered service plan may be developed by the DHS RN prior to determination of Medicaid eligibility, based on information obtained during the in-home functional assessment if the applicant is functionally eligible based on the Independent Assessment Contractor's assessment . The DHS RN must discuss the Provisional Service Plan Policy and have approval from the applicant prior to completing and processing a provisional service plan, which will then be signed by the applicant or the applicant's representative and the DHS RN. The provisional service plan will be provided to the waiver applicant and each provider included on the service plan. The provider will notify the DHS RN via form AAS-9510 (Start of Care Form), indicating the date services begin. No provisional service plans will be developed if the waiting list process has been implemented.

Provisional person-centered service plans expire 60 days from the date signed by the DHS RN and the participant. A comprehensive service plan that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional service plan. Prior to its expiration date, the DHS RN will provide a signed, comprehensive service plan to the ARChoices provider.

The Independent Assessment Contractor will complete a face-to-face functional assessment within 10 working days of receiving a referral from DHS. The DHS RN meets with the participant and develops an ARChoices person-centered service plan. Once the service plan is signed by the DHS RN and the applicant, it is considered a provisional service plan.

If services are started based on the provisional service plan, providers will send the Start of Care (AAS-9510) form to the DHS RN indicating the date services started. No additional notification to the DHS RN is required when the comprehensive service plan is received.

(c) During the person-centered service plan development process, the DHS RN explains the services available through the ARChoices waiver to the participant, including any applicable benefit limits. All services the participant is currently receiving are discussed and documented on the person-centered service plan. This includes all medical and non-medical services, such as diapers, under pads, nonemergency medical transportation, family support or other services that are routinely provided.

(d) The DHS RN develops the person-centered service plan based on the information gathered through the assessment process and the discussion of available services with the participant. The service plan addresses the participant's needs, goals and preferences. The participant may invite anyone they choose to participate in the assessment and service plan development process, including family members and caregivers. Also, the DHS RN may contact anyone who may be able to provide accurate and pertinent information regarding the participant's condition and functional ability.

If there is any indication prior to or during the assessment or person-centered service plan development process that the participant is confused or incapable of answering the questions required for a proper assessment and service plan development, the assessment or service plan development will not be conducted without another person present who is familiar with the participant and his or her condition. This may be a family member, friend, neighbor, caregiver, etc. If unavailable for the interview, this person may be contacted by phone. These individuals' participation in the service plan development process also helps to ensure that the participant's goals, preferences and needs are met.

When developing or updating the person-centered service plan, the participant and their representatives participate in all decisions regarding the types, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services.

(e)- The participant must choose a provider for each waiver service selected. During the service plan development process, the DHS RN informs the participant or their legal guardian or family member of the available services. The participant or guardian/family member may choose the providers from which to receive services. Documentation verifying freedom of choice was assured is included in the participant's record on the person-centered service plan, and on the provider list. Both documents reflect freedom of choice was given to the participant. The freedom of choice form and all related documents are included in the participant's record and reviewed during the DHS RN supervisory review process. Each service included on the service plan is explained by the DHS RN. The amount, frequency, scope and provider of each service is also discussed and entered on the service plan. The DHS RN sends a copy of the service plan to the waiver provider, as well as the participant. The DHS RN tracks the implementation of each service through the Start of Care form, which includes the date services begin.

(f)- Implementation, compliance, and monitoring of the person-centered service plan is the responsibility of DAABHS (Operating Agency), DMS (Medicaid Agency), and providers of ARChoices in Homecare waiver services.

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DHS RN, who is the only authorized individual who may adjust a participant's service plan. Providers agree to render all services in accordance with the Arkansas Medicaid ARChoices in Homecare Home & Community Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or necessitate a change in the participant's person-centered service plan; to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS RN in writing within one week of services being terminated, documenting the termination effective date and the reason for the termination.

Providers assure DPSQA that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted an ARChoices in Homecare service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS RN. Providers acknowledge that the DHS RN is the only authorized individual who may adjust an ARChoices in Homecare waiver participant's service plan. Providers will implement the service plan with the flexibility to schedule hours to best meet the needs of the participant and will be monitored by DAABHS for compliance.

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

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

D-1: (5 of 8) Risk Assessment and Mitigation

The Independent Assessment Contractor assesses a participant's needs, functional abilities, and performance of activities of daily living during the assessment. The DHS RN assesses a participant’s preferences, risks, dangers, and supports during the meeting with the participant to develop a person-

centered service plan. In addition, the service plan development process includes assessment of risk factors and strategies to mitigate risk conducted in a manner that is sensitive to the waiver participant's preferences and the responsibilities required to reduce risk. The risk mitigation includes factors regarding the participant's functioning ability, ADL performance, support systems in place, risk of falls, environmental factors, and other dangers. This information is included on the person-centered service plan and in the participant's record. Services are started as soon as possible in order to mitigate risk.

The person-centered service plan also includes contact information for emergency care and backup plans. The name of a backup caregiver, or the person responsible for the participant, must be included on the person-centered service plan. Backup caregivers are often family members, neighbors or others familiar with the participant.

Routine monitoring of ARChoices in Homecare participants also helps to assess and mitigate risk. DHS RNs make at least annual contact with participants and take action to mitigate risks if an issue arises. Targeted Case Managers are required to monitor the participant monthly at a minimum and must follow frequency requirements as described in the Targeted Case Management Medicaid Provider Manual regarding face-to-face or telephone contacts with the participant. Potential risks identified during these monitoring contacts require the Targeted Case Manager to take action to mitigate the risk.

Also, providers, family members and others who have regular contact with participants are required to report any change in participant condition, or perceived risk or other problem concerning the participant. The DHS RNs also re-evaluate potential participant risks during monitoring visits. DHS RNs and Targeted Case Managers refer any high-risk participants to Adult Protective Services immediately if it is felt that the participant is in danger. DHS RNs also provide patient education on safety issues during the assessment and annual reassessment. The annual contact by the DHS RN is a minimum contact standard. Visits are made as needed during the interim.

Service providers are required to follow all guidelines in the Medicaid Provider manual related to emergencies, including the emergency backup plan process and contact information for emergencies. The provider assures DAABHS all necessary safeguards and precautions have been taken to protect the health and welfare of the participants they serve. Providers agree to operate and provide services in full compliance with all applicable federal, state and local standards including, but not limited to, fire, health, safety and sanitation standards prescribed by law or regulations. Providers assure DAABHS that conditions or circumstances which place a person, or the household of a person, in imminent danger will be brought to the attention of appropriate officials for follow-up. Providers agree to inform the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or would necessitate a change in the participant's service plan.

Also, participants, family members or the participant's representative may also contact the DHS RN or Targeted Case Manager any time a change is needed or a safety issue arises. Additional monitoring is performed by DMS as part of the validation review, by Office of Medicaid Inspector General audits, and in response to any complaints received.

D-1: (6 of 8) Informed Choice of Providers

The participant must choose a provider for each waiver service selected. When a person-centered service plan is developed, the DHS RN must inform the individual, their representative, or family member of all qualified ARChoices in Homecare qualified providers in the individual's service delivery area. The participant, representative, or guardian/family member may choose the providers from which to receive services. The name of the providers chosen by the participant, representative, or family member/representative must be included on the person-centered service plan prior to securing the individual's signature. Along with signing the service plan, and the Freedom of Choice form, an up-to-date provider listing from DPSQA must be signed and initialed. If a family member/representative chooses a provider for the participant, the DHS RN must identify the individual who chose the providers on the service plan and on the Freedom of Choice form. Documentation is also included in the participant's record and reviewed during the DHS RN supervisory review process.

For reassessments, the participant or representative must sign the Freedom of Choice form to show that no change in providers was made. The provider listing does not need to be initialed if there are no changes in providers. However, if a participant wishes to change providers at reassessment, both the Freedom of Choice form and provider listing must be signed and initialed indicating this change. Participants may request a change of providers at any time during a waiver year.

The participant chooses the provider. However, the participant may invite his or her family members or representative to participate in the decision-making process. Any decision made by a family member or representative is done at the participant's request and is documented.

DHS RNs and Targeted Case Managers leave contact information with participants at each visit. The participant may contact the DHS RN at any time to find out more information about providers.

Appendix D: Participant -Centered Planning and Service Delivery
D-1: Service Plan Development (7 of 8)

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

All ARChoices in Homecare person-centered service plans are subject to the review and approval of the Division of Aging, Adult, and Behavioral Health Services (Operating Agency), and the Division of Medical Services (Medicaid Agency).

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval and are made available by the operating agency upon request. DMS reviews a validation sample of participants' records which includes the person-centered service plan. Reviewed service plans are compared to policy guidelines, the functional assessment, and the case notes detailing the participant's living environment, physical and mental limitations, and overall needs.

A statistically valid random sample of service plans is determined, using the Raosoft software calculations program, for review by the DHS RN supervisory staff. Records are reviewed to assess the appropriateness of the service plan, to validate service provision, to ensure that services are meeting the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS RN addresses any needed

corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the Office of Medicaid Inspector General.

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

Information reviewed by both DAABHS and DMS during the record review process includes, but is not limited to: development of an appropriate individualized person-centered service plan, completion of updates and revisions to the service plan and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

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

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

X *Operating agency*

Specify:

The service plan is maintained by the DHS RN in the participant's record and by the ARChoices waiver provider.

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Waiver participants are monitored through a variety of means and all monitoring by DAABHS waiver staff, Targeted Case Managers, and providers includes compliance with the service plan, the health and welfare of the participant, access to services, effectiveness of backup plans, and complaints or problems. Contact with ARChoices participants is maintained to ensure that services are furnished according to the person-centered service plan and that the services meet the participant's needs. Monitoring is an essential component of Targeted Case Management. Targeted Case Managers are required to conduct routine monitoring and report to the DHS RN. Targeted Case Managers must follow the monitoring guidelines and timeframes outlined in the Medicaid Provider Manual.

DHS RNs:

DHS RNs monitor each waiver participant's status on an as-needed basis for changes in service need, reassessment (if necessary), and reporting any participant's complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant may invite anyone they choose to participate in the visit. Most often this is the participant's legal guardian, representative or family member.

At each person-centered service planning meeting, the DHS RN provides the participant with their contact information, an Adult Protective Services (APS) brochure to provide information and the toll-free APS hotline for reporting abuse, maltreatment or exploitation. This information

may be utilized by the participant or guardians/family members to report any issues they deem necessary, so that DAABHS can ensure prompt follow-up to problems.

ARCHOICES IN HOMECARE PROVIDERS:

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting, and documentation requirements. Provider are required to report any change in the participant's condition to the participant's DHS RN.

Targeted Case Managers:

Targeted Case Management is included on each ARChoices service plan, unless declined by the participant.

Targeted Case Managers must maintain contact with participants as frequently as needed, with a minimum of one contact monthly to help determine whether services are being furnished according to the participant's person-centered service plan, the adequacy of the services in the service plan, and changes in the participant's needs or status. These contacts may be face-to-face or by telephone, according to established policy as outlined in the Targeted Case Management Medicaid Provider Manual. Targeted Case Managers must give participants their office phone numbers, and leave a business card or contact sheet in the participant's home in case of concerns or questions.

Targeted Case Managers must conduct monitoring according to current policy, including initial meetings with participants to discuss the participant's needs and to determine who currently provides for any or all of their needs. Following the initial home visit, Targeted Case Managers must make unannounced face-to-face monitoring visits as required by current policy.

If the participant's circumstances remain stable, no provider changes are made and no problems noted, unannounced face-to-face monitoring visits must continue according to current policy. During months no face-to-face visit is conducted, a telephone contact must be made. An ARChoices in Homecare Monitoring Form must be completed during face-to-face visits. A contact is not considered a face-to-face monitoring contact unless the required monitoring form is completed, dated and signed by the case manager and filed in the participant's record. Documentation in the narrative of the participant's record will suffice for telephone contacts, rather than completing the monitoring form. All face-to-face and telephone contacts must be documented in the participant's case record for review and audit purposes.

During each home visit, the Targeted Case Manager must document the participant's condition, the condition of the home, living environment, adequacy of the participant's person-centered service plan, and overall success of service plan delivery. Any problems, changes, complaints, observations, concerns or other participant issues (e.g., provider changes, information regarding change of condition, hospital admissions, hospital discharges, address changes, telephone number changes, deaths, any change in waiver or non-waiver services) must be documented in the participant's record and reported immediately to the DHS RN via the Change of Client Status form (AAS-9511) or email. The AAS-9511 may be transmitted via fax or email to the DHS RN. Copies of required forms and/or communication must be maintained in the participant's record.

Targeted Case Managers review the person-centered service plan with the participant during all face-to-face visits to ensure that services are being provided according to the plan. The Targeted Case Manager will also measure the participant's progress toward service plan goals.

The contacts listed above are a minimum requirement. In an effort to assure health and safety, compliance with the waiver person-centered service plan, and the integrity of services billed to the Medicaid Program, it is the Targeted Case Manager's responsibility to visit, call and support the waiver participant as much as is needed based on the individual's circumstances and the stability of their services.

INFORMATION EXCHANGE:

Both DMS and DAABHS perform regular reviews to support proper implementation and monitoring of the person-centered service plan. Record reviews are thorough and include a review of all required documentation regarding compliance with the service plan development assurance. Reviews include, but are not limited to, completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services; consideration of participants in the service plan development process; clarity and consistency; and, compliance with program policy regarding all aspects of the service plan development, changes and renewal.

The DHS RN maintains an established caseload, covering certain counties in Arkansas. Each participant knows his or her DHS RN and has the DHS RN's contact information. DHS RN supervisors assist in the resolution of problems, monitor the work performed by the DHS RNs by making periodic visits with each DHS RN, and assist in overall program monitoring and quality assurance. Additionally, a record review process is conducted on a monthly basis by DHS RN supervisors. Records are pulled at random and reviewed for accuracy and appropriateness in the areas of medical assessments, service plans, level of care determinations and documentation. Selection begins by reviewing the latest monthly report from the Arkansas Client Eligibility System (ACES). This report reflects all active cases and includes each participant's waiver eligibility date. Records are pulled for review based on established eligibility dates. A comparable pull is made to review new eligibles, established eligibles, recent closures and changes. This method results in all types of charts being reviewed for program and procedural compliance. DAABHS supervisory staff uses the Raosoft Calculation System to determine the appropriate sample size for record review with a 95% confidence level and a margin of error of +/-5%, and selects every name on the list to be included in the sample.

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

D-2: Service Plan Implementation and Monitoring

b. Monitoring Safeguards. *Select one:*

X **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducting in the best interests of the participant**.** *Specify:*

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to emergencies, including the emergency backup plan process and contact information for emergencies. Providers agree to inform the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or would necessitate a change in the participant's person-centered service plan.

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

ARChoices in Homecare providers assure DPSQA that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted an ARChoices in Homecare waiver person-centered service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS RN. Providers acknowledge that the DHS RN is the only authorized individual who may adjust an ARChoices in Homecare waiver participant's service plan. Providers accept full responsibility for the quality and number of service units provided to an ARChoices in Homecare waiver participant by their staff, and assure DAABHS appropriate management and supervision of services takes place at all times.

Person-centered service plans are revised by DHS RNs as needed between assessments, based on information secured through providers, waiver participants and their support systems.

Targeted Case Managers monitor waiver participants' status as needed for changes in service need, referring participants for reassessment if necessary and reporting any participant complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant's legal representative, guardian or family member may participate on their behalf. This oversight ensures that participants are receiving the specified services to meet their needs and according to the person-centered service plan.

DHS RNs and Targeted Case Managers must document all contacts (in person, telephone or correspondence) with or on behalf of the participant in the participant's case record. If a monitoring contact produces any information that warrants further action, DHS RNs and Targeted Case Managers are responsible for following through and taking any action deemed appropriate.

Appendix D: Participant-Centered Planning and Service Delivery
Quality Improvement: Service Plan

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

i. Sub-Assurances

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

Performance Measures:

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

Number and percent of participants reviewed who had service plans that addressed risk factors. Numerator: Number of participants' service plans that address risk factors; Denominator: Number of records reviewed.

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

Performance Measures:

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

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

Performance Measures:

Number and percent of service plans that were reviewed and updated by the DHS RN according to changes in participants' needs before the waiver participants' annual review date. Numerator: Number of participants' service plans that were reviewed and revised by the DHS RN before annual review date; Denominator: Number of records reviewed.

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

d. ***Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*** **Performance Measures:**
Number and percent of participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan. Numerator: Number of participants' service plans who received services specified in the service plan; Denominator: Number of records reviewed.
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

e. ***Sub-Assurance:*** *Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*
Performance Measures:
Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed.
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

Appendix F: Participant Rights
Appendix F-1: Opportunity to Request a Fair Hearing
Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The form DCO-707 (Notice of Action) is issued by the DHS County Office to provide notice to an applicant or waiver participant of any action taken with regard to Medicaid and program eligibility, such as approval and eligibility effective dates, denial and denial effective dates, the reason for action taken, and requests that further information be provided to the DHS County Office by the applicant or participant.

Waiver applicants and participants are advised on the DCO-707 (Notice of Action) or the system-generated Notice of Action by the DHS County Office when adverse action is taken to deny, suspend, reduce, or terminate eligibility for ARChoices in Homecare. The notice explains the action taken, the effective date of the action, the reason for the action, and explains the applicant's or participant's right to a hearing if the individual disagrees with the action the DHS County Office plans to take, the 30-day deadline for requesting a hearing, how to file for a hearing, and the applicant's or participant's right to representation.

Fair hearings are the responsibility of the Department of Human Services, Appeals and Hearings Office. This information and the contact information for the Appeals and Hearings Office is provided on the form DCO-707. The form is available in Spanish and large print formats, and advises the applicant or participant of such.

DHS has set guidelines for retention of the form DCO-707 in the applicant's or participant's case record. If the DCO-707 is a request for information only, the form may be discarded when all requested information is received by the LTSS Eligibility Caseworker. If the information requested is not received, the form may be discarded five years from the month of origin of the request. All other DCO-707 forms will be retained in the applicant's or participant's case record for five years from the date of the last approval, closure or denial.

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

ARChoices participants have the option of continuing Medicaid eligibility and services during the appeal process. They are informed of their options when notified by the DHS county office of the pending adverse action. If the findings of the appeal are not in the participant's favor, and the participant has elected the continuation of benefits, the participant is liable for payment to the provider. If Medicaid has paid the provider, DHS will consider the services that were provided during the period of ineligibility a Medicaid overpayment and will seek reimbursement from the participant.

Participants have the right to appeal if they were not provided a choice in institutional care or waiver services, or a choice of providers.

The service providers and the Department of Human Services county office inform the participant of their potential payment liability if a participant has been denied eligibility for the program and if the determination of an appeal is not in the participant's favor.

During the service plan development process, the DHS RN explains these rights to the participant, family member or representative. Signatures on the service plan verify that the choice between waiver services or institutional care was exercised. Also, during this process, participants choose a provider from a list provided by the DHS RN. Choices of provider are documented on the Freedom of Choice form, and the participant signs the list of providers showing that the choice was made.

NOTE: For reassessments, the freedom of choice form is utilized showing no changes are requested by the participant. No signatures are required on the provider listing; however, the freedom of choice form is signed by the participant or their representative.

Appendix F-3: State Grievance/Complaint System

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Division of Aging, Adult, and Behavioral Health Services

c. Description of System: Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAABHS Central Office or their DHS RN. When DAABHS is contacted regarding a complaint or dissatisfaction, DAABHS explains the complaint process to the participant, and completes the HCBS Complaint Intake Report electronically. Any DAABHS staff receiving a complaint must complete the HCBS Complaint Intake report. DPSQA is responsible for investigating complaints pertaining to provider quality or compliance.

The HCBS Complaint database, is used to track any dissatisfaction or complaint, including complaints against DAABHS staff and DPSQA-certified providers (including individual providers, provider organizations, and employees and contractors of provider organizations). The record of complaint includes the date the complaint was filed.

The complaint database was designed to register different types of complaints. Based on the data entered, the complaint can be tracked by type of complaint (service, provider, DAABHS, etc.) and complaint source (participant, county office, family, etc.), and monitored for trends, action taken to address complaint, access, quality of care, health and welfare. The complaint database provides a means to address any type complaint filed by any source. The complaint database also tracks resolution.

Information entered into the database includes the complaint source and contact information, participant information, person or provider against whom the complaint is being made, the person who received the complaint, the person to whom the complaint is assigned for investigation, the complaint being made, and the action taken relative to investigation findings.

Complaints concerning abuse, neglect and exploitation are routed to Adult Protective Services immediately for appropriate action. State law allows HCBS staff and APS staff to share information concerning clients on a need to know basis, but that information may not be re-disclosed to a third party. A.C.A. 12-12-1717(a)(9) allows disclosure of reports to “the department” (DHS) for founded reports and A.C.A. 12-12-1718(a) and (b)(1)(A) allow disclosure of pending and screened out reports to “the department". All APS reports involving waiver participants are reported on the monthly report and tracked by RN supervisory staff.

The HCBS Complaint Intake Report must be completed within five working days from when DAABHS staff received the complaint. Complaints must be resolved within 30 days from the date the complaint was received. If a complaint received by a DHS RN cannot be resolved by a DHS RN supervisor, the information is forwarded to the DAABHS central office administrative staff to resolve. To ensure that participants are safe during these time frames, the DHS RN may put in place the backup plan on the participant’s service plan or report the situation to Adult Protective Services, if needed.

DHS RNs and DHS RN supervisors work to resolve any complaints. This involves contacting all parties involved to obtain all sides of the issue, a participant home visit and a review of the participant's person-centered service plan, if necessary. The Nurse Manager at the DAABHS central office may also be asked to assist. Based on the nature of the complaint, the Nurse Manager will use their professional judgment on issues that must be resolved more quickly, such as instances where the participant's health and safety are at risk. Compliance with this policy is tracked and reported through the database. This issue continues to be tracked and reviewed by the DHS RN Supervisors and the Medicaid Quality Assurance staff during the record review process.

A follow-up call or correspondence is made to the reporter, if appropriate, to discuss how the issue was resolved without violating confidentiality rules. The participant or representative is informed of the right to appeal any decision and that filing a complaint is not a prerequisite or substitute for a fair hearing.

If a participant is dissatisfied with the resolution of a complaint, a fair hearing request may be made at the local DHS county office.

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

A complaint received on a DHS RN is reported to his or her supervisor, who investigates the complaint.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

Arkansas state law requires that suspected abuse, neglect, and exploitation of endangered and impaired adults be reported to the Adult Maltreatment Hotline for investigation. The method of reporting is primarily by phone to the Hotline; written reports of allegations will be entered into the Adult Protective Services system or routed to the appropriate investigative department.

A.C.A. 12-12-1708(a) specifies mandatory reporters who are required to report suspected adult maltreatment, including abuse, exploitation, neglect, or self-neglect of endangered or impaired adults. Mandated reporters include all physicians, nurses, social workers, case managers, home health workers, DHS employees, facility administrators or owners, employees of facilities, and any employee or volunteer of a program or organization funded partially or wholly by DHS who enters the home of, or has contact with an elderly person. ARChoices in Homecare waiver staff, providers, and DAABHS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

According to the statute, adult abuse includes intentional acts to an endangered or impaired adult which result in physical harm or psychological injury; or credible threats to inflict pain of injury which provoke fear or alarm; or unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Exploitation includes illegal or unauthorized use of the person's funds or property; or use of the person's power of attorney or guardianship for the profit of one's own self; or improper acts or process that deprive the person of rightful access to benefits, resources, belongings and assets. Neglect is an act or omission by the endangered or impaired person (self-neglect), or an act or omission by the person's caregiver (caregiver neglect) constituting failure to provide necessary treatment, care, food, clothing, shelter, supervision or medical services; failure to report health problems and changes in health condition to appropriate medical personnel; or failure to carry out a prescribed treatment plan.

Reporting requirements for providers

In addition to statutory requirements, the Division of Provider Services and Quality Assurance, the licensing and certification agency, requires home and community-based services (HCBS)/non-institutional providers to report the following incident types:

(a) Abuse
(b) Neglect
(c) Exploitation or Misappropriation of Property
(d) Unnatural Death
(e) Unauthorized use of restrictive interventions
(f) Significant Medication Error
(g) Elopement/Missing Person
(h) Other: Includes but is not limited to abandonment, serious bodily injury, incidents that require notification to police or fire department.

In accordance with DPSQA Policy 1001, the above events must be reported to the Division of Provider Services and Quality Assurance by facsimile transmission to telephone number 501-682-8551 of the completed Incident & Accident Intake Form (Form DPSQA-731) no later than 11:00 a.m. on the next business day following discovery by the provider. In addition to the requirement of a facsimile report by the next business day, the provider must conduct a thorough investigation of the alleged or suspected incident and complete an investigation report and submit it to DPSQA on Form DPSQA-742 within five working days.

Reporting requirements for DHS employees and contractors

DHS employees and contractors are required to report incidents in accordance with DHS Policy 1090 (Incident Reporting). Under this policy, any incident requiring a report to the DHS Communications Director must be reported by telephone within one hour of the incident. All other reports must be filed with the Division Director or Designee and the DHS Client Advocate no later than the end of the second business day following the incident. Any employee not filing reports within the specified time is subject to disciplinary action unless the employee can show that it was not physically possible to make the report within the required time.

Telephone notifications and informational e-mails to Division Directors or Designees, the DHS Client Advocate and other parties as appropriate for early reporting of unusual or sensitive information are welcomed. All such reports must be followed with completion and submission of Form DHS-1910.

If the incident alleges maltreatment by a hospital, a copy of the report will be sent to the Arkansas Department of Health by the Division Director or Designee, who should note the notification in the appropriate space on the Form DHS-1910, and forward the information to the DHS Client Advocate as a follow up Incident Report.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The DHS RN provides waiver applicants and their families with an Adult Protective Services (APS) brochure when initial contact is made. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including to the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DHS RNs review this information with participants and family members at the initial assessment and at each annual reassessment. In addition, providers are required to post information about how to report a complaint to APS and the Adult Maltreatment Hotline in a visible area on their premises.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

For incidents involving alleged abuse, neglect, and exploitation regarding adult clients, Adult Protective Services (APS) receives, investigates, evaluates, and resolves reports. Additionally, all incidents defined in DPSQA Policy 1001 must be reported to Division of Provider Services and Quality Assurance (DPSQA). These include alleged abuse, neglect, and exploitation, unnatural death, unauthorized use of restrictive interventions, significant medication error, elopement/missing person, abandonment, serious bodily injury, and incidents requiring notification to the police or fire department.

Adult Protective Services (APS) Responsibilities

APS visits clients within 24 hours for emergency cases or within three working days for non-emergency cases. Emergency cases are instances when immediate medical attention is necessary or when there is imminent danger to health or safety which means a situation in which death or serious bodily harm could reasonably be expected to occur without intervention, according to Ark. Code Ann. 12-12-1703(8). Non-emergency cases refer to situations when allegations do not meet the definition of imminent danger to health or safety. APS fast tracks waiver participants so they can be seen in 24 hours if possible.

As required by law, investigations are completed and an investigative determination entered within 60 days. APS notifies the client and other relevant parties, including the offender, of the determination.

APS communicates with the waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating

agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.

APS communicates with the ARChoices waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. DPSQA and ARChoices staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

Division of Provider Services and Quality Assurance (DPSQA) Responsibilities

DPSQA receives and triages incidents to appropriate divisions for investigation. DPSQA will investigate those incidents that relate to providers licensed and/or certified by DPSQA and forwards incidents regarding clients to the Division of Aging, Adult, and Behavioral Health Services.

Reports to DPSQA are entered into a tracking system which DPSQA uses to determine if further investigation is needed in the event of multiple complaints at one provider locations or facility. DPSQA uses this resource to monitor active participants of the waiver for critical incidents.

As required by statute, investigations are completed and an investigative determination entered within 60 days.

Unexpected client deaths must be reported immediately to the DPSQA contact using the DHS Client Unexpected Death Report. The DPSQA contact investigates the report within two days of receiving the notice of the occurrence and prepares a report of the investigation within 30 days of receiving the notice of the occurrence. The investigation includes reviewing a written report of the facts and circumstances of the unexpected death and documentation listing the client's condition, including diagnoses, prescriptions and service plan.

The DPSQA contact will determine the facts and circumstances of the occurrence. DPSQA's role includes performing a thorough investigation, reviewing current policy, making corrections if necessary and identifying patterns during the process. Final results of investigations are electronically made available to .

All reports to the Adult Maltreatment Hotline and instances of unexpected client deaths are investigated and addressed by DPSQA. Incidents reported to the DHS Incident Reporting Information System (IRIS), a system which enables online submission and transmittal of incident reports, are investigated depending on the type of incident reported.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Division of Provider Services and Quality Assurance assumes responsibility for compiling all incident reports from providers for review and action. Incidents are reported to DPSQA staff through submission of Form DPSQA-731.

DPSQA staff review the reports as incidents occur and identify patterns and make systematic corrections when necessary. Current policy is reviewed at each occurrence and revisions may be made if necessary.

The Adult Protective Services unit tracks APS incidents. APS informs DPSQA of the outcomes of incidents reported to APS applicable to waiver participants. There is a Memorandum of Understanding between DPSQA and APS unit detailing the relationship and activities of each unit, as they relate to the waiver program.

Final results of APS investigations, final results of unexpected death findings, and results of incident reports are electronically made available to DPSQA.

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

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

X The state does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restraints. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.

DHS RN
Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact the DHS RN regarding any concerns for the participant's health and welfare.

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

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

X **No. This Appendix is not applicable.**

Quality Improvement: Health and Welfare

a. Methods for Discovery: Health and Welfare

i. Sub-Assurances

a. *Sub-Assurance:* *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.* (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures:

Number and percent of critical incidents reviews/investigations that were initiated and completed according program policy and state law. Numerator: Number of

critical incident investigations initiated/completed according to policy/law; Denominator: Number of critical incidents reviewed.
Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up; Denominator: Number of critical incidents reviewed.
Number and percent of participant records reviewed where the participant and/or family or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents as specified in the waiver application. Numerator: Number of participants receiving information on abuse, neglect, exploitation and critical incidents; Denominator: Number of records reviewed.
Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents reviewed.
Case Record Review
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

Arkansas addresses this assurance with a three-step process that involves record review, ongoing communication with Adult Protective Services (APS) and Division of Medical Services (DMS) audits of waiver participants' records. Monthly record reviews are performed by DHS RN supervisors to assure that DHS RNs report incidences of abuse or neglect, and that safety and protection are addressed at each assessment and reassessment and reported in the Record Review Summary Report. APS reports specific cases of abuse and neglect affecting waiver participants to DAABHS waiver staff. Findings are reported to the DMS QA Unit.

DAABHS staff are required to review the APS information with participants and other interested parties at each assessment and reassessment. This must include providing APS brochures, as well as information on how to identify possible abuse and neglect and a toll-free number for reporting abuse. Compliance with this requirement is documented in the participant record and reviewed by RN supervisors during each record review. Compliance is a part of the record review and annual reporting process.

Policy requires compliance and mandates the DHS RN to report alleged abuse to APS and/or the DPSQA Office of Long Term Care (OLTC). All reports of alleged abuse, follow-ups and actions taken to investigate the alleged abuse, along with all reports to APS or OLTC must be documented in the nurse narrative. Record reviews include verification of this requirement and are included on the annual report.

The process for reporting abuse as established in Arkansas Code Annotated 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone

number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult Maltreatment Hotline refers the matter immediately to the appropriate investigating agency. Under this statute, a resident of an assisted living facility is identified as a long-term care facility resident, and for the purposes of the statute is presumed to be an impaired person. A report for a long-term care facility resident is to be made immediately to the local law enforcement agency for the jurisdiction in which the long-term care facility is located, and to OLTC under the regulations of that office. DHS has jurisdiction to investigate all cases of suspected maltreatment of an endangered person or an impaired person. The APS unit of DHS shall investigate all cases of suspected adult maltreatment if the act or omission occurs in a place other than a long-term care facility; and all cases of suspected adult maltreatment if a family member of the adult person is named as the suspected offender, regardless of whether or not the adult is a long-term care facility resident. The OLTC unit of DHS shall investigate all cases of suspected maltreatment of a long-term care facility resident.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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, and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems related to participant health and welfare, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to participant health and welfare for the waiver.

DAABHS's remediation efforts in cases where participants or their family members or legal guardians have not received information about how to report abuse, neglect, exploitation or critical incidents include providing the appropriate information to the participant and family member/legal guardian upon discovery that this information was not provided, providing additional training for DHS RNs and considering this remediation as part of RNs' performance evaluations.

In cases where critical incidents were not reported within required time frames, DAABHS provides remediation, including reporting the critical incident immediately upon discovery, and providing additional training and counseling to staff.
If critical incident reviews and investigations are not initiated and completed according to program policy and state law, DAABHS's remediation includes initiating and completing the investigation immediately upon discovery, and providing additional training and counseling to staff. When appropriate follow-up to critical incidents is not conducted according to methods discussed in the waiver application, DAABHS provides immediate follow-up to the incident and staff training as remediation.

DAABHS provides remediation in cases of investigation and review of unexplained, suspicious and untimely deaths that did not result in identification of preventable and unpreventable causes to include staff and provider training, implementing additional services and imposing provider sanctions. The Unexpected Death Report ensures that

remediation of preventable deaths is captured and that remediation data is collected appropriately.

The DAABHS complaint database collects complaints, the outcomes and the resolution for substantiated complaints. Remediation for complaints that were not addressed during the required time frame includes DAABHS addressing the complaint immediately upon discovery, and providing additional staff training and counseling.

All substantiated incidents are investigated by the DAABHS Deputy Director or his/her designee. DAABHS plans to continue this process and reviewing remediation plans remains in development.

Appendix H: Quality Improvement Strategy (2 of 2)
H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DPSQA analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DMS will meet with the operating agencies (DAABHS and DPSQA) to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue, etc.), complexity of the solution (does it require an amendment to the waiver application), and the financial impact. If it is determined that a system change is needed, a computer service request will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DMS and a priority status is assigned. MMIP prioritizes system changes to MMIS and coordinates implementation with the state fiscal agent. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. The MMIP Unit and the DMS QA Unit monitor the system changes.

As a result of the discovery processes:

The interagency agreements were revised to provide a more visible product to clarify roles and responsibilities between the Division of Medical Services (Medicaid agency), the Division of Aging, Adult, and Behavioral Health Services & Adult Services (operating agency), and the Division of Provider Services and Quality Assurance (operating agency).

The agreement between the two divisions has been modified and is updated at least annually.

Medicaid related issues are documented by DAABHS waiver staff and reviewed by DMS QA staff, and recorded on a monthly report to identify, capture and resolve billing and claims submission problems. Error reports are worked and billing issues are resolved by the DMS QA staff. The DMS QA staff reviews reports for proper resolution. These activities occur on a daily basis, and reviews occur monthly by DMS QA staff.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of Medical Services (DMS) both employ staff to assist in system design. When an issue arises that requires development of a Computer Service Request (CSR), meetings with the DHS information technology consultants, DMS Program Development and Quality Assurance staff, DMS Program Integrity staff, and DAABHS waiver staff are held to address needs and resolve issues, including developing new elements and testing system changes. Meetings are scheduled on an as-needed basis with the assigned DHS information technology consulting firm, the Medicaid program's fiscal agent, the DAABHS Deputy Director, DMS QA staff and others as may be appropriate depending on the issue for discussion.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DAABHS and DMS monitor the Quality Improvement Strategy on an ongoing basis and review the Quality Improvement Strategy annually. A review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systematic issues found through discovery and notating desired outcomes. When change in the strategy is indicated, a collaborative effort between DMS and DAABHS is set in motion to complete a revision to the Quality Improvement Strategy which may include submission of a waiver amendment. DMS QA staff utilizes the Quality Improvement Strategy during all levels of QA reviews.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MMIS claims data are audited periodically for program policy alignment, and claims processing worksheets are audited, processed and returned on a daily basis. Discovery and monitoring also includes an ongoing review of annual CMS-372S reports and quarterly CMS-64 reports. DMS reviews are validation reviews of 20% of the records reviewed by DPSQA and include a review of the services billed and paid when compared with the services listed on a participant's person-centered service plan.

The Arkansas Office of Medicaid Inspector General (OMIG) conducts an annual random review of HCBS waiver programs. If the review finds errors in billing, OMIG recoups the money from the waiver provider. If fraud is suspected, the Office of Medicaid Inspector General refers the waiver provider to the Medicaid Fraud Control Unit and Arkansas Attorney General's Office for appropriate action.

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

DAABHS is responsible for the rate determination with oversight conducted by the DMS (Medicaid agency) Financial Section prior to implementation. There is an established procedure followed by both divisions that ensures DMS reviews and approves all reimbursement rates and methodologies. As ARChoices is not a participant-directed program, payment rates are not routinely sent separately to waiver participants. Rates are published for comment and are made available to all providers. Additionally, providers are notified any time a rate changes via a Provider Information Memorandum from DAABHS and/or an Official Notice from DMS. The public is afforded an opportunity to comment on the rate determination process through the DMS website, in the Proposed Rules for Public Comment section. Upon certification, new providers are referred to the Medicaid Provider Manual, which lists rate information.

Various methodologies are used for rate determination depending on the waiver service. The following are the methods used for rate setting for the ARChoices waiver services:

Attendant Care - Attendant Care service is a fee-for-service rate established and approved by the Division of Medical Services (Medicaid agency) and is equivalent to the rate established for state plan agency personal care services that are services similar to Attendant Care services. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Adult Day Health - The various components included in the provision of adult day health services and their costs were provided by providers of adult day health services. The component costs provided included both administrative costs and costs for the provision of adult day health services. The components provided by adult day health providers included salaries, fringe, supplies, travel, facilities and equipment, communications, meals, education and training, maintenance, insurance and other fees, RN supervision and management and general. Fringe, travel/transportation, and meals are not a part of adult day health services provided to ARChoices waiver recipients and thus are not a part of the service definition and were not considered in the rate determination for adult day health services. These costs are considered administrative costs. Using the actual costs of appropriate components included in the provision of adult day health services for the latest SFY, the rate/unit cost of adult day health services was determined. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Respite - Respite service is a fee-for-service rate established and approved by the Division of Medical Services (Medicaid agency) and is equivalent to the rate established for state plan agency personal care services that are services similar to respite services. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Adult Day Services - The various components included in the provision of adult day services and their costs were provided by providers of adult day services. The component costs provided included both administrative costs and costs for the provision of adult day services. The components provided by adult day providers included salaries, fringe, supplies, travel, facilities and equipment, communications, meals, education and training, maintenance, insurance and other fees, RN supervision and management and general. Fringe, travel/transportation, and meals are not a part of

adult day services provided to ARChoices waiver recipients and thus are not a part of the service definition and were not considered in the rate determination for adult day services. These costs are considered administrative costs. Using the actual costs of appropriate components included in the provision of adult day services for the latest SFY, the rate/unit cost of adult day services was determined. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Home-Delivered Meals - the home delivered meal rate was established using the cost for the meal, plus the cost for delivery. The rate is sufficient to secure a sufficient number of providers.

Personal Emergency Response System (PERS) - the rate for the PERS service was established using usual and customary rates and is sufficient to secure a sufficient number of providers.

Prevocational Services – Prevocational services is a fee-for-service rate established and approved by the Division of Medical Services (Medicaid agency). The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Environmental Accessibility Adaptations/Adaptive Equipment - A maximum amount of $7,500 per lifetime of each active participant was approved by the Medicaid agency to cover this service. The amount may be utilized all at once or for separate services. The amount was established utilizing usual and customary charges for adaptive equipment and environmental accessibility adaptations. The rate is consistent with efficiency, economy and quality of care, and is sufficient to enlist plenty of providers.

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

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

Facility-Based Respite care is available in licensed facilities, as indicated in Appendix C. Reimbursement does not include the cost for room and board. Rates are a fee for service, 1 unit equals 15 minutes of service as described in the service definition.

Quality Improvement: Financial Accountability

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 and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings as needed to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to financial accountability for the waiver.

The performance measure for number and percent of waiver claims paid using the correct rate specified in the waiver application will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate.

DAABHS' remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discovery, making system changes and training staff.

DAABHS remediation for claims for services not specified in the participant's service plan includes adding services to the participant's service plan if necessary, recouping payment to the provider, imposing provider sanctions, training providers and conducting a participant monitoring visit.

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

I-2: Financial Integrity and Accountability

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DPSQA staff verifies services were provided according to the person-centered service plan through an internal monthly monitoring system. When claims are paid incorrectly, adjustments are made, recoupments are initiated, or case is referred to the Office of Medicaid Inspector General.

All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable.

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8504.21	9666	18170.21	47580	2520	50100	31929.79
2	7726.73	9934	17660.73	48898	2590	51488	33827.27
3	8248.9	10209	18457.9	50252	2662	52914	34456.1
4	4704.77	10492	15196.77	51644	2735	54379	39182.23
5	5503.41	10782	16285.41	53075	2811	55886	39600.59

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	
Year 1	11350		
Year 2	11350		
Year 3	11350		
Year 4	11350		
Year 5	11350		

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

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

Waiver Services	
Adult Day Health	
Respite	
Adult Day Services	
~~**Adult Family Home**~~ **[**delete from table] Prevocational Services [Add to table]	
Attendant Care Services	
Environmental Accessibility Adaptations/Adaptive Equipment	
Home-Delivered Meals	
Personal Emergency Response System (PERS)	

J-2: Derivation of Estimates (5 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**799606**
Adult Day Health		15 Minutes	63	4068	3.12	**799606**	
Respite Total:							**6441774**
Respite In-Home		15 Minutes	1147	1228	4.5	**6338322**	
Respite Short-Term Facility-Based		15 Minutes	75	779	1.68	**98154**	
Respite Long-Term Facility-Based		15 Minutes	10	946	0.56	**5298**	
Adult Day Services Total:							**2176785**
Adult Day Services		15 Minutes	234	3721	2.5	**2176785**	
Adult Family Home Total:							**12001**
Adult Family Home - Level A		Day	1	76	56.25	**4275**	
Adult Family Home - Level C		Day	1	76	48.22	**3665**	
Adult Family Home - Level B		Day	1	76	53.43	**4061**	
Attendant Care Services Total:							**77957591**
Attendant Care Services		15 Minutes	6577	2291	4.5	**67805582**	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	1050	3806	2.43	**9711009**	
CSM Transition Costs-1st Year		15 Minutes	1050	6	70	**441000**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**715864**
Environmental Accessibility Adaptations/Adaptive Equipment		Package	172	1	4162	**715864**	
Home-Delivered Meals Total:							**6927039**
Home-Delivered Meals		Meal	5422	214	5.97	**6927039**	
Personal Emergency Response System (PERS) Total:							**1492093**
PERS Installation		One Installment	938	1	29.9	**28046**	
PERS Unit Monitoring		Day	5324	257	1.07	**1464047**	
GRAND TOTAL:							96522753
Total: Services included in capitation:							
Total: Services not included in capitation:							96522753
Total Estimated Unduplicated Participants:							11350

Factor D (Divide total by number of participants):	8504.21
Services included in capitation:	0
Services not included in capitation:	8504.21
Average Length of Stay on the Waiver:	276

J-2: Derivation of Estimates (6 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**799606**
Adult Day Health		15 Minutes	63	4068	3.12	**799606**	
Respite Total:							**6574398**
Respite In-Home		15 Minutes	1171	1228	4.5	**6470946**	
Respite Short-Term Facility-Based		15 Minutes	75	779	1.68	**98154**	
Respite Long-Term Facility-Based		15 Minutes	10	946	0.56	**5298**	
Adult Day Services Total:							**2176785**
Adult Day Services		15 Minutes	234	3721	2.5	**2176785**	
Adult Family Home Total:							**12001**
Adult Family Home - Level A		Day	1	76	56.25	**4275**	
Adult Family Home - Level C		Day	1	76	48.22	**3665**	
Adult Family Home - Level B		Day	1	76	53.43	**4061**	
Attendant Care Services Total:							**68857151**
Attendant Care Services		15 Minutes	6679	2291	4.5	**68857151**	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0	2.43	**0**	
CSM Transition Costs-1st Year		15 Minutes	0	0	70	**0**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**753322**
Environmental Accessibility Adaptations/Adaptive Equipment		Package	181	1	4162	**753322**	
Home-Delivered Meals Total:							**7033078**
Home-Delivered Meals		Meal	5505	214	5.97	**7033078**	
Personal Emergency Response System (PERS) Total:							**1492093**
PERS Installation		One Installment	938	1	29.9	**28046**	

PERS Unit Monitoring		Day	5324	257	1.07	**1464047**	
GRAND TOTAL:	**87698432.4**						87698434
Total: Services included in capitation:							
Total: Services not included in capitation:	87698432.4						87698434
Total Estimated Unduplicated Participants:	**11350**						11350
Factor D (Divide total by number of participants):	**7726.73**						7726.73
Services included in capitation:							0
Services not included in capitation:	7726.73						7726.73
Average Length of Stay on the Waiver:							276

J-2: Derivation of Estimates (7 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**863067**
Adult Day Health		15 Minutes	68	4068	3.12	**863067**	
Respite Total:							**6707022**
Respite In-Home		15 Minutes	1195	1228	4.5	**6603570**	
Respite Short-Term Facility-Based		15 Minutes	75	779	1.68	**98154**	
Respite Long-Term Facility-Based		15 Minutes	10	946	0.56	**5298**	
Adult Day Services Total:							**2223298**
Adult Day Services		15 Minutes	239	3721	2.5	**2223298**	
Adult Family Home Total:							**24000**
Adult Family Home - Level A		Day	2	76	56.25	**8550**	
Adult Family Home - Level C		Day	2	76	48.22	**7329**	
Adult Family Home - Level B		Day	2	76	53.43	**8121**	
Attendant Care Services Total:							**74331495**
Attendant Care Services		15 Minutes	7210	2291	4.5	**74331495**	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0	2.43	**0**	
CSM Transition Costs-1st Year		15 Minutes	0	0	70	**0**	

Environmental Accessibility Adaptations/Adaptive Equipment Total:							**844886**
Environmental Accessibility Adaptations/Adaptive Equipment		Package	203	1	4162	**844886**	
Home-Delivered Meals Total:							**7139117**
Home-Delivered Meals		Meal	5588	214	5.97	**7139117**	
Personal Emergency Response System (PERS) Total:							**1492093**
PERS Installation		One Installment	938	1	29.9	**28046**	
PERS Unit Monitoring		Day	5324	257	1.07	**1464047**	
GRAND TOTAL:							93624978
Total: Services included in capitation:							
Total: Services not included in capitation:							93624978
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							8248.9
Services included in capitation:							0
Services not included in capitation:							8248.9
Average Length of Stay on the Waiver:							276

J-2: Derivation of Estimates (8 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**983561**
Adult Day Health		15 Minutes	77	4068	3.14	**983561**	
Respite Total:							**7223887**
Respite In-Home		15 Minutes	1280	1228	4.53	**7120435**	
Respite Short-Term Facility-Based		15 Minutes	75	779	1.68	**98154**	
Respite Long-Term Facility-Based		15 Minutes	10	946	0.56	**5298**	
Adult Day Services Total:							**2343672**
Adult Day Services		15 Minutes	255	3721	2.47	**2343672**	

Adult Family Home Total:							**0**
Adult Family Home - Level A		Day	0	0	0	**0**	
Adult Family Home - Level C		Day	0	0	0	**0**	
Adult Family Home - Level B		Day	0	0	0	**0**	
Prevocational Services Total:							**282974**
Prevocational - Skills Development		Hour	114	67	25.59	**195456**	
Prevocational - Career Exploration		Hour	114	30	25.59	**87518**	
Attendant Care Services Total:							**32724720**
Attendant Care Services		15 Minutes	4200	1720	4.53	**32724720**	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0	2.43	**0**	
CSM Transition Costs-1st Year		15 Minutes	0	0	70	**0**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**915640**
Environmental Accessibility Adaptations/Adaptive Equipment		Package	220	1	4162	**915640**	
Home-Delivered Meals Total:							**7429128**
Home-Delivered Meals		Meal	5815	214	5.97	**7429128**	
Personal Emergency Response System (PERS) Total:							**1495548**
PERS Installation		One Installment	938	1	29.9	**28046**	
PERS Unit Monitoring		Month	5324	8.45	32.62	**1467502**	
GRAND TOTAL:							53399130
Total: Services included in capitation:							
Total: Services not included in capitation:							53399130
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							4704.77
Services included in capitation:							0
Services not included in capitation:							4704.77
Average Length of Stay on the Waiver:							276

J-2: Derivation of Estimates (9 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**996335**
Adult Day Health		15 Minutes	78	4068	3.14	**996335**	
Respite Total:							**8030499**
Respite In-Home		15 Minutes	1425	1228	4.53	**7927047**	
Respite Short-Term Facility-Based		15 Minutes	75	779	1.68	**98154**	
Respite Long-Term Facility-Based		15 Minutes	10	946	0.56	**5298**	
Adult Day Services Total:							**2499917**
Adult Day Services		15 Minutes	272	3721	2.47	**2499917**	
Adult Family Home Total:							**0**
Adult Family Home - Level A		Day	0	0	0	**0**	
Adult Family Home - Level C		Day	0	0	0	**0**	
Adult Family Home - Level B		Day	0	0	0	**0**	
Prevocational Services Total:							**282974**
Prevocational - Skills Development		Hour	114	67	25.59	**195456**	
Prevocational - Career Exploration		Hour	114	30	25.59	**87518**	
Attendant Care Services Total:							**40516320**
Attendant Care Services		15 Minutes	5200	1720	4.53	**40516320**	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0	2.43	**0**	
CSM Transition Costs-1st Year		15 Minutes	0	0	70	**0**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**1040500**
Environmental Accessibility Adaptations/Adaptive Equipment		Package	250	1	4162	**1040500**	
Home-Delivered Meals Total:							**7601601**
Home-Delivered Meals		Meal	5950	214	5.97	**7601601**	
Personal Emergency Response System (PERS) Total:							**1495548**
PERS Installation		One Installment	938	1	29.9	**28046**	
PERS Unit Monitoring		Month	5324	8.45	32.62	**1467502**	

GRAND TOTAL:	62463694
Total: Services included in capitation:	
Total: Services not included in capitation:	62463694
Total Estimated Unduplicated Participants:	11350
Factor D (Divide total by number of participants):	5503.41
Services included in capitation:	0

Services not included in capitation:	5503.41
Average Length of Stay on the Waiver:	276

200.000 ARCHOICES IN HOMECARE (ARCHOICES) HCBS WAIVER PROGRAM GENERAL INFORMATION

201.000 Arkansas Medicaid Certification Requirements for ARChoices HCBS Waiver Program 1-1-16

All ARChoices Home and Community-Based Services (HCBS) Waiver providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

ARChoices HCBS Waiver providers must be licensed and/or certified by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

Certification by the Division of Provider Services and Quality Assurance ~~Aging and Adult Services~~ does not guarantee enrollment in the Medicaid program.

All providers must maintain their provider files at the Provider Enrollment Unit by submitting current certification, licensure, all DPSQA~~DAAS~~-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider, etc.

Copies of licensure/certifications and renewals required by DPSQA~~DAAS~~ must be maintained by DPSQA~~DAAS~~ to avoid loss of provider certification. These copies must be submitted to DPSQA~~DAAS~~ Provider Certification. **View or print the Division of Provider Services and Quality Assurance ~~Aging and Adult Services~~ Provider Certification contact information.** Payment cannot be authorized for services provided beyond the certification period.

~~201.010 ARChoices Transition Plan 10-1-16~~

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

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

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

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

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

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

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

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

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

201.100 Providers of ARChoices HCBS Waiver Services in Bordering and Non-Bordering States 1-1-16

An ARChoices provider must be physically located in the State of Arkansas or physically located in a bordering state and serving a trade-area city. The trade-area cities are limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas.

All providers must be licensed and/or certified by their states' appropriate licensing/certifying authorities. Copies of all appropriate licenses and certifications must be submitted to DPSQA~~DAAS~~ for certification as a potential ARChoices provider.

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

201.105 Provider Assurances 10-1-16

A. Agency Staffing

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

The Provider agrees:

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

B. Code of Ethics

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

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized beneficiaries are to accompany the employee to beneficiary's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the beneficiary's residence;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

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

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

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

HCBS settings must have the following characteristics:

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

e. The setting is physically accessible to the individual.

f. Any modification of the additional conditions specified in items 6.a. through 6.~~d~~e. above must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:

i. Identify a specific and individualized assessed need.

ii. Document the positive interventions and supports used prior to any modifications to the PCSP.

iii. Document less intrusive methods of meeting the need that have been tried but did not work.

iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

viii. Include an assurance that interventions and supports will cause no harm to the individual.

210.000 PROGRAM COVERAGE

211.000 Scope 1-1-16

The Arkansas Medical Assistance (Medicaid) Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to persons age 21 through 64 who are determined to have a physical disability through the Social Security Administration or the DHS Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or are 65 years of age or older and require an intermediate level of care in a nursing facility. The community-based services offered through the ARChoices Home and Community-Based Waiver, described herein as ARChoices, are as follows:

~~Adult Family Homes~~

A. Attendant Care Services

B. Home-Delivered Meals

C. Personal Emergency Response System

D. Adult Day Services

E. Adult Day Health Services

F. Prevocational Services

G. Respite Care

H. Environmental Accessibility Adaptations/Adaptive Equipment

These services are designed to maintain Medicaid eligible beneficiaries at home in order to preclude or postpone institutionalization of the individual.

In accordance with 42 CFR 441.301(b) (1) (ii) ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

212.000 Eligibility for the ARChoices Program 10-1-16

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

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

The ARChoices Program processes for beneficiary intake, assessment, and service plan development include:

1. Determination of categorical eligibility;
2. Determination of financial eligibility;
3. Determination of nursing facility level of care;
4. Development of a person-centered service plan (PCSP);
5. Development of an individual services budget (ISB);
6. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services; and
7. Choice by the beneficiary among certified providers.

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

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

1. The individual is unable to perform either of the following:
   a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon another person; or
   b. At least 2 of the 3 ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or
2. ~~Functional assessment results in a score of three or more on Cognitive Performance Scale~~ The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,

3. ~~Functional assessments results in a Change in Health, End-Stage Disease and Signs and Symptoms (CHESS) score of three or more.~~ The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

~~4. Definitions:~~

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

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

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

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

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

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

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

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

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

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

~~j. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care;~~

and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.

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

ii. Intravenous injections and hypodermoclysis or intravenous feedings.

iii. Levin tubes and nasogastric tubes.

iv. Nasopharyngeal and tracheostomy aspiration.

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

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

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

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

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

x. Ventilator care and maintenance.

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

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

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

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

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

D. Individuals who require a skilled level of care as defined in Department of Human Services regulations are not eligible for the ARChoices waiver.

E. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment. The tiers are intended to help inform waiver program oversight and

administration and person-centered service planning. Tier levels are also a population-based factor used in determining participants' prospective individual services budgets. The tiers do not replace the Level of Care criteria described in Section C above, waiver eligibility determinations, or the person-centered service plan process.

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

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

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

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

For more information on ARIA, please see the ARIA Manual.

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

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

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

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

1. Each ARChoices application will be accepted and medical and financial eligibility will be determined.

2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled and that the applicant is number X in line for an available slot.

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

    a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;

    b. Waiver application determination date for persons being discharged from a

nursing facility after a 90- day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;

c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);

d. Waiver application determination date for all other persons.

212.050 Definitions

A. ARIA ASSESSMENT TOOL means the Arkansas Independent Assessment (ARIA) instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan.

B. DHS RN means a registered nurse authorized by DHS to develop the person-centered service plan for a participant.

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

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

E. INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the ARIA assessment tool for the purpose of collecting information used in determining level of care and developing the person-centered service plan.

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

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

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

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

J. PCSP means a person-centered service plan.

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

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

1. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.
2. Intravenous injections and hypodermoclysis or intravenous feedings.
3. Levin tubes and nasogastric tubes.
4. Nasopharyngeal and tracheostomy aspiration.
5. Application of dressings involving prescription medication and aseptic techniques.
6. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.
7. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.
8. Initial phases of a regimen involving administration of medical gases.
9. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.
10. Ventilator care and maintenance.
11. The insertion, removal and maintenance of gastrostomy feeding tubes.

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

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

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

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

~~**212.100 An Overview of Resource Utilization Groups (RUGs)** **12-1-18**~~

~~The ARChoices Waiver provides beneficiaries with a monthly allocation of attendant care hours to be used at the beneficiary's discretion throughout the month. The number of attendant care hours approved for each beneficiary is based on the results of that beneficiary's most recent assessment using the ArPath Assessment Tool.~~

~~The ArPath Assessment Tool uses a software program that includes an algorithm to evaluate certain responses within an extensive questionnaire to determine whether the beneficiary meets the functional eligibility criteria to participate in the waiver program. The ArPath Assessment Tool then uses another algorithm to evaluate other responses to determine which Resource Utilization Group (RUG) reflects the beneficiary's functional abilities. A RUG is a tier group consisting of individuals with similar functional abilities.~~

~~In 2013, attendant care services were determined based on an RN's discretionary interpretation of a beneficiary's responses to the ArPath Assessment Tool's questionnaire. Between 2013 and~~

~~January 1, 2016, when the ARChoices program was implemented, DAAS recorded beneficiary RUG placement and the number of paid attendant care hours utilized by beneficiaries each month in order to determine the type and amount of resources that beneficiaries with similar functional abilities were used in a given month.~~

~~While the reality of living with a disease or condition can vary greatly even among individuals with the same diagnosis, a RUG placement allows DAABHS to better predict the type and extent of care that an individual needs. The purpose of transitioning to a RUG-based care allocation system is to provide more predictable and objective outcomes that better reflect the reality of a beneficiary's needs by organizing the allocation around functional ability.~~

~~As of January 1, 2016, the allocation of attendant care hours became based on which RUG the beneficiary is placed in by the ArPath Assessment Tool. The specific number of attendant care hours assigned to a particular RUG was determined by considering an average of the number of hours used by beneficiaries placed in that RUG prior to the implementation of the ARChoices program. The following chart shows the number of hours assigned to each RUG.~~

~~RUG Category~~	~~RUG~~	~~Monthly Hours~~
~~Special Rehab~~	~~RB0~~	~~157~~
	~~RA2~~	~~97~~
	~~RA1~~	~~55~~
~~Extensive Care~~	~~SE3~~	~~352~~
	~~SE2~~	~~201~~
	~~SE1~~	~~153~~
~~Special Care~~	~~SSB~~	~~161~~
	~~SSA~~	~~112~~
~~Clinically Complex~~	~~CC0~~	~~143~~
	~~CB0~~	~~94~~
	~~CA2~~	~~69~~
	~~CA1~~	~~36~~
~~Impaired Cognition~~	~~IB0~~	~~116~~
	~~IA2~~	~~81~~
	~~IA1~~	~~38~~
~~Behavioral Problems~~	~~BB0~~	~~118~~
	~~BA2~~	~~62~~
	~~BA1~~	~~30~~
~~Reduced Physical Function~~	~~PD0~~	~~137~~
	~~PC0~~	~~99~~
	~~PB0~~	~~81~~
	~~PA2~~	~~53~~
	~~PA1~~	~~28~~

~~RUG Requirements~~

~~The ArPath Assessment Tool evaluates the assessment responses using an algorithm, which is basically a "rule book" for the software. This particular rulebook is divided into chapters, known as screeners, and each screener is responsible for evaluating a small portion of the assessment responses in order to produce a numerical score. Below is a list of the screeners and the possible scores:~~

~~Screener~~	~~Possible Scores~~
~~Activities of Daily Living (ADL)~~	~~4-18~~
~~Instrumental Activities of Daily Living (IADL)~~	~~0-3~~
~~Rehab~~	~~0-1~~
~~Behavior Problems~~	~~0-1~~
~~Extensive Care~~	~~0-1~~
~~Special Care~~	~~0-1~~
~~Clinically Complex~~	~~0-1~~
~~Cognitive Impairment~~	~~0-1~~
~~Cumulative~~	~~0-5~~

~~Each RUG requires a different combination of screener scores in order for a beneficiary to be placed in that RUG. The ArPath Assessment Tool utilizes the criteria for each RUG in the exact order that they are listed in the above chart and it places the beneficiary in the first RUG on the list whose criteria are satisfied by the assessment responses.~~

~~The following is a description of the screener scores required for each Special Rehab RUG.~~

~~A. RB0 requires a Rehab screener score of 1 and an ADL score of at least 11.~~

~~B. RA2 requires a Rehab screener score of 1, an IADL score of at least 2, and an ADL score of no more than 10.~~

~~C. RA1 requires a Rehab screener score of 1, an IADL score of 1 or 0, and an ADL score of no more than 10.~~

~~The following is a description of the screener scores required for each Extensive Care RUG.~~

~~A. SE3 requires a Cumulative screener score of at least 4, an Extensive Care screener score of 1, and an ADL score of at least 7.~~

~~B. SE2 requires a Cumulative screener score of either 2 or 3, an Extensive Care screener score of 1, and an ADL score of at least 7.~~

~~C. SE1 requires a Cumulative screener score of no more than 1, an Extensive Care screener score of 1, and an ADL score of at least 7.~~

~~The following is a description of the screener scores required for each Special Care RUG.~~

~~A. SSB requires an ADL score of at least 14 and a score of 1 for either the Extensive Care screener or the Special Care screener.~~

~~B. SSA has two possible combinations:~~

1. An Extensive Care screener score of 1 with and ADL score of no more than 6, or

2. An ADL score within the range of 7-13 and a score of 1 for either the Extensive Care screener or the Special Care screener.

The following is a description of the screener scores required for each Clinically Complex RUG.

A. CC0 requires an ADL score of at least 11 and a score of 1 for either the Clinically Complex screener or the Special Care screener.

B. CB0 requires an ADL score within the range of 6-10 and a score of 1 for either the Clinically Complex screener or the Special Care screener.

C. CA2 requires and ADL score no higher than 5, an IADL score of at least 1, and a score of 1 for either the Clinically Complex screener or the Special Care screener.

D. CA1 requires and ADL score no higher than 5, an IADL score of 0, and a score of 1 for either the Clinically Complex screener or the Special Care screener.

The following is a description of the screener scores required for each Impaired Cognition RUG.

A. IB0 requires a Cognitive Impairment screener score of 1 and an ADL score within the range of 6-10.

B. IA2 requires a Cognitive Impairment screener score of 1, an IADL score of at least 1, and an ADL score of no more than 5.

C. IA1 requires a Cognitive Impairment screener score of 1, an IADL score of 0, and an ADL score of no more than 5.

The following is a description of the screener scores required for each Behavioral Problems RUG.

A. BB0 requires a Behavior Problems screener score of 1 and an ADL score within the range of 6-10.

B. BA2 requires a Behavior Problems screener score of 1, an IADL score of at least 1, and an ADL score of no more than 5.

C. BA1 requires a Behavior Problems screener score of 1, an IADL score of 0, and an ADL score of no more than 5.

The following is a description of the screener scores required for each Reduced Physical Function RUG.

A. PD0 requires a Rehab screener score of 0 and an ADL score of at least 11.

B. PC0 requires a Rehab screener score of 0 and an ADL score of 9 or 10.

C. PB0 requires a Rehab screener score of 0 and an ADL score of 6, 7, or 8.

D. PA2 requires a Rehab screener score of 0, an IADL score of at least 1, and an ADL score of no more than 5.

E. PA1 requires a Rehab screener score of 0, an IADL score of 0, and an ADL score of no more than 5.

Screener Requirements

Activities of Daily Living (ADL)

~~A beneficiary's ADL score ranges from 4 to 18. It is based on the collective score among responses to the 5 items in the assessment that are listed below. Only 4 of the 5 responses will add to the overall ADL score because the response to Mode of nutritional intake may override the response to Eating.~~

~~A. Bed mobility~~

~~B. Transfer toilet~~

~~C. Toilet use~~

~~D. Eating~~

~~E. Mode of nutritional intake~~

~~Bed mobility, Transfer toilet, and Toilet use are all scored in the following way:~~

~~A. Independent gets 1 point,~~

~~B. Independent, set up help only gets 1 point,~~

~~C. Supervision gets 1 point,~~

~~D. Limited assistance gets 3 points,~~

~~E. Extensive assistance gets 4 points,~~

~~F. Maximal assistance gets 5 points,~~

~~G. Total dependence gets 5 points, and~~

~~H. Activity did not occur gets 5 points~~

~~Eating is scored in the following way:~~

~~A. Independent gets 1 point,~~

~~B. Independent, set up help only gets 1 point,~~

~~C. Supervision gets 1 point,~~

~~D. Limited assistance gets 2 points,~~

~~E. Extensive assistance gets 3 points,~~

~~F. Maximal assistance gets 3 points,~~

~~G. Total dependence gets 3 points, and~~

~~H. Activity did not occur gets 3 points.~~

~~However, 3 points will be added to the ADL score, and the Eating score will be overridden if the response to Mode of nutritional intake is any of the following:~~

~~A. Combined oral and parenteral or tube feeding,~~

~~B. Nasogastric tube feeding only,~~

~~C. Abdominal feeding tube, or~~

~~D. Parenteral feeding tube only~~

~~E. Instrumental Activities of Daily Living (IADL)~~

A beneficiary's IADL score ranges from 0 to 3. It is based on the collective score among the responses to the following items in the assessment:

A. Meal preparation performance,

B. Managing medication performance, or

C. Phone use performance.

The responses to each item are scored in the following way.

A. Independent gets 0 points.

B. Independent, set up help only gets 0 points.

C. Supervision gets 0 points.

D. Limited assistance gets 0 points.

E. Extensive assistance gets 0 points.

F. Maximal assistance gets 1 point.

G. Total dependence gets 1 point.

H. Activity did not occur gets 1 point.

Rehab

A beneficiary's Rehab screener score is 0 by default, but it equals 1 if during the week prior to the assessment the beneficiary spends a total of at least 120 minutes in any combination of the following types of therapy:

A. Speech-language pathology,

B. Occupational therapy, or

C. Physical therapy.

Behavior Problems

A beneficiary's Behavior Problems score is 0 by default, but it equals 1 if the beneficiary has exhibited any of the following at any time within 3 days of the assessment:

A. Wandering,

B. Verbal abuse,

C. Physical abuse,

D. Socially inappropriate or disruptive behavior,

E. Resists care,

F. Delusions, or

G. Hallucinations.

Extensive Care

A beneficiary's Extensive Care screener score is 0 by default, but it equals 1 if the response to Mode of nutritional intake is either Abdominal feeding tube or Parenteral feeding tube only. It will

~~also equal 1 if the assessment records that any of the following treatments have been utilized within 3 days of the assessment:~~

~~A. IV medication,~~

~~B. Suctioning,~~

~~C. Tracheostomy care, or~~

~~D. Ventilator or respirator.~~

~~Special Care~~

~~A beneficiary's Special Care screener score is 0 by default, but it equals 1 if the assessment records that Radiation therapy has been utilized within 3 days of the assessment or any of the following combinations of responses are logged in the assessment:~~

~~A. A turning/repositioning program has been utilized within 3 days of the assessment and the response to Most severe pressure ulcer is either:~~

~~1. Deep craters in the skin or~~

~~2. Breaks in the skin exposing muscle or bone;~~

~~B. Aphasia has been exhibited within 3 days of the assessment and the Mode of nutritional intake is either:~~

~~1. Nasogastric tube feeding or~~

~~2. Combined oral and parenteral or tube feeding;~~

~~C. Wound care has been performed within 3 days of the assessment and the response to either of the following items is yes:~~

~~1. Major skin problems or~~

~~2. Skin tears or cuts;~~

~~D. Fever and Vomiting are exhibited within 3 days of the assessment;~~

~~E. Fever is exhibited within 3 days of the assessment and the response to Weight loss of 5% is yes;~~

~~F. Fever is exhibited within 3 days of the assessment and the response to Mode of nutritional intake is either:~~

~~1. Nasogastric tube feeding or~~

~~2. Combined oral and parenteral or tube feeding;~~

~~G. Fever is exhibited within 3 days of the assessment and the response to Pneumonia is any of the following:~~

~~1. Primary diagnosis for current stay;~~

~~2. Diagnosis present, receiving active treatment; or~~

~~3. Diagnosis present, monitored but no active treatment;~~

~~H. Fever is exhibited within 3 days of the assessment and the response to Dehydration is yes; or~~

~~I. A beneficiary's ADL score is at least 10 and the response to either Multiple sclerosis or Quadriplegia is any of the following:~~

~~1. Primary diagnosis for current stay;~~

2. Diagnosis present, receiving active treatment; or

3. Diagnosis present, monitored but no active treatment.

Clinically Complex

A beneficiary's Clinically Complex screener score is 0 by default, but it equals 1 if any of the following is recorded during the assessment:

A. Mode of nutritional intake is either Nasogastric tube feeding or Combined oral and parenteral or tube feeding;

B. The response to Cognitive skills for daily decision making is No discernable consciousness, coma and the response to any of the following is either Total dependence or Activity did not occur:

1. Bed mobility,

2. Transfer toilet,

3. Toilet use, or

4. Eating;

C. Any form of Sepsis is recorded in the Other Diseases section of the assessment;

D. The response to Dehydration is yes;

E. The beneficiary's ADL score is at least 10 and the response to Hemiplegia is any of the following:

1. Primary diagnosis for current stay;

2. Diagnosis present, receiving active treatment; or

3. Diagnosis present, monitored but no active treatment;

F. GI or GU bleeding has been exhibited in the 3 days prior to the assessment;

G. The response to Pneumonia is any of the following:

1. Primary diagnosis for current stay;

2. Diagnosis present, receiving active treatment; or

3. Diagnosis present, monitored but no active treatment;

H. The response to End stage disease, 6 or fewer months to live is yes;

I. Chemotherapy was utilized within 3 days of the assessment;

J. Dialysis was utilized within 3 days of the assessment;

K. A transfusion occurred within 3 days of the assessment;

L. Oxygen therapy was utilized within 3 days of the assessment; or

M. The response to Foot problems is either Foot problems limit walking or Foot problems prevent walking.

Impaired Cognition

A beneficiary's Impaired Cognition screener score is 0 by default, but it equals 1 if the score recorded on the Cognitive Performance Scale (CPS) is at least a 3.

Cumulative

~~A beneficiary's Cumulative screener score can range from 0 to 5. It is based on the collective score after adding the scores from the Special Care, Clinically Complex, and Impaired Cognition screeners. An additional point may be added if either of the following occurs:~~

~~A. The response to Mode of nutritional intake is Parenteral feeding only or~~

~~B. IV medication is utilized within 3 days of the assessment.~~

212.200 Prospective Individual Services Budget

A. Individual Services Budget (ISB):

1. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.

2. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by DAABHS for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.

3. Each participant's Individual Services Budget shall be explained when the DHS RN consults with the individual on the person-centered service plan. This may be done through written information.

4. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.

B. Adjustments, Considerations, and Safeguards Regarding Individual Services Budgets:

1. During the development of each person-centered service plan, after considering the participant's assessed needs, priorities, preferences, goals, and risk factors, and to ensure that the cost of all ARChoices services for each participant does not exceed the applicable Individual Services Budget amount, the DHS RN shall, as necessary:

    a. Limit and modify the type, amount, frequency, and duration of waiver services authorized for the participant (notwithstanding any service-specific limits established in Appendix C: Participant Services); and

    b. Make referrals to appropriate services available through the Medicaid State Plan or another waiver program, Medicare, the participant's Medicare Advantage (MA) plan (including targeted and other supplemental benefits the MA plan may offer), the participant's Medicare prescription drug plan, and other federal, state, or community programs.

2. Should the DHS RN determine that the ARChoices waiver services authorized for the participant within the limit of the applicable Individual Services Budget, other Medicaid or Medicare covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DHS RN shall counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The DHS RN may also order a re-assessment of the participant.

3. In the event that a participant's ISB requires changes or limitations to ARChoices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type, or amount of ARChoices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.) Any such participant-requested changes and substitutions are subject to the following:

    a. The services chosen by participant are otherwise covered and reimbursable under ARChoices and do not exceed any applicable service limitations;

    b. The services chosen by participant are necessary and appropriate for the individual and consistent with the results of the independent assessment;

    c. The cost of all ARChoices waiver services authorized for or received by the participant, including any participant-requested changes and substitutions, do not exceed the applicable ISB amount; and

    d. The DHS RN determines the changes are reasonable and necessary for the individual and reflected in the approved person-centered service plan.

4. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. This exceptions process is intended as a safeguard to address exceptional, unexpected circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:

    a. In the professional opinion of the nurse panel, unique circumstances indicate that additional time is reasonably needed by the participant (or the participant's family on his or her behalf) to (1) adjust waiver service use costs to within the applicable Individual Services Budget (ISB) amount, (2) arrange for the start of or increase in non-Medicaid services (such as informal family supports and Medicare-covered services), and/or (3) arrange for placement in an alternative residential or facility-based setting.

    b. Such unique circumstances must be (1) specific to the individual; (2) supported by documentation provided to the nurse panel; (3) relevant to the individual's assessed needs and risk factors; (4) relevant to the temporary need for additional, medically necessary coverable waiver services in excess of the person's pre-exception ISB amount; and (5) not the result of a need for skilled services or other services not covered under the waiver.

c. Such unique circumstances may include (1) recent major life events not known at the time the current person-centered service plan was approved, including without limitation death of a spouse or caregiver, and loss of a home or residential placement; and (2) A temporary increase in care needs, for a period not to exceed ninety (90) days after a discharge from inpatient acute treatment or post-acute care.

d. If the exception request is due to the participant (or participant's family on his or her behalf) encountering delays or difficulties in arranging new care arrangements or an alternative residential or facility-based placement in the state, an exception may be granted if the nurse panel determines reasonable efforts are being made and the delays or difficulties experienced are exceptional or due to rural or remote location of the participant's home.

e. The factors considered by the nurse panel must be reasonably relevant to the necessity for additional waiver services in total cost in excess of the person's pre-exception ISB amount and for a temporary period of time not to exceed one year.

5. If the projected cost of services identified in an individual's person-centered service plan (whether such plan is under development, provisional, or final or renewed, amended, or extended) is less than the applicable Individual Services Budget amount, this shall not be construed to permit, suggest, or justify approval, coverage, or reimbursement of different or additional waiver services (including changes in amount, frequency, or duration); coverage and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or other actions to increase spending to use the remaining "unused" portion of the ISB amount.

6. The Individual Services Budget shall not apply to environmental accessibility adaptations/adaptive equipment.

C. Transition Process:

1. The Individual Services Budget limit shall apply to the following:

   a. New ARChoices participants, including individuals determined newly eligible for ARChoices following a period of ineligibility for this or another HCBS waiver program, when they are determined waiver eligible, and effective for their first person-centered service plan and thereafter; and

   b. Existing ARChoices participants immediately upon any of the following events, whichever may occur first:

      i. Waiver eligibility is re-evaluated;

      ii. The Level of Care is reaffirmed or revised;

      iii. A new independent assessment or re-assessment is performed;

      iv. Expiration, renewal, extension, or revision of the participant's person-centered service plan occurs; or

      v. Admission to or discharge from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or transfer from a hospice facility occurs.

2. For all other ARChoices participants not otherwise identified above, the Individual Services Budget limit shall apply no later than 60 days after the effective date of this waiver amendment.

3. For the following ARChoices participants, the DAABHS deputy director (or his/her designee) may on a case-by-case basis extend the effective date of the participant's first Individual Services Budget by a maximum of 60 days per participant upon written request of the participant (or legal representative) or the participant's personal physician, if:

   i. The specific participant's recent pattern of waiver service expenditures exceeds the average Individual Services Budget amount by an estimated twenty-five (25) percent or more; and/or

   ii. DAABHS determines that unique, intervening circumstances indicate that additional time is reasonably needed by the participant and the participant's family and providers. Examples of unique, intervening circumstances include the death of the spouse, loss of home, or unexpected difficulties in accessing or arranging care or placement, among others.

D. Methodology for Determining Individual Services Budgets:

1. The Individual Services Budget amount for a participant is based on that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The three ISB Levels are:

   a. Intensive: The participant requires total dependence or extensive assistance from another person in all three areas of mobility, feeding, and toileting.

   b. Intermediate: The participant requires total dependence or extensive assistance from another person in two of the areas of mobility, feeding, or toileting.

   c. Preventative: The participant meets the functional need eligibility requirements for ARChoices in Section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate.

2. The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (3) below, is as follows:

   a. For an individual with an assessed ISB Level of Intensive, the Individual Services Budget is $30,000 annually.

   b. For an individual with an assessed ISB Level of Intermediate, the Individual Services Budget is $20,000 annually.

   c. For an individual with an assessed ISB Level of Preventative, the Individual Services Budget is $5,000 annually.

3. For a participant with total waiver expenditures of more than $30,000 in calendar year 2018:

   a. The participant will be granted a Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures in calendar year 2018.

   b. In the year following the Transitional Allowance, the participant's maximum Individual Services Budget will be 95% of the participant's total waiver expenditures in calendar year 2019.

   c. For purposes of this subsection (3), "total waiver expenditures" for a calendar year shall be calculated as the sum total of claims submitted and paid by December 31 of that calendar year for all waiver services received by the participant in that calendar year, and then modified by:

i. If the cumulative expenditures are for less than 12 months, annualizing the total to reflect what the expenditures would have been if the participant had received the same monetary amount of services for 12 consecutive months; and

ii. Excluding amounts expended for environmental accessibility adaptations/adaptive equipment services.

4. For purposes of determining the projected cost of all waiver services in an individual's person-centered service plan, DAABHS shall assume that:

a. The individual will receive or otherwise use all services identified in the service plan and in their respective maximum authorized amounts, frequencies, and durations; and

b. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.

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

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

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

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

1. Beneficiary identification and contact information, including full name and address, phone number, date of birth, Medicaid number and the effective date of ARChoices Waiver eligibility;

2. Contact person;

3. Physician's name and address;

4. The amount, frequency and duration of ARChoices Waiver services to be provided and the name of the service provider chosen by the beneficiary or representative to provide the services. **Note: Attendant Care, Respite Care, and State Plan Personal Care hours are authorized ~~on the waiver PCSP~~ based on the number of hours calculated by application of the Task and Hour Standards (THS) which is described below in Section D ~~a Resource Utilization Group (RUG) score produced from the ArPath assessment~~. Attendant Care, Respite Care, and State Plan Personal Care hours are authorized in a monthly amount ~~on~~ in the waiver PCSP. ~~The provider and beneficiary determine how to use the Attendant Care hours based on the beneficiary's needs and preferences.~~ The**

beneficiary's chosen, Medicaid-certified provider is responsible for properly delivering Attendant Care, Respite Care, and State Plan Personal Care services to support the needed activity of daily living (ADL) and instrumental activity of daily living (IADL) tasks, consistent with the approved PCSP, this manual, and other applicable Arkansas Medicaid policy.

5. Other services outside the ARChoices services, regardless of payment source, identified and/or ordered to meet the beneficiary's needs including the option for the self-directed service delivery model;

6. The election of community services by the waiver beneficiary or representative; ~~and,~~

7. The name and title of the ~~DAAS~~DHS RN responsible for the development of the beneficiary's PCSP; and

8. The individual services budget for the participant.

D. **Task and Hour Standards (THS):**

1. Background on THS

The Task and Hour Standards ("THS") is the written methodology used by the DHS RNs as the basis for calculating the number of Attendant Care, Respite Care, and State Plan Personal Care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

The current DAABHS-approved THS is located on the web at [insert website address]

The THS includes the following four components, described in a grid format:

a. The participant's Needs Intensity Score (0, 1, 2, or 3) for each task;

b. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;

c. The frequency with which a task is necessary and reasonably performed; and

d. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary Attendant Care, Respite Care, and State Plan Personal Care services hours, with the minute ranges and frequencies providing DHS nurses with the ability to adjust PCSPs based on unique factors related to a given beneficiary's needs, preferences, and risks.

The number of Attendant Care, Respite Care, and State Plan Personal Care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN consistent with the THS grid and based on:

a. Responses by the participant and their representatives to certain relevant questions in the ARIA assessment instrument, and

b. As appropriate, information obtained by the DHS RN during their PCSP meeting with the participant and participants' representatives or from participant's physician.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

The Arkansas THS is also used to calculate the reasonable quantity of hours to perform medically necessary tasks covered under IndependentChoices self-directed personal assistance or State Plan personal care services for adults aged 21 or older.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

2. Needs Intensity Score:

For each task, the DHS RN will assign a Needs Intensity Score to the participant based on the participant's and/or representative's responses to questions during the ARIA assessment and information collected by the DHS RN during the PCSP meeting with the participant. The four Impairment Scores are defined as follows:

Needs Intensity Score 0 – The participant has no functional impairment with regard to the task and can perform it without assistance.

Needs Intensity Score 1 (Mild): Minimal/mild functional impairment. The participant is able to conduct activities with minimal difficulty and need minimal assistance.

Needs Intensity Score 2 (Severe): Extensive/severe functional impairment. The participant has extensive difficulty carrying out activities and needs extensive assistance.

Needs Intensity Score 3 (Total): The participant is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

3. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN preparing the PCSP will determine the number of minutes within the range that are appropriate for the participant based on conditions specific to the participant. For example, if a participant has cognitive or behavioral issues, the DHS RN may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a participant who is bald.

If the participant has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN must obtain supervisory approval. For supervisory approval, the DHS RN must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the PCSP.

4. The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information collected by the DHS RN during the PCSP meeting with the participant.

5. The amount of assistance with ADLs and IADLs provided by other sources

ARChoices does not cover assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then ARChoices attendant care is not necessary and no time for that task is included in the PCSP. When another source is available to provide assistance with a needed ADL or IADL task, the time associated with the assistance from that other source is deducted from the total minutes per week.

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information gathered by the DHS RN during the PCSP meeting with the participant.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task. For example, the participant's daughter may bathe her mother once a week and prepare all meals on weekends, eliminating the need for an attendant care aide to perform those tasks. For this participant, the total minutes per week for the tasks of bathing and meal preparation would be adjusted by the minutes associated with an aide assisting with one bath and six meals per week.

6. Calculation of total hours of attendant care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of attendant care hours approved for the participant for a month. **The projected total cost of attendant care plus all other authorized services in the PCSP (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.**

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

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

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

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

Each ARChoices service must be provided according to the beneficiary PCSP. For services included in the waiver PCSP, Medicaid reimbursement is limited to the amount and frequency that is authorized in the PCSP, subject to the participant's individual services budget. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

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

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

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

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

All revisions to the PCSP must be consistent with and not exceed the participant's applicable individual services budget.

212.305 Targeted Case Management Services (Non-Waiver Service) 1-1-16

Each ARChoices PCSP will include Targeted Case Management, unless refused by the waiver beneficiary. The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in their service need, referring the beneficiary for reassessment, if necessary, and reporting any beneficiary complaints and changes in status to the ~~DAAS~~DHS RN or Nurse Manager immediately upon learning of the change.

NOTE: As stated in this manual, the service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Each service included on the ARChoices PCSP must be justified by the ~~DAAS~~DHS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the ~~DAAS~~DHS RN.

For ARChoices beneficiaries whose waiver PCSP includes TCM at the time the ~~DAAS~~DHS RN signs the PCSP, the ARChoices PCSP, signed by a ~~DAAS~~DHS RN, will serve as the authorization for TCM services for one year from the date of the ~~DAAS~~DHS RN's signature, as described above.

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

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

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

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

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

A. A provisional PCSP may be developed and sent to providers only when the assessment outcome indicates functional eligibility and the ~~DAAS~~ DPSQA-Office of Long Term Care determines based on the results of the ARIA assessment, ~~believes, in his or her professional judgment,~~ that the applicant meets the level of care criteria for an adult with a functional need, as explained in Section 212.000, Eligibility for the ARChoices Program.

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

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

      AND

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

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

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

D. Provisional PCSPs are subject to the participant's individual services budget.

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

212.311 Denied Eligibility Application 10-1-16

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

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

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

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

1. If the individual has no unpaid ARChoices Waiver charges, Medicaid coverage will begin on the date of the appeal decision. However, the waiver portion of the case will not be approved until the date the DHS Division of County Operations ~~county office and the DAAS LTSS Program Eligibility Specialist~~ completes the case.

2. If the individual has unpaid waiver charges and services were authorized by the ~~DAAS~~DHS RN, eligibility for both Medicaid and waiver services will begin on the date service began unless the hearing decision sets a begin date.

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

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

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

The comprehensive PCSP expiration date will be 365 days from the date of the ~~DAAS~~DHS RN's signature on form AAS-9503, the ARChoices PCSP. Once the application is either approved or denied by the DHS Division of County Operations ~~county office~~, ~~DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialis~~ the providers will be notified by the ~~DAAS~~DHS RN. The notification for the approval will be in writing via a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.

212.313 ARChoices Applicants Leaving an Institution 1-1-16

The policy regarding retroactive eligibility applies to applicants entering the waiver program from the community and to applicants entering the program from an institution. The same process and the same policy determining the waiver eligibility date will apply to applications of each type.

EXCEPTION: No waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a provisional PCSP is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest waiver eligibility date will be the day the applicant is discharged from the facility.

NOTE: For inpatients, if a waiver application is filed at the local DHS Division of County Operations ~~county office~~, prior to discharge AND if a provisional PCSP is developed by the ~~DAAS~~DHS RN prior to discharge, it may be possible to establish retroactive eligibility back to the date the applicant returned to his or her home if the applicant is ultimately found eligible for the program. (Note: Medicaid beneficiaries in nursing facilities do not have to complete a new application when applying for ARChoices. Their signature on the PCSP electing waiver services serves as the application.)

If no waiver application is filed and no functional assessment or provisional PCSP is completed by the Independent Assessment Contractor and ~~DAAS~~DHS RN prior to an applicant's discharge from an institution, retroactive eligibility will not be possible back to the date the applicant returned to his home.

Functional assessments and PCSPs may be completed during a period of institutionalization; however, a discharge date must be scheduled. Since the purpose of the assessment and the PCSP is to depict the applicant's condition and needs in the home, premature assessments and PCSP development do not meet the intent of the program.

This policy applies to applicants leaving hospitals or nursing facilities.

212.320 Authorization of The ARChoices Person-Centered Service Plan (PCSP) with Personal Care Services 1-1-16

The following applies to individuals receiving both personal care services and ARChoices services.

A. The ~~DAAS~~DHS RN is responsible for developing an ARChoices PCSP that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the ~~DAAS~~DHS RN authorizing the services.

B. ~~A~~ PCSP developed on or after the effective date of this Provider Manual may not include attendant care services unless the PCSP provides for at least 64 hours per month of personal care services. Attendant care services are intended to supplement personal care services available under the Medicaid state plan.

C. The ARChoices PCSP signed by the ~~DAAS~~ DHS RN will suffice as the "Personal Care Authorization" for services required in the Personal Care Program. The personal care service plan developed by the Personal care provider is still required.

The responsibility of developing a personal care service plan is not placed with the ~~DAAS~~ DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

NOTE: For ARChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a ~~DAAS~~DHS RN, will serve as the authorization for personal care services for one year from the date of the ~~DAAS~~DHS RN's signature, as described above.

D. The ARChoices PCSP is effective for one year, once signed by the ~~DAAS~~ DHS RN~~; the authorization for personal care services, when included on the ARChoices PCSP, will be for one year from the date of the DAAS RN's signature, unless revised by the DAAS RN. If personal care services continue unchanged as authorized on the ARChoices PCSP, a new service plan is not required at the 6-month interval~~.

~~**NOTE: It is the personal care provider's responsibility to place information regarding the agency's presence in the home in a prominent location so that the DAAS RN will be aware that the provider is serving the beneficiary. Preferably, the provider will place the information atop the refrigerator or under the phone the beneficiary uses, unless the beneficiary objects. If so, the provider will place the information in a location satisfactory to the beneficiary, as long as it is readily available to and easily accessible by the DAAS RN.**~~

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

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

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

212.400 Temporary Absences from the Home 10-1-16

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

A. Absence from the Home due to Institutionalization

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

1. When a waiver beneficiary is admitted to a hospital, the ~~DAAS LTSS Program Eligibility Specialist~~ DHS Division of County Operations ~~county office~~, will not take action to close the waiver case unless the beneficiary does not return home within 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the ~~DAAS~~DHS RN will notify the ~~DAAS LTSS Program Eligibility Specialist~~ DHS Division of County Operations ~~county office~~ and action will be initiated to close the waiver case.

2. If the DHS Division of County Operations ~~county office~~ becomes aware that a beneficiary has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of the admission, but the Medicaid case will be left open. When the beneficiary returns home, the waiver case may be reopened effective the date the beneficiary returns home. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the beneficiary's admission to the facility.

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

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

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

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

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

B. Absence due to Reasons Other than Institutionalization

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

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

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

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

The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in service need, referring the beneficiary for reassessment if necessary and

reporting any beneficiary complaints and changes in status to the ~~DAAS~~DHS RN, or ~~DAAS~~DHS RN Supervisor immediately upon learning of the change.

212.600 Restrictions on Who May Provide ~~Relatives Providing~~ ARChoices Services 1-1-16

~~All ARChoices services, except for Adult Family Homes, may be provided by a beneficiary's relative, unless stated otherwise in this manual. No Adult Family Home provider, employee or family member of the provider may be related to the Adult Family Home waiver beneficiary.~~

~~For the purposes of this section, a relative or family member shall be defined as all persons related to the beneficiary by virtue of blood, marriage, or adoption. The following is applicable for all waiver services:~~

A. Individuals providing attendant care, environmental accessibility adaptations/adaptive equipment, prevocational services, or respite care may not:

   1. Reside (permanently, seasonally, or occasionally) in the same premises as the participant;

   2. Have a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or

   3. Be related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

B. ARChoices services other than attendant care, environmental accessibility adaptations/ adaptive equipment, prevocational services, and respite care may be provided by a person who is the beneficiary's relative, as defined in Subsection (A)(3) above, unless stated otherwise in this manual.

C. Under no circumstances may Medicaid payment be made for any waiver service rendered by the waiver beneficiary's:

1. Spouse

2. Legal guardian of the person

3. Attorney-in-fact granted authority to direct the beneficiary's care

D. All providers, including relatives, are required to meet all ARChoices provider certification requirements, Arkansas Medicaid enrollment requirements and provide services according to the beneficiary's PCSP and any established benefit limits for that specific service.

213.000 Description of Services

~~213.100 Adult Family Homes~~ ~~10-1-16~~

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

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

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

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

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

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

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

~~A. Bathing~~

~~B. Dressing~~

~~C. Grooming~~

~~D. Care for occasional incontinence (bowel/bladder)~~

~~E. Assistance with eating~~

~~F. Enhancement of skills and independence in daily living~~

~~G. Transportation to allow access to the community~~

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

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

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

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

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

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

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

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

~~213.110 Adult Family Homes Certification Requirements~~ ~~10-1-16~~

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

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

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

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

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

213.210 Attendant Care Services 10-1-16

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Activities of daily living include:

A. Eating

B. Bathing

C. Dressing

D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene, etc.)

E. Toileting

F. Mobility/ambulating, including functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

A. Meal planning and preparation of meals consumed only by the participant

B. ~~Managing finances~~

~~C.~~ Laundry for the participant or incidental to the participant's care

~~D.~~ C. Shopping ~~and errands~~ for food, clothing, and other essential items required specifically for the health and maintenance of the participant;

~~E. Communication~~

~~F. Traveling~~

D. Housekeeping (cleaning of furniture, floors, and areas directly used by the participant)

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

Health-related tasks are limited to the following activities:

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

B. Additional assistance with self-administration of prescribed medications; and/or

C. Emptying and replacing colostomy and ostomy bags.

Health-related tasks must be:

A. Consistent with all applicable State scope of practice laws and regulations;

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

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

D. Necessary to meet specific needs of the participant consistent with a written plan of care by a physician or registered nurse; and

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

The provision of assistance with ADLs, IADLs, or health-related tasks does not entail nursing care.

Attendant care services tasks must be:

A. Reasonable and medically necessary, supported by the individual's latest independent assessment, and consistent with the individual's Level of Care;

B. Not available from another source (including without limitation family members, a member of the participant's household, or other unpaid caregivers; a Medicaid State Plan covered service; the Medicare program; the participant's Medicare Advantage plan or Medicare prescription drug plan; or private long-term care, disability, or supplemental insurance coverage);

C. Expressly authorized in the individual's person-centered service plan;

D. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services;

E. Provided by qualified, Medicaid-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and

F. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

Attendant care services exclude all of the following:

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

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

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

D. Companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);

E. Cleaning of any spaces of a home or place of residence (including without limitation kitchen, bathroom, living room, dining room, family room, and utility or storage rooms, and the floors, furnishings, and appliances therein) shared by the participant with one or more adults who are, together or separately, physically able to perform housekeeping of these areas; and

F. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

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

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

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

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

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

The amount, frequency, and duration of attendant care services must be consistent with the amounts, frequencies, and durations specified in the DAABHS Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider

manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, month, and year. Any amounts, frequencies, or durations in excess of the THS specifications are not covered.

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

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

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

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

D. When attendant care services delivered through a home health agency or private care agency are provided by any person who (i) resides (permanently, seasonally, or occasionally) in the same premises as the participant; (ii) has a business, financial, or fiduciary relationship of any kind with the participant or the participant's guardian or legal representative; or (iii) is related to the participant by blood (i.e., a consanguinity relationship) or by marriage or adoption (i.e., an affinity relationship) to the fourth degree; and/or

E. On dates of service when the participant:

    1. Receives personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan for the same tasks;

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

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

    4. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the DHS RN;

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

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

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

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

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

Benefit limits will be determined on a client basis based on application of the Task and Hour Standards (THS) and the service limitations described in this manual. ~~the assessed level of need by the DAAS RN. The highest RUG level allows a maximum allocation of 324 units (81 hours) per week, 1,436 units (359 hours) per month, or 16,848 units (4,212 hours) per year.~~

DAABHS will update the Person-Centered Service Plan to take into account any changes in the participant's condition and/or living arrangements that would affect the number of hours of attendant care that could be approved under the Task and Hour Standards.

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

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

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

213.230 Attendant Care Services Certification Requirements 1-1-18

The following requirements must be met prior to certification by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS~~) by providers of attendant care services. The provider must:

A. Hold a current Arkansas State Board of Health Class A and/or Class B license, Or Private Care Agency license.

B. All owners, principals, employees, and contract staff of an attendant care services provider must have ~~comply with~~national and state criminal background checks and central registry checks. Criminal background and central registry checks must comply with ~~according to~~ Arkansas ~~State Law at~~ Code Annotated §§ 20-33-213 and 20-38-101 *et seq*. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

C. Employ and supervise direct care staff who:

1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
2. Possess the necessary skills to perform the specific services required to meet the needs of the beneficiary the direct care staff member is to serve; and
3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and ~~DAAS~~DPSQA certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DPSQA annually

~~DAAS every three years; however, the provider must submit a copy the agency's current license to DAAS each year when the license is renewed~~.

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

~~NOTE: The Class A, Class B or Private Care Agency license provider's ElderChoices and AAPD certification will be valid as an Attendant Care services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices and AAPD.~~

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

Environmental Accessibility Adaptations/Adaptive Equipment services enable the individual to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise. Environmental Accessibility Adaptations/Adaptive Equipment is physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, to function with greater independence in the home and preclude or postpone institutionalization. Adaptive equipment also enables the ARChoices beneficiary to increase, maintain and/or improve his/her functional capacity to perform daily life tasks that would not be possible otherwise and perceive, control or communicate with the environment in which he or she lives.

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

Permanent fixtures are not allowed on rented or leased properties.

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment services provided by:

1. Any person related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree;
2. A resident of the participant's home or place of residence (whether permanent, seasonal, or occasional);
3. Any of the participant's regular caregiver(s) for whom respite is being provided;
4. Any person who has a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or
5. Any provider organization that employs or contracts with any above individual.

213.280 Provider Qualifications Environmental Accessibility Adaptations/Adaptive Equipment 1-1-16

Individuals or businesses seeking certification by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ and enrollment as Medicaid providers of environmental accessibility adaptations/adaptive equipment services must meet the following criteria:

A. The provider of services must be a builder, tradesman or contractor.

B. The provider must be licensed (where applicable) as appropriate for home improvement contracting or adaptation and equipment provided.

C. The provider must certify that his or her work meets state and local building codes.

D. The provider must obtain all applicable permits.

E. The provider must be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines.

F. Contractors are required to adhere to the Uniform Federal Accessibility Standards.

NOTE: All environmental modifications requiring electrical or plumbing work must be completed by ~~a~~ an appropriately licensed professional. If the proposed work requires a plumbing or electrical license, the contractor must submit a copy of the contractor's plumbing or electrical license with the claim form. If a contractor subcontracts with an electrician or plumber, the contractor must submit a copy of the subcontractor's license with the claim form.

213.290 Environmental Modifications/Adaptive Equipment 10-1-16

Prior to payment for this service, the waiver beneficiary is required to secure 3 separate itemized bids for the same service. Each bid must itemize the work to be done and must specifically identify any work that requires a plumbing or electrical license. The bids are reviewed by the ~~Division of Aging and Adult Services (DAAS)~~ Division of Aging, Adult, and Behavioral Health Services (DHS~~DAAS~~ RN) or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided. All modification funds must be verified by DAABHS ~~the DAAS Provider Certification Unit~~ prior to receiving services.

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

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

213.310 Hot Home-Delivered Meals 1-1-16

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

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

Additionally, the beneficiary must:

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

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

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

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

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

Hot Home-Delivered Meals must be provided according to the beneficiary's written ARChoices PCSP.

Procedure Code	Required Modifier	Description
S5170	U2	Hot Home-Delivered Meal
S5170	—	Frozen Home-Delivered Meal
S5170	U1	Emergency Home-Delivered Meal

213.311 Hot Home-Delivered Meal Provider Certification Requirements 1-1-18

To be certified by the ~~Division of Aging and Adult Services (DAAS)~~ Division of Provider Services and Quality Assurance (DPSQA) as a provider of Hot Home-Delivered Meal services, a provider must:

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

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

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

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

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

E. All owners, principals, employees, and contract staff of a hot, home-delivered meal services provider must comply have ~~comply with~~ national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with ~~according to~~ Arkansas ~~State Law at~~ Code Annotated §§ 20-33-213 and 20-38-101 *et seq*. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

F. Notify the ~~DAAS~~DHS RN immediately if:

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

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

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

Hot Home-Delivered Meals providers must recertify with ~~DAAS every three years; however,~~DAAS ~~must maintain,~~ DPSQA annually, and the provider shall attach a copy of the agency's current Food Establishment Permit ~~at all times~~ to the annual recertification.

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

213.320 Frozen Home-Delivered Meals 1-1-16

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

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

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

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

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

NOTE: While the individual has freedom of choice regarding this service, it is the responsibility of the ~~DAAS~~DHS RN developing the PCSP to ensure the appropriateness of the service. A hot meal delivered daily remains the food service of choice, when available. Therefore, a frozen meal must be approved by the ~~DAAS~~DHS RN. The service must be included on the PCSP. If the individual responsible for developing the PCSP does not think the frozen meals are appropriate for the individual, other options will be considered. Those options include removing the Home-Delivered Meal service rather than authorizing a frozen meal.

It is the certified provider's responsibility to deliver the meals regardless if they are hot or frozen. Meals may not be left on the doorstep. The meals cannot be mailed to the individual via United States Postal Service or delivered by paid carrier such as Fed Ex or UPS.

213.321 Beneficiary Requirements for Frozen Home-Delivered Meals 1-1-16

The beneficiary must:

A. Be homebound, which is defined by the following requirements:

1. The person is normally unable to leave home without assistance (physical or mental) from another person;
2. The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
3. Leaving home requires considerable and taxing effort by the individual; and
4. Absences of the individual from home are infrequent, of relatively short duration or attributable to the need to receive medical treatment.

B. Be unable to prepare some or all of his or her meals or require a special diet and be unable to prepare it.

C. Have no other individual available to prepare his or her meals and the provision of a Frozen Home-Delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal.

D. Have adequate and appropriate storage and be able to perform the simple tasks associated with storing and heating a Frozen Home-Delivered Meal or have made other appropriate arrangements approved by ~~DAAS~~DAABHS.

E. Have the provision of frozen meals included on his or her PCSP as developed by the appropriate ~~DAAS~~DHS RN.

Frozen Home-Delivered Meals must be documented on the ARChoices PCSP by the ~~DAAS~~DHS RN and must be provided in accordance with the beneficiary's written ARChoices PCSP.

213.323 Frozen Home-Delivered Meal Provider Certification Requirements 1-1-18

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

To be certified by ~~DAAS~~DPSQA as a provider of Home-Delivered Meal services, a meal provider must:

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

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

C. If applicable, ensure that intermediate sources of delivery meet or exceed federal, state and local laws regarding food transportation and delivery*

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

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

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

E. All owners, principals, employees, and contract staff of a home-delivered meal services provider must have ~~comply with~~ national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with ~~according to comply with criminal background checks according to~~ Arkansas Code Annotated §§ ~~State Law at~~ 20-33-213 and 20-38-101 *et seq*. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

F. Provide frozen meals that:

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

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

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

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

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

~~H.~~ I. Verify quarterly that all beneficiaries receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of

performing simple associated tasks unless other appropriate arrangements have been made and approved by ~~DAAS~~DAABHS. Any changes in the individual's circumstances must be reported to the ~~DAAS~~DHS RN via form AAS-9511.

~~I.~~ J. Notify the appropriate ~~DAAS~~DHS RN immediately if:

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

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

K. Contact each individual daily Monday through Friday, either in person or by phone, to ensure the individual's safety and well-being. This is not required for:

1. Individuals receiving Frozen Home-Delivered Meals only for weekends; or
2. Individuals who receive Attendant Care services or Personal Care services at least three (3) times per week.

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

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

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

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

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

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

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

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

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

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

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

HDM providers delivering frozen meals may deliver 14 at one time if the ~~DAAS~~DHS RN enters 14 meals delivery approved in the comments section of the HDM entry on the

PCSP. If this statement is not on the PCSP, or if any of the other factors above are not in place, the meal providers cannot deliver more than seven (7) meals at one time.

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

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

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

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

213.340 Combination of Hot and Frozen Home-Delivered Meals 1-1-16

In instances where the ARChoices beneficiary wishes to receive a combination of hot and frozen meals, the ~~DAAS~~DHS RN shall evaluate the beneficiary's situation based on the criteria set forth in Section 213.320, Frozen Home-Delivered Meals. If the criteria are met, the ~~DAAS~~DHS RN may prescribe on the PCSP a combination of hot and frozen meals to be delivered.

213.350 Emergency Meals 10-1-16

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

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

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

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

213.400 Personal Emergency Response System 1-1-16

Procedure Code	Required Modifier	Description
S5161	UA	PERS Unit
S5160	—	PERS Installation

The Personal Emergency Response System (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center.

PERS enables an elderly, infirm or homebound individual to secure immediate help in the event of a physical, emotional or environmental emergency.

PERS is specifically designed for high-risk beneficiaries whose needs have been carefully determined based on their level of medical vulnerability, functional impairment and social isolation. PERS is not intended to be a universal benefit. The ~~DAAS~~DHS RN must verify that the individual is capable, both physically and mentally, of operating the PERS unit.

PERS must be included in the beneficiary's written ARChoices PCSP.

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

A log of all beneficiary calls received must be maintained by the emergency response center. The log must reflect the date, time and nature of the call and the response initiated by the center. All calls must be documented in the beneficiary's record. See Section 214.000 for other documentation requirements.

One (1) unit of service equals one (1) ~~day~~ month. PERS is limited to a maximum of ~~thirty-one (31) units per month~~ twelve (12) units per year.

The installation of PERS will be allowed once per lifetime or period of eligibility. Claims submitted for the installation of PERS should use procedure code **S5160**. Procedure code **S5160** may be billed for ARChoices beneficiaries who are accessing PERS services for their first time or for the current period of re-eligibility for ARChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging, Adult, and Behavioral Health Services ~~of Aging and Adult Services~~ for extension of the benefit.

~~**View or print Division of Aging, Adult, and Behavioral Health Services contact information of Aging and Adult Services .**~~

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

To be certified by Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ as a provider of personal emergency response services, a provider must:

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

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

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

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

PERS providers must recertify annually with DPSQA~~DAAS~~.

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

213.500 Adult Day Services 10-1-16

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

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

When provided according to the beneficiary's written ARChoices Person-Centered Service Plan (PCSP), ARChoices beneficiaries may receive adult day services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day, according to the beneficiary's written PCSP. Adult day services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month. One (1) unit of service equals 15 minutes.

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

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

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

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

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

213.510 Adult Day Services Certification Requirements 10-1-16

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

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

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

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

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

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

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

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

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

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

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

B. Pharmaceutical supervision,

C. Diagnostic evaluation or

D. Health monitoring

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

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

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

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

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

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

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

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

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

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

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

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

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

213.620 Prevocational Services

Procedure Code	Modifier	Description
T2015		Prevocational Services Skills Development
T2015	U3	Prevocational Services Career Exploration

Prevocational services are available to ARChoices waiver participants with physical disabilities who wish to join the general workforce. Prevocational Services comprise a range of learning and experiential type activities that prepare a participant for paid employment or self-employment in the community.

Prevocational services are as follows:

1. Development and teaching of general employability skills (non-job-task-specific strengths and skills) directly relevant to the participant's pre-employment needs and successful participation in individual paid employment. These skills are: ability to communicate effectively with supervisors, coworkers, and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; and skills related to obtaining paid employment. Excluded are services involving development or training of job-specific or job-task oriented skills.

2. Career exploration activities designed to develop an individual career plan and facilitate the participant's experientially-based informed choice regarding the goal of individual paid employment. These may include business tours, informational interviews, job shadows, benefits education and financial literacy, assistive technology assessment, and local job exploration events. The expected outcome of career exploration activities is a written, actionable, person-centered career plan designed to lead to community employment or self-employment for the participant.

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the participant interacts with individuals without disabilities, other than those providing services to the participant or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Prevocational services may be provided one-to-one or in a small group format and may be provided as a site-based service or in a community setting, consistent with requirements of the ARChoices provider manual.

All prevocational services must be prior approved in the participant's person-centered service plan, provided through a DPSQA-certified prevocational services provider, and delivered and documented consistent with requirements of the ARChoices provider manual.

Prevocational services exclude any services otherwise available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 (Rehab Act), the Individuals with Disabilities Education Act (IDEA), or any other federally funded (non-Medicaid) source. Proper documentation shall be maintained in the file of each individual receiving prevocational services under the waiver.

The amount of all prevocational services provided to any participant shall not exceed $2,500 per lifetime.

The amount of career exploration activities provided per participant shall not exceed 30 hours.

The duration of prevocational services provided to any given participant shall be limited to 180 days (six months). Services not completed within this timeframe are not covered.

Providers of Prevocational Services under the ARChoices waiver program must be certified by the Division of Provider Services and Quality Assurance and must recertify annually.

Reimbursement is not permitted for prevocational services provided by:

a. Any person related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree;
b. A resident of the participant's home or place of residence (whether permanent, seasonal, or occasional);
c. Any of the participant's regular caregiver(s) for whom respite is being provided;
d. Any person who has a business, financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or
e. Any provider organization that employs or contracts with any above individual.

213.700 Respite Care 10-1-16

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

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

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

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

1. The participant lives at home and is cared for, without compensation, by their families or other informal support systems;

2. As determined by the independent assessment, the participant has a severe physical, mental, or cognitive impairment(s) that prevents him or her from being left alone safely in the absence or unavailability of the primary caregiver;

3. The primary caregiver to be relieved is identified and with sufficient documentation that he or she furnishes substantial care of the client comparable to or in excess of services described under the Attendant Care service;

4. No other alternative caregiver (e.g., other member of household, other family member) is available to provide a respite for the primary caregiver(s);

5. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b) supervision necessary to maintain the

health and safety of the participant, as supported by the independent assessment and determined medically necessary by the DHS RN; and

6. Respite Care solely serves to supplement (not replace) and otherwise facilitate the continued availability of care provided to waiver participants by families and other informal support systems.

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

Respite Care is available in the following locations:

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

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

1. In-home respite may be provided for up to 24 hours per date of service.

2. Facility-based respite care may be provided outside the participant's home on:

   a. A short-term basis (eight (8) hours or less per date of service), or

   b. A long-term (maximum of 24 hours per date of service and used most often when respite needed exceeds the short-term respite amount).

Reimbursement is only permitted for direct care rendered according to the participant’s person-centered service plan by trained respite care workers employed and supervised by certified in-home respite providers.

Respite care is subject to the following limitations:

6. The amount, frequency, and duration of Respite Care must be entirely consistent with the amounts, frequencies, and durations specified in the DAABHS Task and Hour Standards (“THS”), as issued by DAABHS and posted publicly on the DHS website in the webpage of DAABHS publications. Any amounts, frequencies, or durations in excess of the Standards specifications are not covered.

7. Respite Care excludes:

   a. Skilled health professional services, including physician, nursing, therapist, and pharmacist services.

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

c. Services provided for any other person other than the participant;

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

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

8. Participants are limited to no more that 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof.

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

10. Reimbursement is not permitted for Respite Care services provided by:

a. Any person related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree;
b. A resident of the participant's home or place of residence (whether permanent, seasonal, or occasional);
c. Any of the participant's regular caregiver(s) for whom respite is being provided;
d. Any person who has a business, financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or
e. Any provider organization that employs or contracts with any above individual.

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

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

213.711 Facility-Based Respite Care 10-1-16

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

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

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

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

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

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

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

213.712 In-Home Respite Care Certification Requirements 1-1-16

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)Division of Aging and Adult Services (DAAS)~~ as a provider of in-home respite care services, a provider must:

A. Hold a current Class A and/or Class B Home Health Agency license or a Private Care Agency license to provide personal care and/or home health services as issued by the state licensing authority;

B. Employ and supervise direct care staff trained and qualified to provide respite care services; and

C. Agree to the minimum Assurances of Providers of ARChoices Waiver Services.

In-Home Respite Care providers as described in A. above must recertify with ~~DAAS every three years~~ annually; however, DPSQA~~DAAS~~ must maintain a copy of the agency's current license at all times.

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

~~NOTE: The Class A, Class B or Private Care Agency license ElderChoices provider's certification will be valid as a Respite services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.~~

213.713 Facility-Based Respite Care Certification Requirements 1-1-16

To be certified by the Division of Aging and Adult Services as a provider of facility-based respite care services, a provider must be licensed in their state as one or more of the following:

~~A. A certified adult family home~~

A. A licensed adult day care facility

B. A licensed adult day health care facility

C. A licensed nursing facility

D. A licensed residential care facility

E. A licensed Level I or Level II Assisted Living Facility

F. A licensed hospital

Facility-Based Respite Care providers as listed above~~, with the exception of a certified adult family home~~, must recertify with ~~DAAS every three years~~ DPSQA annually; however, DPSQA~~DAAS~~ must maintain a current copy of the facility's current license at all times.

~~A certified and Medicaid enrolled adult family home which is also certified by DAAS to provide facility-based respite services must recertify with DAAS annually.~~

~~NOTE: The Class A, Class B or Private Care Agency facility-based respite ElderChoices provider's license certification will be valid as a facility-based respite services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.~~

215.000 ARChoices Forms 1-1-16

ARChoices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the ~~Division of Aging and Adult Services~~Division of Aging, Adult, and Behavioral Health Services. These forms include but are not limited to:

A. Person Centered Service Plan — AAS–9503

B. Start Services — AAS–9510

C. Beneficiary Change of Status — AAS–9511

Providers may request form AAS–9511 by writing to the Division of Aging, Adult, and Behavioral Health ~~and Adult~~ Services. **~~View or print the Division of Aging and Adult ServicesDivision for Aging, Adult, and Behavioral Health Services contact information.~~**

Forms AAS–9503 and AAS–9510 will be mailed to the provider by the ~~DAAS~~DHS RN.

Instructions for completion and retention are included with each form. If there are questions regarding any ARChoices form, providers may contact the ~~DAAS~~DHS RN in your area.

240.000 PRIOR AUTHORIZATION 1-1-16

Attendant care and personal care services provided under an authorized PCSP require prior authorization. ~~Services~~ Other services provided under the ARChoices Program under an authorized PCSP do not require prior authorization.

250.000 REIMBURSEMENT

251.010 Fee Schedules 1-1-16

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

260.000 BILLING PROCEDURES 1-1-16

262.100 HCPCS Procedure Codes 10-1-16

The following procedure codes must be billed for ARChoices Services.

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

Procedure Code	Modifiers	Description	Unit of Service	National POS for Claims
~~S5140~~	~~Level A U1~~ ~~Level B U2~~ ~~Level C U3~~	~~Adult Family Homes~~	~~1 day~~	~~99~~
S5125		Attendant Care Services	15 minutes	12
S5125	U2	Agency Attendant Care Traditional	15 minutes	12, 99
S5170	U2	Home-Delivered Meals	1 meal	12
S5170		Frozen Home-Delivered Meal	1 meal	12
S5170	U1	Emergency Home Delivered Meals	1 meal	12
S5161	UA	Personal Emergency Response System	1 day	12
S5160		Personal Emergency Response System – Installation	One install	12
S5100	U1	Adult Day Services, 8 to 20 units per date of service	15 minutes	99
S5100		Adult Day Services, 21 to 40 units per date of service	15 minutes	99
S5100	TD, U1	Adult Day Health Services, 8 to 20 units per date of service	15 minutes	99
S5100	TD	Adult Day Health Services, 21 to 40 units per date of service	15 minutes	99
S5150		Respite Care – In-Home	15 minutes	12
S5135		Respite Care – Short-Term Facility-Based	15 minutes	99, 21, 32
T1005		Respite Care – Long-Term Facility-Based	15 minutes	21, 32, 99
T2015		Prevocational Services Skills Development	One hour	11, 12, 99
T2015	U3	Prevocational Services Career Exploration	One hour	11, 12, 99

262.210 Place of Service Codes 1-1-16

The national place of service (POS) code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Beneficiary's Home	12
Day Care Facility	99
Nursing Facility	32
Provider's Office	11
Other Locations	99

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

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

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

SECTION II - INDEPENDENTCHOICES
CONTENTS

200.000 INDEPENDENTCHOICES GENERAL INFORMATION

200.100 IndependentChoices 1-1-16

The IndependentChoices program is a state plan service under 1915(j) of the Social Security Act. IndependentChoices is operated by the ~~Division of Aging and Adult Services (DAAS)~~ Division of Provider Services and Quality Assurance (DPSQA) with support from the Division of Aging, Adult, and Behavioral Services (DAABHS). The program offers Medicaid-eligible individuals who are elderly and individuals with disabilities an opportunity to self-direct their personal assistant services.

IndependentChoices seeks to increase the opportunity for consumer direction and control for Medicaid beneficiaries receiving or needing personal assistant services. Personal Assistant services in IndependentChoices include state plan personal care for Medicaid beneficiaries and attendant care services for ARChoices ~~beneficiaries~~ in Homecare (ARChoices) beneficiaries. IndependentChoices offers an allowance and counseling services in place of traditional agency-provided personal assistance services and items related to personal assistance needs.

The participant or designee is the employer and accepts the responsibility in directing the work of their employee to the degree necessary to meet their individual needs for assistance with activities of daily living and instrumental activities of daily living.

~~If the IC participant can make decisions regarding his or her care but does not feel comfortable reading and filling out forms or talking on the phone, he or she can appoint a Communications Manager. The Communications Manager can act as the participant's voice and complete and sign forms, but will not make decisions for the participant. The Communications Manager will not hire, train, supervise or fire the personal assistant for the IC participant.~~

If the participant needs someone to hire and supervise the personal assistant, make decisions about care and administer the cash expenditure plan as well as complete all forms, a ~~Decision-Making Partner~~ Representative will be appointed.

IndependentChoices participants or their ~~Decision-Making Partner~~ Representative must be able to assume the responsibilities of becoming an employer by hiring, training, supervising and firing if necessary their directly hired workers. In doing so the program participant accepts the risks, rights and responsibilities of directing their care and having their health care needs met.

The IndependentChoices program respects the employer authority of the participant who chooses to direct his or her care by hiring an employee who will be trained by the employer ~~or Decision-Making Partner~~ (the participant or Representative) to provide assistance how, when, and where the employer determines will best meet the participant's individual needs. The Medicaid beneficiary assumes the risks, rights and responsibilities of having their health care needs met in doing so.

NOTE: The IndependentChoices Program follows the rules and regulations of the State Plan approved Personal Care Program, unless stated otherwise in this manual.

200.200 Eligibility 1-1-16

To be eligible for IndependentChoices, a participant must:

A. Be 18 years of age or older

B. Be eligible for Medicaid, as determined by the DHS Division of County Operations, in a category that covers personal care, or be eligible for Supplemental Security Income (SSI) through the Social Security Administration, or be eligible for ARChoices and determined in need of attendant care services or personal care by the ~~DAAS~~DHS Registered Nurse (RN).

C. Be receiving personal assistance services or be medically eligible to receive personal assistance services. Personal assistance services include state plan personal care and ARChoices attendant care services.

1. **Personal Care:** In determining eligibility and level of need for personal care, IndependentChoices follows policy found in the Arkansas Medicaid Personal Care Provider Manual.

2. **Attendant Care:** The ~~DAAS~~DHS RN must determine and authorize attendant care services based on ARChoices policy.

D. Not be living in a home or property owned, operated or controlled by a provider of services unless the provider is related by blood or marriage to the participant. This includes single family homes, group homes, adult family homes, congregate settings, a living situation sponsored or staffed by an agency provider, etc.

E. Be willing to participate in IndependentChoices and understand the rights, risks and responsibilities of managing his or her own care with an allowance; or, if unable to make decisions independently, have a willing ~~representative decision-maker~~ Representative who understands the rights, risks and responsibilities of managing the care of the participant with an allowance.

202.100 Participants 11-1-09

Individuals meeting participant eligibility requirements may enroll in the program. Personal contact will be made by telephone and in person to determine the individual's ability to understand the requirements for directing his or her own personal assistance services. Individuals who are not comfortable with this responsibility or who are determined to be unable to understand this responsibility will be asked to identify a ~~Decision-Making Partner~~ Representative. Individuals who are unable to understand the risks, rights and responsibilities of managing personal assistance services with an allowance and who do not have anyone to serve as a ~~Decision-Making Partner~~ Representative will be discouraged from participating in IndependentChoices.

If the individual has a mental or cognitive limitation that restricts him or her from voicing his or her preferences and self-directing his or her care, the individual will not be able to participate in IndependentChoices without a ~~Decision-Making Partner~~ Representative. Individuals able to voice their preferences and self-direct their care, but having limitations that hinder their ability to keep up with the paperwork involved, such as signing timesheets, etc., may ~~designate a communications manager to~~ have their Representative assist them. ~~If they do not have a Communications Manager to designate, they may still participate, but will be followed with intensified counseling to give them the opportunity to self-direct.~~ If at any time the individual's health and safety is jeopardized because of the inability to self-direct his or her care and there is no ~~Decision-Making Partner~~ Representative available, the individual will be disenrolled from IndependentChoices.

202.200 ~~Decision-Making Partners~~ Representative(s) 11-1-09

A ~~Decision-Making Partner~~ Representative will be required if the individual interested in participating has a court-appointed legal guardian, other appointed representative, i.e., power of attorney, or an established payee of income. A ~~Decision-Making Partner~~ Representative will also be required for any potential enrollee or participant who is:

A. Unable to understand his or her own care needs

B. Unable to make decisions about his or her care

C. Unable to organize his or her life style and environment by making these choices

D. Unable to understand how to recruit, hire, train and supervise personal assistants

E. Unable to understand the impact of his or her decisions and assume responsibility for the results

F. Noncompliant with project objectives when circumstances indicate a change of competency or ability to self direct

The enrollee, counseling staff, or a representative of the fiscal agency may request a ~~Decision-Making Partner~~ Representative. A ~~Decision-Making Partner~~ Representative may be a legal guardian, other legally appointed ~~Decision-Making Partner~~ Representative, an income payee, family member, or friend. The ~~Decision-Making Partner~~ Representative may not be paid for this service and may not be an employee of the participant. A ~~Decision-Making Partner~~ Representative must be at least 18 years of age and demonstrate a strong personal commitment to the participant and be knowledgeable of the participant's preferences. The individual chosen as ~~Decision-Making Partner~~ Representative must be willing and capable of complying with all program criteria and responsibilities. ~~Each Decision-Making Partner will be required to complete and sign a Decision-Making Partner Screening Questionnaire (DAAS IC-05) and Designation for Authorized Decision-Making Partner Form (DAAS IC-05A).~~

202.300 Enrollment 1-1-18

The ~~Division of Aging and Adult Services (DAAS)~~ Division of Aging, Adult, Behavioral Services (DAABHS) is the point of entry for ARChoices waiver participants who choose self-direction via ~~all enrollment activity for~~ the IndependentChoices program. The counseling entity is the point of entry for Personal Care participants who choose self-direction. The IndependentChoices program is limited based on an approved number through the Medicaid State Plan.

The individual or their designee will first call ~~the IndependentChoices toll-free number at 888-682-0044 or~~ the Counseling Entity's toll-free number at 866-710-0456. Information about the program is provided to the individual and verification made that the individual is currently enrolled in a Medicaid category that covers personal assistance services. If the individual is currently enrolled in an appropriate Medicaid category and has an assessed physical dependency need for "hands on" assistance with personal care needs, ~~DAAS~~ DPSQA will enter the participant's information into a ~~DAAS~~ DPSQA database. If the individual is not currently enrolled in an appropriate Medicaid category, the individual will be referred to the DHS County Office for eligibility determination.

The counseling entity's support coordinators ~~DHS nurse~~ and fiscal agent will then work with the individual to complete the enrollment forms either by mail and telephone contact or by a face-to-face meeting. The individual will be provided with a program manual, which explains the individual's responsibilities regarding enrollment and continuing participation. The individual must complete the forms in the Enrollment Packet, which consists of the Participant Responsibilities and Agreement, the Backup Personal Assistant (Caregiver) and the Authorization to Disclose Health Information. The individual must also complete the forms in the Employer Packet, which includes the Limited Power of Attorney, IRS and direct deposit forms related to being a household employer. Each caregiver/employee ~~personal assistant~~ must complete the forms in the Employee Packet which include the standard tax withholding forms normally completed by an employee, the Employment Eligibility Verification Form (I-9), a Participant/~~Personal Assistant~~Caregiver Agreement, Employment Application,~~and~~, a ~~Provider~~Caregiver/Employee Agreement, as well as documents pertinent to a criminal background check including maltreatment registry requests and a consent form to release results of a criminal history report from the Arkansas Crime Information Center (Arkansas State Police). Each packet includes step-by-step instructions on how to complete the above forms. Assistance is available to the individual, ~~Decision-Making Partner/Communications Manager~~ Representative and the personal assistant to help complete the forms and answer any questions.

As part of the enrollment process, the ~~DAAS RN~~ DHS Independent Assessment contractor will complete an assessment, ~~using the Home and Community Based Services (HCBS) Level of Care Assessment Tool. The DAASDHS RN will determine, through the completed assessment and professional judgment,~~ DHS professional staff or contractor(s) designated by DHS will use the Arkansas Medicaid Task and Hour Standards to determine the level of medical necessity.

This determination creates the budget for self-directed services. Eligibility for personal care services is based on the same criteria as state plan personal care services.
NOTE: For ARChoices beneficiaries, the ~~DAAS~~DHS RN will determine the need for personal care and attendant care hours ~~needed~~ using the Task and Hour Standards, subject to the beneficiary's ARChoices Individual Services Budget. The ARChoices ~~plan of care~~ person-centered service plan will reflect that the beneficiary chooses IndependentChoices as the provider. ~~DAAS-HCBS staff will obtain authorization from DHS professional staff or contractor(s) designated by DHS for persons not receiving ARChoices waiver services.~~

After the ~~in-home~~ independent assessment, ~~the DAAS RN will complete the paperwork and coordinate with the IndependentChoices counselor. The counselor~~ the counseling entity's support coordinators and the fiscal agent will process all of the completed enrollment forms. The assessment is sent to DHS professional staff or contractor(s) designated by DHS for authorization if the beneficiary is not authorized for services through a waiver ~~plan of care~~ person-centered service plan for ARChoices. State and IRS tax forms will be retained by the fiscal agent. Disbursement of funds to a beneficiary or their employee will not occur until all required forms are accurately completed and in the possession of the fiscal agent.

~~Personal care assessments for beneficiaries aged 21 years or older and authorized DHS professional staff or contractor(s) designated by DHS in excess of 14.75 hours per week are forwarded to DAAS for coordination with Utilization Review in the Division of Medical Services for approval. **View or print Utilization Review contact information.**~~ For beneficiaries under age 21, all personal care hours must be authorized through the designated DHS contractor. ~~Medicaid's contracted Quality Improvement Organization (QIO). View or print AFMC contact information.~~

IndependentChoices follows the rules and regulations found in the Arkansas Medicaid Personal Care Provider Manual in determining and authorizing personal care hours. For beneficiaries receiving services through the ARChoices waiver program, the signature of the ~~DAAS~~DHS RN is sufficient to authorize personal care services. After the service plan is authorized, the actual day services begin is dependent upon all of the following conditions:

A. ~~DAAS~~DAABHS issues a seven-day notice to discontinue service to any agency personal care, ARChoices provider currently providing services to the individual.

B. The date the participant/employer's caregiver/employee is able to begin providing the necessary care. It can be no earlier than the date DHS professional staff or contractor(s) designated by DHS authorized the service plan for the non-waiver eligible participant, if an agency provider is not providing the personal care services.

C. The fiscal agent is in possession of all required employer and employee documents.

If the beneficiary is not also a beneficiary of ARChoices services, then continuation of personal assistance services requires reauthorization prior to the end of the current service plan end date.

~~When the approval by Utilization Review is received, or the beneficiary needs 14.75 hours or less per week, the~~ The counseling entity's support coordinator will contact the ~~beneficiary or Decision-Making Partner/Communications Manger~~ participant/employer to develop the cash expenditure plan. ~~The Medicaid beneficiary as the employer and the counselor will determine when IndependentChoices services can begin, but~~ Services may not commence prior to the date authorized by DHS professional staff or contractor(s) designated by DHS.

202.600 Cash Expenditure Plan 1-1-13

The amount of the Cash Expenditure Plan (CEP) is determined by DHS professional staff or contractor(s) designated by DHS using the Arkansas Medicaid Task and Hour Standards to determine the level of medical necessity. ~~the assessment performed by the DAAS RN.~~ The

~~counselor~~ counseling entity's support coordinator and the participant/employer or ~~Decision-Making Partner~~ Representative will work together to develop the CEP, which may be updated and revised whenever a need arises. The CEP is intended to be a blueprint of how the monthly allowance may be spent to meet the needs identified in the service plan. The CEP may include ten percent of the amount of the participant's plan as a discretionary expenditure not to exceed $75.00. The discretionary expenditure is used to purchase personal hygiene items and does not require the participant to maintain receipts for the purchases. For reporting purposes, discretionary purchases will be self-declared by the participant and will be part of the quarterly reporting requirement performed by the fiscal agent.

202.800 Participant/~~Personal Assistant~~ Caregiver Agreements 1-1-15

The fiscal agent is responsible for obtaining the Worker Information and Qualification Form ~~Participant/Personal Assistant Agreement form DAAS-IC-17.~~ The purpose of this form ~~the Participant/Personal Assistant Agreement form DAAS-IC-17~~ is to state the agreements to which both the employer and the employee(s) are in agreement. The agreement is signed by both the beneficiary or ~~Decision-Making Partner~~ Representative and the employee.

202.900 Back-up Plans 1-1-15

Having a back-up worker is required for participation in IndependentChoices. The ~~counselor~~ counseling entity will assist the ~~Medicaid beneficiary as the employer~~ participant/employer or ~~Decision-Making Partner~~ Representative as the employer in developing a back-up plan to outline how the ~~beneficiary's~~ participant's needs will be met should the ~~assistant~~ caregiver/employee be absent from the home for any reason. The back-up plan must identify ~~caregivers, either formal or informal, who will provide back-up personal attendant services~~ a back-up caregiver. This back-up caregiver will need to enroll as a caregiver for the IndependentChoices program. The back-up plan may also identify an informal back-up caregiver.

220.100 Cash Allowance 1-1-16

~~The cash allowance allows the program participant to purchase those services that help the program participant receive assistance at times of the day that best meet his or her individual preferences. The allowance also supports the purchase of goods and services that lessen the need for human assistance while increasing the participant's ability to maintain independence in the community.~~

~~Primarily the allowance is used to pay the participant's employee's salary. The list of services listed below were developed by the IndependentChoices Advisory Committee comprised of representatives from Area Agencies on Aging, Department of Health, Spinal Cord Commission and advocates. Not all of these services are widely used, but the availability of these services on an individual basis has impacted the quality of life of individual program participants.~~

~~Following is a list of possible uses of the cash allowance:~~

~~A. Personal Assistance Services including personal care and attendant care services for ARChoices beneficiaries~~

~~B. Medical related transportation not provided through the Non-Emergency Transportation (NET) Waiver~~

~~C. Prescription Medication Not Covered by Insurance, Medicaid or Medicare Part D~~

~~D. Over-the-counter Drugs~~

~~E. Adaptive Equipment (Purchase or Rental)~~

~~F. Communication Devices~~

~~G. Discretionary Cash used to purchase personal hygiene items~~

~~H. Home Modifications~~

~~I. Emergency Food and Clothing~~

~~J. Safety Devices~~

~~K. Technology (Computers)~~

~~L. Environmental Equipment~~

~~M. Emergency Pest Control~~

~~N. Emergency Housing~~

~~O. Emergency Utilities~~

~~P. Education~~

~~Q. Service Animal Purchase and Maintenance~~

~~R. Other, with approval by the Division of Aging and Adult Services.~~

A. Purpose of Cash Allowance: The cash allowance allows the IndependentChoices participant to directly purchase personal assistance services and certain other goods and services that lessen the need for Medicaid-funded human assistance while increasing the participant's ability to maintain independence in the community. The cash allowance is primarily used to pay the salary or wages of the participant's employee. The other goods and services for which the cash allowance may be used to purchase are not widely used but in some cases may help further support a beneficiary's independence and need for paid personal assistance.

B. Permissible Uses of Cash Allowance: An IndependentChoices participant's cash allowance may only be used for the following expenses if consistent with the individual's approved patient-centered service plan and service budget:

1. Self-directed Personal Assistance Services: Salary or wages of self-hired personal assistant(s) to provide self-directed Personal Assistance Services, in lieu of State Plan personal care services and ARChoices attendant care services. Such Personal Assistance Services are covered for medically necessary human assistance with specific activities of daily living (ADL) tasks, instrumental activities of daily living (IADL) tasks, and health-related tasks to the extent covered under either the State Plan personal care services benefit or the ARChoices attendant care services benefit (if the individual is a ARChoices waiver participant). The ADL, IADL, and health-related tasks supported must also be consistent with the individual's assessed needs.

2. Backup and Respite Personal Assistance: Purchasing Personal Assistance Services from a licensed home health agency or a licensed personal care agency to supplement or back up self-hired personal assistants or to provide respite care to relieve unpaid caregivers.

3. Technology for Safety, Communication, and Independence: Purchase or rental of adaptive technology used to assist the beneficiary with completing activities of daily living, communicating with others, and residing safely and independently at home (i.e., augmentative and alternative communication devices, assistive listening or reading devices, captioned telephones, other sensory adaptive equipment, visual or audible

alerting devices, and personal computer with accessibility technology and accommodations for the individual's physical or sensory limitations).

4. Service Animal: Purchase and maintenance of a service animal. This includes necessary food, veterinarian services, dog license, handling material (collar, harness, and leash), and training of beneficiary in proper care and handling of the service animal. "Service animal" is as defined under federal Americans with Disabilities Act (ADA) regulations at 28 CFR 35.104.
5. Cost of a complete national fingerprint-based criminal background check on a self-hired personal assistant(s).
6. Discretionary Cash used to purchase personal hygiene items for the beneficiary.
7. With the prior written approval by the Division of Provider Services and Quality Assurance (DPSQA) director (or his/her designee):

   (a) Environmental Accessibility Adaptations: The purchase and installation of interior or exterior physical adaptations to the beneficiary's home necessary to ensure their health and safety, decrease the need for paid and unpaid human assistance, and enable the individual to function with greater independence in the community. Such adaptations must provide direct medical or remedial benefit to the beneficiary due to a disability(ies) and functional limitation(s). The ARChoices waiver provides similar coverage for Environmental Accessibility Adaptations. For ARChoices waiver participants, the Environmental Accessibility Adaptations available under IndependentChoices, ARChoices, or the two benefits in combination may not be used to provide Environmental Accessibility Adaptations in excess, duplication, or circumvention of what may be covered and reimbursed through IndependentChoices or ARChoices separately.

   (b) Emergency Goods and Services: On a time-limited basis, the following goods and services in the event of a documented emergency representing a risk to the beneficiary's health and welfare: food and clothing; housing for beneficiary (and their service animal, if any); household utilities (i.e., electricity, water, heating fuel, and telephone); and pest control.

   (c) Other goods and services on a case-by-case basis provided DPSQA determines such purchases (1) will likely increase the participant's independence and reduce the need for Medicaid-funded paid human assistance, (2) can be economically purchased and reliably provided, (3) will not result in funds in the individual's IndependentChoices budget being insufficient to meet the participant's needs, (4) are consistent with the participant's assessed needs, and (5) are consistent with the participant's person-centered service plan and self-directed services budget.

220.200 Personal Assistance (Caregiver) Services 1-1-15

~~Assistants~~Caregivers/employees will be recruited, interviewed, hired and managed by the ~~Medicaid beneficiary~~participant as the employer or a designated ~~Decision-Making Partner~~ Representative. Family members, other than those with legal responsibility to the beneficiary, may serve as personal assistants. A court appointed legal guardian, spouse, power of attorney or income payee may not serve as a ~~Personal Assistant~~caregiver/employee.

The ~~beneficiary's~~participant/employer's ~~personal assistant~~caregiver/employee performs the services under the agreed upon terms of the Worker Information and Qualification Form and the Employer Responsibilities and Attestation Form ~~DAAS-IC-17 IndependentChoices Participant/Personal Assistant Agreement.~~

220.205 Personal Care 7-1-15

The Arkansas Medicaid program covers up to 14.75 hours per week (64 hours per calendar month) of State Plan Personal Care Services for participants aged 21 and older assessed as needing personal care. The hour limit does not apply to beneficiaries under age 21. ~~For Individuals under age 21 all personal care hours must be authorized through Medicaid's contracted Quality Improvement Organization (QIO) for these services.~~ **~~View or print AFMC contact information.~~** ~~Any additional hours of Personal Care Services needed by the individual age 21 or older must go to Utilization Review for approval of an extension of benefits.~~ Personal care is allowed in the home and outside the home, such as in the workplace. IndependentChoices follows the policy in the Arkansas Medicaid Personal Care Provider Manual in determining eligibility and the level of assistance of personal care needed by the IndependentChoices participant. Participants needing personal care in the workplace must meet the requirements found at 213.540 of the Arkansas Medicaid Personal Care Provider Manual.

Field Code Changed

220.210 Personal Care/Hospice Policy Clarification 1-1-16

Medicaid beneficiaries are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice aide and attendant care services.

A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in-home providers.

B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aide and attendant care services necessary for the treatment of the terminal condition.

C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the IndependentChoices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

~~Extension of benefits for personal care for beneficiaries receiving both hospice services and personal care services will be considered based on the individual beneficiary's physical dependency needs. Requests for increased personal care hours will be reviewed for medical necessity; duplication of services will be adjusted accordingly.~~

NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice care in the home that provides the amount of services required to meet the needs of the beneficiary, the

amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the hospice and personal care records must explain the need for both and be supported by the policy in this section.

220.300 Attendant Care Services 1-1-16

In-home services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible participant's function in his or her own home. IndependentChoices allows ARChoices participants the choice of self-directed attendant care services rather than receiving attendant care services through a certified agency.

The ~~DAAS~~DHS RN will determine the number of hours of attendant care services needed by the participant, using the Arkansas Medicaid Task and Hour Standards, as indicated on the ARChoices ~~Plan of Care~~ person-centered service plan. If the participant chooses to self-direct attendant care services, the ~~DAAS~~DHS RN will refer the participant to the IndependentChoices program by sending the ~~plan of care~~ person-centered service plan to IndependentChoices, notating that IndependentChoices was selected.

220.400 Exclusions from Coverage and Reimbursement

A. Goods and services of any kind are not available (not covered and not reimbursable) under IndependentChoices, including through the use of the cash allowance, when and to the extent any of the following may apply:

1. When available to the participant from another source, including without limitation family members, a member of the participant's household, or other unpaid caregivers; a Medicaid State Plan covered service; the Medicare program (Medicare Part A, Part B, or Part D); the participant's Medicare Advantage plan (including targeted or other supplemental benefits offered by the plan); the participant's Medicare prescription drug plan; and private medical, long-term care, disability, or supplemental insurance coverage. This includes reasonably comparable or substitute goods and services;

2. When not for the sole benefit of the participant or the maintenance of the participant's service animal;

3. When provided contrary to any Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, pharmacists, or other licensed professionals;

4. When goods and services of any kind are acquired or received for re-sale, or otherwise re-sold or gifted, whether for cash, barter or in-kind trade, or other compensation or consideration, and regardless who may benefit; and

5. When goods and services of any kind are acquired or received to substitute, or otherwise replace, other goods or services sold, traded, or gifted or intended to be sold, traded, or gifted.

B. In addition, the following types of goods and services are not available (not covered and not reimbursable) under IndependentChoices, including through the use of the cash allowance:

1. Alcoholic beverages of any kind, including distilled spirits, wine, malt beverages, and alcoholic soft drinks;
2. Tobacco products of any kind;
3. Medical marijuana;
4. Any controlled substance listed under 21 CFR Part 1308 or any controlled substance analogue as defined under 21 USC § 802(32)(A);
5. Prescription drugs, non-prescription (over-the-counter) drugs, vitamins, minerals, or other dietary supplements;
6. Illegal goods and services of any kind;
7. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including without limitation aseptic or sterile procedures; application of dressings; medication administration; injections; observation and assessment of health conditions; insertion, removal, or irrigation of catheters; tube or other enteral feedings; tracheostomy care; oxygen administration; ventilator care; drawing blood; and care and maintenance of any medical equipment;
8. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
9. Services provided for or goods used by any person other than the participant, including without limitation a provider, family member, household resident, or neighbor;
10. Companion, socialization, entertainment, or recreational services or activities of any kind, including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship;
11. Cleaning of any spaces of a home or place of residence (including without limitation kitchen, bathroom, living room, dining room, family room, and utility or storage rooms, and the floors, furnishings, and appliances therein) shared by the participant with one or more adults who are, together or separately, physically able to perform housekeeping of these areas; and
12. Habilitation services, including without limitation assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

230.000 BENEFIT LIMITS AND DURATION OF SERVICES

230.100 Benefit Limits 11-1-09

Benefits are limited by the amount of the participant's allowance. Each individual participant has a maximum allowance based on his or her individual service plan. The Division of Provider Services and Quality Assurance ~~Aging, Adult and Behavioral Health Services and Adult Services~~ will authorize the allowance~~through an eligibility screen on the MMIS~~. Payment is made

prospectively by the Medicaid fiscal intermediary. The participant's allowance will be issued monthly directly from the Medicaid fiscal intermediary to the IndependentChoices fiscal agent as long as the individual remains Medicaid eligible and the individual is not receiving hospice or nursing facility services. The IndependentChoices fiscal agent will disburse the cash allowance in accordance with the approved cash expenditure plan and timesheets completed by the participant or ~~Decision-Making Partner~~ Representative and signed by the personal attendant twice monthly in equal intervals.

231.000 Loss of Medicaid Eligibility 4-1-08

Participants must remain Medicaid eligible to continue participation in IndependentChoices. Participants will be advised to report any changes in the amount of household income or resources to the DHS county office. ~~The DAAS~~ DPSQA will notify the counseling entity, fiscal agent, and DHS RNs ~~provide weekly reports to contractors, counselors and nurses~~ informing them of participants who have lost Medicaid eligibility. IndependentChoices staff will then take action to close the IndependentChoices case within the MMIS. Internal edits within the MMIS system prevent the Medicaid fiscal agent from adjudicating a claim for any person not Medicaid eligible on the date(s) of service.

231.100 Loss of Medical Eligibility for Personal Assistant Services 11-1-09

If at any time the IndependentChoices nurse determines that personal assistance services are not necessary for an IndependentChoices participant, the participant's IndependentChoices case will be closed after a 10-day notice and ~~DAAS~~DPSQA staff will terminate the eligibility.

231.300 Hospitalization 1-1-13

An IndependentChoices participant's allowance paid prospectively during hospitalization must be returned to the Medicaid Program. The day of admission and day of discharge are allowable days when the participant receives personal assistance services prior to admission or after discharge from the hospital. The participant is instructed to provide supporting hospital documentation to the counseling entity's support coordinators and the ~~their counselor and Financial Management Services provider~~ fiscal agent to support receipt of personal assistance services on the day of admission. The fiscal agent ~~DAAS Financial Management Service~~ will be responsible for calculating and collecting the refund.

231.400 Long-Term Care Placement 4-1-08

If at any time a participant requires placement in a long-term care facility, ~~DAAS~~ the DHS RN and IndependentChoices program specialist must be notified immediately by the ~~counselor~~ counseling entity's support coordinators or fiscal ~~provider~~ agent. The IndependentChoices case will be closed on the date ~~of~~ prior to entry into ~~to~~ a facility. No monthly allowance is allowed during the time of institutionalization. The Medicaid fiscal intermediary will not disburse the cash allowance if Medicaid is currently making payment for long-term care facility services.

231.500 Voluntary Disenrollment 1-1-13

When the participant voluntarily elects to discontinue participation in IndependentChoices, ~~the counselor~~ DHS professional staff will discuss with the ~~individual~~ participant or their designated Representative the reason for disenrollment and assist the participant ~~individual~~ in resolving any barriers or problems that may exist in preventing continuation. If the participant wishes to continue with the option to disenroll, ~~the counselor~~ DHS staff will assist the participant by informing him or her of traditional agency personal care providers in the participant's area. ~~The counselor~~ DHS staff will assist with the coordination of agency services to the degree requested by the participant. The participant or their designated Representative may also reach out to the Aging and Disability Resource Center (866-801-3435) for assistance in identifying available

agency services. If the participant is an ARChoices waiver participant, the DHS RN may be contacted to assist with transitioning waiver clients to appropriate agency services.

IndependentChoices can continue until agency services are established or the participant may elect to use informal supports until agency services are established.

231.600 Involuntary Disenrollment 1-1-18

Participants may be disenrolled for the following reasons:

A. **Health, Safety and Well-being**: At any time that DHS or the counseling entity ~~DAAS~~ determines that the health, safety and well-being of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program.

B. **Change in Condition**: Should the participant's cognitive ability to direct his or her own care diminish to a point where he or she can no longer direct his or her own care and there is no ~~Decision-Making Partner~~ Representative available to direct the care, the IndependentChoices case will be closed. DHS and the counseling entity ~~The counselor~~ will assist the participant with a referral to traditional services.

C. **Misuse of Allowance**: Should a participant or the ~~Decision-Making Partner~~ Representative who is performing all of their payroll functions (and not using the fiscal agent) use the allowance to purchase items unrelated to personal care needs, fail to pay the salary of a~~n assistant~~caregiver/employee, misrepresent payment of an ~~assistant's~~ caregiver/employee's salary, or fail to pay related state and federal payroll taxes, the participant or ~~Decision-Making Partner~~ Representative will receive a warning notice that such exceptions to the conditions of participation are not allowed. The participant will be permitted to remain on the program, but will be assigned to the fiscal agent~~fiscal intermediary~~, who will provide ~~maximum bookkeeping services~~ increased oversight coordinated with the counseling entity's support coordinators. The participant or ~~Decision-Making Partner~~ Representative will be notified that further failure to follow the expenditure plan could result in disenrollment. Should an unapproved expenditure or oversight occur a second time, the participant or ~~Decision-Making Partner~~ Representative will be notified that the IndependentChoices case is being closed and they are being returned to traditional personal assistance services. The Office of Medicaid Inspector General is informed of situations as required. DHS and the counseling entity ~~The counselor~~ will assist the participant with transition to traditional services. The preceding rules are also applicable to participants using the fiscal agent.

D. **Underutilization of Allowance**: The fiscal agent is responsible for monitoring the use of the Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using it according to the cash expenditure plan, the fiscal agent will inform the counseling ~~entities~~entity's support coordinators and the IndependentChoices program specialist through ~~quarterly reports~~weekly and monthly reports on request. The ~~counselor~~ counseling entity's support coordinators will discuss problems that are occurring with the participant and their support network. The ~~counselor~~ counseling entity's support coordinators will continue to monitor the participant's use of their allowance through both review of reports and personal contact with the participant. If underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADL's even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days after disenrollment. Funds accrued in the absence of a savings plan will be returned to Medicaid within a twelve-month filing deadline. Involuntary disenrollment may be considered if the participant has been hospitalized for more than 30 days and a discharge date is unknown to the participant or ~~Decision-Making Partner~~ Representative. Participants with approval by DHS professional staff or contractor(s) designated by DHS for an out-of-state visit may be involuntarily disenrolled if their stay extends past the approval period. The participant is

required to provide a copy of authorizations by DHS professional staff or contractor(s) designated by DHS to their ~~counselor~~ support coordinator for monitoring purposes.

E. **Failure to Assume Employer Authority**: Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Disenrollment will not occur without guidance and counseling by ~~the counselor~~ counseling entity's support coordinator or by the fiscal ~~intermediary~~agent. When this occurs, the ~~counselor~~ counseling entity's support coordinator will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the DHS or the counseling entity ~~counselor~~, ask ~~the counselor~~ DHS or the counseling entity to coordinate or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.

Whenever a participant is involuntarily disenrolled, the IndependentChoices program will mail a notice to close the case. The notice will provide at least 10 days but no more than 30 days before IndependentChoices will be discontinued, depending on the situation. During the transition period, ~~the counselor~~ DHS or the counseling entity will work with the participant or Representative to provide services to help the individual transition to the most appropriate services available.

~~232.000 Reporting Changes in Participant's Status 11-1-09~~

~~It is the responsibility of the participant or Decision-Making Partner and personal attendant to report changes to the IndependentChoices counselor immediately so that proper action can be taken. Participants or Decision-Making Partners may complete the IndependentChoices change form DAAS-IC-09 and send it to the IndependentChoices counselor. The copy is retained in the participant's case record. Whether or not the change results in any action, participants/ Decision-Making Partner must report all changes in the participant's status to the IndependentChoices counselor.~~

250.000 COMPLAINTS/GRIEVANCES AND APPEALS

250.100 Complaints/Grievances

Grievances based on dissatisfaction with any service or level of service provided by the counseling entity's support coordinators, fiscal agent, or DHS staff may be made in writing to the Division of Provider Services and Quality Assurance (DPSQA), IndependentChoices Program, P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437, or by telephone to IndependentChoices at 1-866-801-3435.

250.2100 Appeal Rights

IndependentChoices participants have the right to appeal certain decisions or actions with which they disagree. The method used to make the appeal and the time frames within which an appeal is made depends on the basis of the appeal. The Division within the Department of Human Services that will hear the appeal is also based on the reason for the appeal.

Appeals for hearings will also be handled in several ways based on the reason the appeal was made.

250.2300 Reason for Appeal 7-1-15

If the participant loses eligibility for personal assistance services, he or she may ask for an Administrative Reconsideration according to Section 161.200 of the Medicaid Provider Manual or may appeal the decision according to Medicaid Provider Manual policy 161.300 through 169.000.

An appeal may be filed by a participant or ~~Decision-Making Partner~~ Representative based on actions or circumstances listed below:

A. Dissatisfaction with action taken by the counseling entity's support coordinator fiscal agent

B. Involuntary case terminations including but not limited to:

1. Loss of Medicaid eligibility
2. Institutionalization
3. Dissatisfaction with number of personal care hours
4. Health, safety or well being of participant is compromised
5. Duplication of services
6. IndependentChoices case closure based on noncompliance with program requirements

C. Loss of Medicaid eligibility will result in the closure of the case. Any appeal made by the participant must be filed with the Office of Appeals and Hearings according to Medicaid Provider Manual Policy 161.300 through 169.000.

~~D. Request for personal care hours above 14.75 denied by Utilization Review (UR) in the Division of Medical Services. Appeals must be filed with the Office of Appeals and Hearings according to Medicaid Provider Manual Policy 161.300 through 169.000.~~

~~E~~. ~~Requests for personal care hours for beneficiaries under age 21 denied by Medicaid's contracted QIO may be filed for reconsideration. Reconsideration requests must be made in writing to the contracted Quality Improvement Organization (QIO) and must include additional documentation to substantiate the medical necessity of the requested services.~~ **~~View or print AFMC contact information.~~** ~~If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, the QIO issues a written notification of the decision to all relevant parties. Any further appeal on this action must be filed with the Office of Appeals and Hearings according to Medicaid Provider Manual Policy 161.300 through 169.000.~~

Field Code Changed

~~250.210 Counselor or Fiscal Agent 4-1-08~~

~~Appeals based on dissatisfaction with any service or level of service provided by the counselor, nurse or fiscal agent may be made in writing to the Division of Aging and Adult Services (DAAS), IndependentChoices Program, P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437 or by telephone to DAAS IndependentChoices toll free number (1-800-682-0044).~~

250.400 Administrative Review and Appeal of Involuntary Disenrollment 4-1-08

A participant may request administrative review of the involuntary closure of his/her ~~a~~ case by ~~may be appealed in~~ writing to ~~the Division of Aging and Adult Services (DAAS), IndependentChoices Program, the~~ Division of Provider Services and Quality Assurance, ~~P~~P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437 or may be sent by fax (1-501-683-4180).

~~When a participant is involuntarily disenrolled from the IndependentChoices program, the participant may be returned to the traditional personal care program. If the participant appeals this decision, the participant will continue to receive Medicaid personal care services through a personal care agency during the time of the appeal.~~

The participant has thirty (30) days from the date of notification of disenrollment to file an administrative review of this decision. Administrative Review requests may be mailed or faxed to ~~DAAS~~DPSQA and must be post marked or received within 30 days of the disenrollment decision. All notifications of Involuntary Disenrollment must be made in writing and sent by Certified Mail

with a receipt to assure that the date the notification was received is documented. Requests received after the 30-day limit will not be reviewed. Reviews will be completed and decisions will be available within 45 days of the request.

The Administrative Review decision, if unfavorable, may be appealed through the established DHS Hearings and Appeals policy according to Medicaid Provider Manual Policy 161.300 through 169.000.

When a participant is involuntarily disenrolled from the IndependentChoices program, the participant may be returned to the traditional personal care program. If the participant appeals this decision, the participant will continue to receive Medicaid personal care services through a personal care agency during the time of the appeal.

260.000 REIMBURSEMENT

260.100 Fiscal Support Services 1-1-15

Beneficiaries in IndependentChoices will be offered a monthly allowance in lieu of traditional agency-provided personal assistance services. The intended use of the monthly allowance is to purchase items or other medically necessary personal assistance services that are allowed. All payments are by electronic funds transfer (EFT). Use of the monthly allowance is determined by the beneficiary/representative exercising budget authority outlined on the Cash Expenditure Plan. Requests to purchase nontraditional or unusual items over $50.00 will require the approval of the IndependentChoices program specialist. The fiscal agent, or bookkeeper, will receive the beneficiary's cash payment from the Arkansas Medicaid fiscal intermediary. The Medicaid fiscal intermediary will make monthly prospective payments to the fiscal agent based on active IndependentChoices participants as indicated on the MMIS. ~~DAAS is responsible for accurately maintaining the IndependentChoices eligibility segments.~~

Personal assistants will complete their timesheets and obtain the authorizing signature of the beneficiary. The timesheet will be submitted to the fiscal agent bi-weekly.

The fiscal agent will perform all payroll functions. This will include preparation and payment through EFT for assistants and compliance with applicable state and federal employer/employee laws.

260.410 ~~DAAS~~ DPSQA Responsibilities 4-1-08

IndependentChoices seeks to ensure that providers contracted by ~~DAAS~~DPSQA are competent and experienced and possess the technical ability to perform all required functions. To assure this goal is met ~~DAAS~~DPSQA will:

- Competitively procure a ~~providers and hire counselors~~ counseling entity and fiscal agent that understand the concepts of independent living and consumer direction and have experience providing counseling or fiscal services to participants
- Clearly identify performance standards, corrective action plans and consequences for deviations from the standards
- Monitor performance standards to assure that ~~counselors~~ support coordinators and fiscal agents are providing the service and quality required
- Conduct on-site survey reviews of fiscal agents as needed, but no less than annually

260.420 Employer Authority 1-1-18

The IndependentChoices participant is the employer of record, and as such, hires a Personal Assistant who meets these requirements:

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

B. Has a valid Social Security number

C. Signs a Work Agreement with the participant/~~ Decision-Making Partner~~ Representative

D. Must be able to provide references if requested

E. Submit to ~~a criminal background check prior to employment and every three years thereafter, identity verification, and fingerprinting~~ central registry checks and national and state criminal background checks in compliance with Ark. Code Ann. §§ 20-33-213 and 20-38-101 et seq. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

F. Obtains a Health Services card from the Division of Health if requested

G. May not be an individual who is considered legally responsible for the client, e.g., spouse or guardian

H. Must be 18 years of age or older

I. Must be able to perform the essential job functions required

260.430 Counseling 1-1-15

Counseling is provided to beneficiaries statewide through a self-directed service budget (SDSB) contract. The counseling entity must adhere to performance based contracting standards and the Scope of Service established by ~~DAAS~~DPSQA in addition to State and Federal requirements. The support coordinators representing the contract must have a minimum of three years experience working with the general public with experience in teaching, mentoring or coaching with outcome based expectations. Examples of potential support coordinators may include but are not limited to active or retired teachers, public servants, health professionals, social workers or non-professionals who have exceptional communication skills and pass the self-directed service budget delivered training offered by the SDSB counseling contractor.

A counseling entity may not provide SDSB enrollment or monitoring activities to a family member. A family member is defined as an individual currently related to the counselor by virtue of blood, marriage, adoption or a relative of any degree.

Other job-related education and/or experience may be substituted for all or part of these basic requirements with approval of ~~DAAS~~DPSQA.

The current contract requires the IndependentChoices counseling entity to perform the following:

A. Enrollment of new beneficiaries

B. Develop and implement beneficiary directed budget

C. Coordinate with Financial Management Services (FMS) provider and DMS

D. Orientation to IndependentChoices and the concept of consumer direction

E. Skills training on how to recruit, interview, hire, evaluate, manage or dismiss assistants

F. Consumer-directed counseling support services

G. Monitor IndependentChoices participants/~~ Decision-Making Partners~~ Representatives

H. Monitor over and under expenditures of the Cash Expenditure Plan

I. Provide monthly reports to ~~DAAS~~DPSQA

J. Use RNs to assess functional need for personal care

K. Inform ~~DAAS~~DPSQA of beneficiaries' readiness to begin self-direction and when disenrollment occurs

260.440 Financial Management Services (FMS) 1-1-15

Financial management services (FMS) will be participant-directed and provided by the IndependentChoices fiscal agent. The FMS contractor must adhere to performance based contracting standards and the Scope of Service established by DMS in addition to State and Federal requirements. If FMS is provided by a Certified Public Accountant (CPA), the CPA must be licensed in the State of Arkansas. Subcontracts with FMS direct-service providers must be approved by ~~DAAS~~DPSQA. The entity providing the direct FMS service must have an IRS FEIN (Federal Employer Identification Number) dedicated to fiscal agency services. The entity providing this service must have at least 3 years experience providing fiscal employer agency work to individuals with physical disabilities in Arkansas.

The FMS will provide the following supports and services:

A. Collect and process timesheets of support workers

B. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

C. Prepare and disburse IRS Forms W-2 and W-3 annually

D. Receive and disburse funds for payment of participant-directed services under an agreement with Medicaid and the Medicaid fiscal intermediary

E. Assure that all expenditures match the written budget

F. The current contract with the FMS requires the following:

1. Creation of systematic processes, internal controls, policies and procedures to comply with FMS requirements
2. Receiving and reviewing all necessary Federal and State forms required for enrolling the participant to be a "Household Employer," as well as New Hire Packets from the enrolling participant's caregiver/employee
3. Obtaining individual FEIN number enabling FMS provider to act as a Household Employer Agent
4. Communicating and assisting participants in the completion of these forms if needed
5. Resending and monitoring receipt of forms as needed
6. Accepting the participant's allowance from Medicaid's fiscal intermediary (fiscal agent) once monthly
7. Accurately posting allowance income and expenditures and developing and submitting a monthly report on carry-over balance
8. Disbursing the monthly allowance as directed on the Cash Expenditure Plan
9. Withhold and pay State and Federal payroll taxes per regulations
10. Informing the counseling entity and IndependentChoices program specialist when a participant has 30 days of their allowance (excluding savings directed toward a specific purchase) remaining at the end of the month on the Cash Expenditure Plan
11. Notifying ~~DAAS~~DPSQA and providing a corrective action plan in the event any participant's allowance ever becomes less than zero

12. Making refunds to Arkansas Medicaid within 45 days post disenrollment or sooner if no outstanding obligations are present upon disenrollment
13. Providing monthly management reports to participants and ~~DAAS~~DPSQA
14. Respond to requests for income verification
15. Providing to ~~DAAS~~DPSQA, by the end of February, an annual report of the previous years' activity. The report will inform by participant, by month, the amount of the allowance received, the wages paid to participant's caregiver/employee, taxes withheld, and, in descriptive terms, how the allowance was spent.
16. Mail W-2s in January of each year if the caregiver/employee's wages meet the earnings threshold per IRS Publication 926—Household Employer's Tax Guide

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

I. Request Information

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

B. Waiver Title (*optional*): Living Choices Assisted Living

C. CMS Waiver Number: **AR.0400**

D. Amendment Number (*Assigned by CMS***):**

E.1 Proposed Effective Date: 01-01-2019

E.2 Approved Effective Date *(CMS Use):*

II. Purpose(s) of Amendment

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

The Living Choices Assisted Living waiver is being amended as follows:

1. Section 1.F is amended to clarify that the State does not enroll individuals who need a skilled level of nursing care. Conforms to current State administrative rules.

2. For assessments and re-assessments, transition from (a) independent assessments performed by DHS registered nurses (DHS RNs) using the ArPath assessment instrument to (b) independent assessments performed by RNs of the DHS Independent Assessment Contractor using the Arkansas Independent Assessment (ARIA) instrument.

3. Provides for a new reimbursement rate determination methodology for Assisted Living Facility services.

4. Various technical revisions are being made to reflect responsibilities of the new DHS Division of Provider Services and Quality Assurance (DPSQA) (a new operating agency), a new name of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (formerly Division of Aging and Adult Services, an operating agency), and the location of Office of Long-Term Care (OLTC) in DPSQA.

III. Nature of the Amendment

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

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

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

☐	Modify target group(s)
X	Modify Medicaid eligibility
☐	Add/delete services
X	Revise service specifications
☐	Revise provider qualifications
☐	Increase/decrease number of participants
☐	Revise cost neutrality demonstration
☐	Add participant-direction of services
X	Other (specify): 1. Transition independent assessment process from (a) DHS RNs using the ArPath instrument to (b) RNs of independent assessment contractor using the Arkansas Independent Assessment (ARIA) instrument. DHS RNs will gather additional information from individuals in connection with developing the person-centered service plan (PCSP). 2. Provide for a new reimbursement rate determination methodology for Assisted Living Facility services. 3. Technical edits to reflect changes in operating divisions (names, responsibilities).

IV. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Tami
Last Name	Harlan
Title:	Director
Agency:	Arkansas Department of Human Services, Division of Medical Services
Address 1:	P. O. Box 1437, Slot S-295
City	Little Rock
State	AR
Zip Code	72203-1437
Telephone:	(501) 682-8292
E-mail	tami.harlan@dhs.arkansas.gov
Fax Number	(501) 682-1197

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

First Name:	Stephenie
Last Name	Blocker
Title:	Assistant Director
Agency:	Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services
Address 1:	P. O. Box 1437, Slot S-530
City	Little Rock
State	AR
Zip Code	72203-1437
Telephone:	(501) 320-6569
E-mail	stephenie.blocker@dhs.arkansas.gov
Fax Number	(501) 682-8155

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

Signature:

_____

State Medicaid Director or Designee

Date:	

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

REQUESTED AMENDMENT TO WAIVER INFORMATION

1. Request Information
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):

X Nursing Facility

X Nursing Facility as defined in 42 CFR 440.40 and 42 CFR 440.155

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

Individuals requiring a skilled level of care are not eligible for the Living Choices program.

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. However, assisted living services are not intended as a substitute for nursing facility or hospital care for individuals needing skilled care, and room and board services are not covered per federal law.

Living Choices includes 24-hour on-site response staff to assist with participants' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living facility staff will perform their duties and conduct themselves in a manner that fosters and promotes participants' dignity and independence. Supervision, safety and security are required components of the assisted living environment. Living Choices includes therapeutic, social and recreational activities suitable to the participants' abilities, interests, and needs. Assisted living participants' living units are separate and distinct from all others. Laundry and meal preparation and service are in a congregate setting for participants who choose not to perform those activities themselves. The principles of negotiated service plans and managed risk are applied.

Extended Prescription Drug Coverage is available for Living Choices participants who are eligible for regular Medicaid drug benefits, plus three additional prescriptions. Participants dually eligible for Medicare and Medicaid must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

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

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

Attachment #1: Changes from Previous Approved Waiver That May Require a Transition Plan.

Instructions: If applicable, check the box next to any of the following changes from the current approved waiver that you are making with this application. Check all of the boxes that apply. If you check any of the boxes, you will be prompted to complete a transition plan.

	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
X	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.
X	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.

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

All types of services covered in the approved waiver continue to be covered in the amended waiver.

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

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

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

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

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

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

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

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

Re-assessments of existing participants will be performed through the new ARIA independent assessment process on a revolving basis as previously approved person-centered service plans near expiration or earlier if appropriate (such as in the event of care transitions).

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

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

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

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

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

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

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

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

Relevant beneficiary materials will be updated to describe policy changes.

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

REQUESTED AMENDMENTS TO WAIVER APPENDICES

Appendix A: Waiver Administration and Operation

A-1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver:

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

- Department of Human Services (DHS), Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency).
- Department of Human Services (DHS), Division of Provider Services and Quality Assurance (DPSQA) (operating agency).

Appendix A: Waiver Administration and Operation

A-2. Oversight of Performance.

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

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

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

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

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

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

A-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)

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

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

A contractor ("Independent Assessment Contractor") will perform independent assessments that gather functional need information about each Living Choices waiver applicant and participant using the Arkansas Independent Assessment (ARIA) instrument. The information gathered is used to determine the individual's level of care and the tier level (which is intended to help inform waiver program oversight and administration and person-centered service planning).

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

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

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

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

The Independent Assessment Contractor's quality monitoring and assurance process must include (1) the staff necessary to perform quality monitoring and assurance reviews for accuracy, data consistency, integrity, and completeness of assessments and (2) procedures for assessing the performance of the staff

conducting the assessments, include a desk review of assessments, tier determinations, and recommended attendant care services hours according to the Task and Hour Standards for a statistically significant number of cases. The Independent Assessment Contractor is required to include the results of the quality monitoring and assurance process in the monthly reports submitted to the Contract Monitor in the format required by DHS.

The monthly reports include the following:

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

The annual report includes the following:

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

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

Appendix A: Waiver Administration and Operation
Quality Improvement: Administration Authority of the Single State Medicaid Agency

a. Methods for Discovery: Administrative Authority

i. Performance Measures

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

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.
Medicaid Quarterly QA Report (Chart Reviews)
Case Record Review
Sampling Approach *(check each that applies)*
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DPSQA during the Chart Record Review process.

Performance Measure:
Number and percent of participant service plans completed by DAABHS in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of service plans completed by DAABHS in time frame; Denominator: Number of service plans reviewed.
Case Record Review
Sampling Approach *(check each that applies)*
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DPSQA during the Chart Record Review process.

Performance Measure:
Number and percent of LOC assessments completed by Optum in the time specified in the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by Optum in time frame; Denominator: Number of LOC assessments reviewed.
Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DPSQA during the Chart Record Review process.

Performance Measure:
Number and percent of LOC assessments completed by an Optum-qualified evaluator according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by an Optum-qualified evaluator; Denominator: Number of LOC assessments reviewed.
Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DPSQA during the Chart Record Review process.

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.
Case Record Review
Sampling Approach *(check each that applies)*
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DPSQA during the Chart Record Review process.

Appendix B: Evaluation/Reevaluation of Level of Care
Quality Improvement: Level of Care

a. Methods for Discovery: Level of Care Assurances/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 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.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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:

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.

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.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

b. Methods for Remediation/Fixing Individual Problems

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 Provider Services and Quality Assurance (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. DPSQA and DMS have an Interagency Agreement that includes measures related to level of care determinations for the waiver.

Appendix B: Participant Access and Eligibility

B-6. Evaluation/Reevaluation of Level of Care

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

Directly by the Medicaid agency

X By the operating agency specified in Appendix A.

Specify the entity:

Currently, independent assessments and reassessments for the waiver are performed by DHS RNs using the ArPath instrument. Upon implementation of the new independent assessment program for the waiver program, an Independent Assessment Contractor under contract with the Division of Medical Services (Medicaid agency) will perform independent assessments and reassessments using the Arkansas Independent Assessment (ARIA) instrument and the contractor's team of registered nurses. The Office of Long Term Care (OLTC), now part of the DHS Division of Provider Services and Quality Assurance (DPSQA) (an operating agency), continues to be responsible for reviewing results of independent assessment and reassessments, establishing the level of care, and determining eligibility. (Registered nurses in the Division of Aging, Adult, and Behavioral Health Services (DAABHS), an operating agency, remain responsible for the development and approval of person-centered service plans.)

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

Level of Care Criteria:

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

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

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

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

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

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

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

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

2. Not require a skilled level of care, as defined in the rule.

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

Instrument/Tool Used:

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

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

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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.

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

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

Level of Care Instrument for Institutional Care:

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

Level of Care Instrument for Waiver Program:

The level of care instrument for the Living Choices waiver program will be the Arkansas Independent Assessment (ARIA) system will be used to support the level of care determination process.

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level 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 new process for evaluating waiver applicants and re-evaluation of waiver program participants for their respective needs for the level of care under the waiver is described below.

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

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

Re-evaluations will continue to be performed on at least an annual basis, with the level of care re-affirmed or revised and a written determination issued by the Office of Long Term Care. A re-evaluation may also be performed anytime upon request the participant (or their legal representative or physician), if requested by the DHS RN responsible for the participant's person-centered service plan, or in cases a participant has experienced a significant change in circumstances, such as a inpatient hospital or skilled nursing facility admission or the loss of a primary caregiver.

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

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

In summary:

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

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

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

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

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

Specifically, DAABHS uses a "tickler" file system approach that DAABHS registered nurses (DHS RNs) and RN supervisors use to monitor upcoming review data and service plan expirations. The process of reassessment begins two months prior to the expiration date of the current person-centered service plan or two months prior to the annual anniversary date of the last independent assessment, whichever is earlier. The case is added to the assessment schedule of the independent contractor. Once the re-assessment is completed and the level of care revised as appropriate, the DHS RN begins development of the new person-centered service plan.

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

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

Each Targeted Case Manager is also required to maintain a "Tickler" system to track the Medicaid eligibility reevaluation date and the service plan expiration date. If the reassessment process has not been

completed timely, the Targeted Case Manager notifies the DHS RN prior to the expiration date of the current service plan.

Appendix B: Participant Access and Eligibility

B-6. Evaluation/Reevaluation of Level of Care

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

a. Methods for Discovery: Level of Care Assurances/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 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.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

e. ***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:
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.
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.
Case Record Review
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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

Level of Care assessments are required annually using the approved assessment instrument (currently, ArPath instrument, and upon the effective date of this Amendment, the Arkansas Independent Assessment (ARIA) instrument) and applying the level of care criteria. The DHS RN supervisors complete a regional monthly activity report, which lists the number of level of care evaluations and re-evaluations conducted. Remediation efforts are included on the DHS RN supervisors' monthly report.

The DHS RN supervisors complete a review to evaluate trends and identify where additional training is needed for the RNs and the OLTC staff performing level of care determinations. Remediation in these areas includes ongoing training by DAABHS for the Independent Assessment Contractor's RNs who perform these assessments conducted correctly, consistent with the assessment instrument and level of care criteria, and that initial and annual re-evaluation of level of care are completed within the required timeframes. DHS RN supervisors develop a corrective plan when remediation in this area is needed.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.
Copies of the waiver participant's service plan are maintained with the Division of Aging, Adult, and Behavioral Health Services (operating agency) and with the providers chosen by the participant and included on the service plan. Freedom of Choice forms and person-centered service plans are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

Appendix B: Participant Access and Eligibility

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

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

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

Appendix C: Participant Services

C-1/C-3: Provider Specifications

Provider Type - Licensed Level II Assisted Living Facility

Provider Qualifications

License (specify)

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Level II Assisted Living Facility.

Other Standard

Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) as an Assisted Living Level II facility to be eligible to participate in the Arkansas Medicaid Program. A copy of the ALF's current license must accompany the provider application and Medicaid contract.

Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency's written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client's' condition; and, a client's right to confidentiality. This training must be provided prior to the delivery of waiver services.

The facility must be located within the state of Arkansas.

Consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the concurrence of the federal Centers for Medicare and Medicaid Services (CMS), DPSQA may temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers in the Living Choices HCBS waiver program. If DPSQA determines temporary caps, limits, or moratoria are appropriate and would not adversely impact beneficiaries' access to assisted living facility services, it will initiate the process through filing a Request for State Implemented Moratorium (CMS–10628 Form) with CMS.

Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Provider Services and Quality Assurance?]
Frequency of Verification:
Annual

Provider Type - Licensed Class A Home Health Agency
Provider Qualifications
License (specify)
Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Class A Home Health Agency.
Other Standard
Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance as a Class A Home Health Agency to be eligible to participate in the Arkansas Medicaid Program. A copy of the Class A Home Health Agency's current license must accompany the provider application and Medicaid contract.
Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency's written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client's condition; and, a client's right to confidentiality. This training must be provided prior to the delivery of waiver services.

The facility must be located within the state of Arkansas.
Provider qualifications, licenses, training, education and experience for the staff of Home Health Agencies are the same as Medicaid enrolled Home Health Agencies.
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Provider Services and Quality Assurance
Frequency of Verification:
Annual

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

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

Targeted case managers

Appendix C: Participant Services
C-2: General Services Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):
Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

A criminal history record check is required for employees of long-term care facilities, according to Ark. Code Ann. §20-33-213. The Division of Provider Services and Quality Assurance (DPSQA), Office of Long-Term Care, requires state and national criminal history record checks on employees of long-term care facilities, including assisted living facilities. Employees include any person who has unsupervised access to participants; provides care to participants on behalf of a service provider, under supervision of, or by arrangement with the assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility to provide care to participants. Before making an offer of employment, the assisted living facility shall inform an applicant that employment is contingent on the satisfactory results of criminal history record checks.

When a facility operator applies for licensure to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from the Office of Long Term Care. The forms and appropriate fees shall be submitted to the Office of Long Term Care attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the Office of Long Term Care shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to the Office of Long Term Care for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure.

Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks on applicable employees so that no applicable employee exceeds five years without a new criminal record check.

Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule.

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor.

Home Health Agencies that contract with the ALF's must meet the same requirements for initial criminal history record checks.

Criminal history/background investigations in LTC/NF facilities are monitored through the Office of Long Term Care Licensing and Surveying Unit.

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

The Division of Provider Services and Quality Assurance (DPSQA), Office of Long-Term Care, requires that assisted living facilities conduct adult abuse registry checks on employees prior to licensure. The facility must provide documentation that employees have not been convicted or do not have a substantiated report of abusing or neglecting residents or misappropriating resident property. The facility shall, at a minimum, prior to employing any individual or for any individuals working in the facility through contract with a third party, make inquiry to the

Employment Clearance Registry of the Office of Long Term Care and the Adult Abuse Register maintained by the Adult Protective Services Unit within the Division of Aging, Adult, and Behavioral Health Services. Employees must be re-checked every five years. The Office of Long Term Care requires that each facility have written employment and personnel policies and procedures, which include verification that an adult abuse registry check has been completed.

Employees include any person who has unsupervised access to participants; provides care to participants on behalf of a service provider, under supervision of, or by arrangement with the assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility to provide care to participants.

The OLTC Licensing and Surveying Unit ensures that mandatory screenings have been conducted.

When a facility operator applies for licensure to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from the Office of Long Term Care. The forms and appropriate fees shall be submitted to the Office of Long Term Care attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the Office of Long Term Care shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to the Office of Long Term Care for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure.

Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks on applicable employees so that no applicable employee exceeds five years without a new criminal record check.

Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule.

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor.

Home Health Agencies that contract with the ALF's must meet the same requirements for initial criminal history record checks.

Criminal history/background investigations in LTC/NF facilities are monitored through the Office of Long Term Care Licensing and Surveying Unit.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*: Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services

rendered. *Also specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians*

All Living Choices waiver services may be provided by a family member of the participant when the family member is employed by the assisted living facility. Legally responsible family members or caregivers (spouse or legal guardian of the person) are prohibited from receiving reimbursement for direct provision of covered services for the Living Choices participant.

Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual and be licensed as an Assisted Living Level II facility or Class A Home Health Agency.

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Living Choices provider enrollment is open and continuous. Prospective Living Choices Assisted Living Providers may contact the Medicaid program's Provider Enrollment Unit for information about becoming a provider. There are no restrictions applicable to requesting this information. This process is open and available to any interested party.

The website of the Division of Provider Services and Quality Assurance (DPSQA) lists information for potential Living Choices providers. In addition, the Office of Long Term Care within DPSQA provides information about becoming a waiver provider during the process of licensing facilities, upon request.

Appendix C: Quality Improvement

Quality Improvement: Qualified Providers

a. Methods for Discovery: Level of Care Assurances/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:

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

Performance Measure: Number and percent of qualified providers will be licensed by the Division of Provider Services and Quality Assurance. Qualified providers will be offered using the freedom of choice list. Numerator: Number of providers with maintained license; Denominator: Total number of providers.

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

The state identifies and rectifies situations where providers do not meet requirements. This is accomplished by monitoring certification/license expiration dates within MMIS and continuing communication with the Medicaid fiscal agent responsible for provider enrollment functions, and reviewing monthly reports that identify providers

whose participation is terminated for inactivity or violations. Participation in provider training is documented and monitored through monthly activity reports.

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

Each month the DHS RN receives a provider list for each county included in their geographical area. This provider list may be used at each assessment and reassessment to give the participant a choice of providers for each service included on the service plan. In addition, this list is used to identify the providers who are new or who have been reinstated in the program.

Providers are required to follow all guidelines in the Medicaid Provider Manual related to provider training of employees and staff orientation, including documentation requirements, provider participation requirements, and any penalties or sanctions applicable for noncompliance.

DPSQA and DAABHS work collaboratively to train providers on program policy, including documentation requirements, reporting, claims processing and billing, the Medicaid Provider Manual and other areas. This training is scheduled, at a minimum, two times per year based on training needs.

Training requirements are explained in the provider manual. In addition, DPSQA is responsible for contacting new providers according to program policy. These contacts provide information regarding proper referrals, eligibility criteria, documentation requirements, forms, reporting, general information about the program, Section II of the Medicaid provider manual, and claims processing problems, etc. Within three months of appearing on the provider list, each new provider must meet with the DHS RN face-to-face to discuss all of the above, plus any problems noted in the first three months of participation.

Evaluations from in-services are used to address strengths and weaknesses in the training process, topics for future in-services and policy enhancements. As a result of in-services, policy clarifications have been issued; forms have been revised; training topics have been chosen; documentation requirements have been revised; training sessions have been redesigned.

The Medicaid fiscal agent provides DPSQA access to Provider License/Certification Status. If needed, this provides a second monitoring tool for monitoring licensure compliance.

The mandatory Medicaid contract, signed by each waiver provider, includes compliance with required enrollment criteria. Failure to maintain required licensure results in loss of their Medicaid provider enrollment. Each provider is notified in writing at least two months prior to the licensure expiration date that renewal is due and failure to maintain proper licensure will result in loss of Medicaid enrollment.

In accordance with the Medicaid provider manual, the provider must require staff to attend orientation training prior to allowing the employee to deliver any waiver services. This orientation shall include, but not be limited to, descriptions of the

purpose and philosophy of the Living Choices program; discussion and distribution of the provider agency's written code of ethics; activities which shall and shall not be performed by the employee; instructions regarding Living Choices record keeping requirements; the importance of the service plan; procedures for reporting changes in the participant's condition; discussion, including potential legal ramifications, of the participant's right to confidentiality.

All waiver providers are responsible for all provider requirements, penalties and sanctions as detailed in the Medicaid provider manual.

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.

To continue Medicaid enrollment, a waiver provider must maintain certification by DPSQA. In cases where providers do not maintain certification, DPSQA's remediation may include requesting termination of the provider's Arkansas Medicaid enrollment, recouping payment for services provided after certification/licensure has expired, and allowing the participant to choose another provider.

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services:

None.

D-1: Service Plan Development

D-1: Service Plan Development (3 of 8) - Supporting the Participant in Service Plan Development

When scheduling the person-centered service plan development visit, the DHS Division of Aging, Adult, and Behavioral Health Services (DAABHS) registered nurse (DHS RN) explains to the participant or authorized representative the process and informs the participant that they may invite anyone they choose to participate in the service plan development process. Involved in this assessment visit is the participant and anyone they choose to have attend, such as their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment process or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting.

During the service plan development, the DHS RN explains to the participant the services available through the Living Choices waiver.

When developing the person-centered service plan, all services and any applicable benefit limits are reviewed, as well as the comprehensive goals, objectives and appropriateness of the services. The participant and their representatives participate in all decisions regarding the type of services, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services. This information is recorded on the service plan, which is signed by the participant.

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

a) DHS RNs will develop initial person-centered service plans for Living Choices participants based on the Independent Assessment Contractor's assessment of the participant's needs and information gathered during the service plan development meeting with the participant. The DHS RN will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting. The DHS RN will assist in notifying interested parties if requested by the participant or the representative.

The development of the person-centered service plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor within 10 working days of the Independent Assessment Contractor receiving a referral from DHS. Following the assessment and assignment of a tier level by the Independent Assessment Contractor, a DHS RN will schedule a meeting with the participant to develop the service plan. Reassessments, which will be conducted by the Independent Assessment Contractor, will be completed annually or more often, if deemed appropriate by the DHS RN. Following the reassessment by the Independent Assessment Contractor, the DHS RN will develop a person-centered service plan. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans are developed and sent to all providers before services may begin.

(b) The Independent Assessment Contractor will assess the participant's needs. The DHS RN will assess the participant's comprehensive goals and objectives related to the participant's care and reviews the appropriateness of Living Choices services. If necessary, the DHS RN will read any of the information provided during the assessment to the participant. If this is done, it is documented in the participant's record. All forms and information will be provided in an alternate format upon request. If an alternate format is requested and/or provided, the DHS RN will document in the participant's record the format requested and/or provided.

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

The results of the Independent Assessment Contractor's functional assessment using the ARIA assessment tool will be used by the Office of Long Term Care to evaluate the level of care and by the DHS RN to develop the person-centered service plan. Information collected for the Independent Assessment Contractor's functional assessment using the ARIA tool will include demographic

information and information on the waiver participant's ability to perform the activities of daily living; transferring and ambulation; continence status; nutritional status; hearing, vision, speech and language; skin condition; behavior and attitude; orientation level; other medical conditions; psychosocial and cognitive status; and, medications/treatments.

The assessment is a complete functional assessment and includes a medical history. The Independent Assessment Contractor will evaluate the participant's physical, functional, mental, emotional and social status, and will obtain a medical history to ensure that the service plan addresses the participant's strengths, capacities, health care, and other needs. The DHS RN will assess the participant's preferences, goals, desired outcomes, and risk factors. Support systems available to the participant are identified and documented, along with services currently in place. Based on this assessment information, the DHS RN will discuss the service delivery plan with the participant.

When the service plan development process results in an individual being denied the services or the providers of their choice, the state must afford the individual the opportunity to request a Fair Hearing.

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

Provisional person-centered service plans expire 60 days from the date signed by the DHS RN and the participant. A comprehensive service plan that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional service plan. Prior to its expiration date, the DHS RN will provide a signed, comprehensive service plan to the Living Choices provider.

The Independent Assessment Contractor will complete a face-to-face functional assessment within 10 working days of receiving a referral from DHS. The DHS RN meets with the participant and develops a Living Choices person-centered service plan. Once the service plan is signed by the DHS RN and the applicant, it is considered a provisional service plan.

If services are started based on the provisional service plan, providers will send the Start of Care (AAS-9510) form to the DHS RN indicating the date services started. No additional notification to the DHS RN is required when the comprehensive service plan is received.

(c) During the person-centered service plan development process, the DHS RN explains the services available through the Living Choices waiver to the participant, including any applicable benefit limits. All services the participant is currently receiving are discussed and documented on the person-centered service plan. This includes all medical and non-medical services, such as diapers, under pads, nonemergency medical transportation, family support or other services that are routinely provided.

(d) The DHS RN develops the person-centered service plan based on the information gathered through the assessment process and the discussion of available services with the participant. The service plan

addresses the participant's needs, goals and preferences. The participant may invite anyone they choose to participate in the assessment and service plan development process, including family members and caregivers. Also, the DHS RN may contact anyone who may be able to provide accurate and pertinent information regarding the participant's condition and functional ability.

If there is any indication prior to or during the assessment or person-centered service plan development process that the participant is confused or incapable of answering the questions required for a proper assessment and service plan development, the assessment or service plan development will not be conducted without another person present who is familiar with the participant and his or her condition. This may be a family member, friend, neighbor, caregiver, etc. If unavailable for the interview, this person may be contacted by phone. These individuals' participation in the service plan development process also helps to ensure that the participant's goals, preferences and needs are met.

When developing or updating the person-centered service plan, the participant and their representatives participate in all decisions regarding the types, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services.

(e)- The participant must choose a provider for each waiver service selected. During the service plan development process, the DHS RN informs the participant or their legal guardian or family member of the available services. The participant or guardian/family member may choose the providers from which to receive services. Documentation verifying freedom of choice was assured is included in the participant's record on the person-centered service plan, and on the provider list. Both documents reflect freedom of choice was given to the participant. The freedom of choice form and all related documents are included in the participant's record and reviewed during the DHS RN supervisory review process. Each service included on the service plan is explained by the DHS RN. The amount, frequency, scope and provider of each service is also discussed and entered on the service plan. The DHS RN sends a copy of the service plan to the waiver provider, as well as the participant. The DHS RN tracks the implementation of each service through the Start of Care form, which includes the date services begin.

(f)- Implementation, compliance, and monitoring of the person-centered service plan is the responsibility of DAABHS (Operating Agency), DMS (Medicaid Agency), and providers of Living Choices Assisted Living waiver services.

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DHS RN, who is the only authorized individual who may adjust a participant's service plan. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Home & Community Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or necessitate a change in the participant's person-centered service plan; to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS RN in writing within one week of services being terminated, documenting the termination effective date and the reason for the termination.

Providers assure DPSQA that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted a Living Choices Assisted Living service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS RN. Providers acknowledge that the DHS RN is the only authorized individual who may adjust a Living Choices Assisted Living waiver

participant's service plan. Providers will implement the service plan with the flexibility to schedule hours to best meet the needs of the participant and will be monitored by DAABHS for compliance.

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

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

D-1: (5 of 8) Risk Assessment and Mitigation

The Independent Assessment Contractor will assess a participant's needs, functional abilities, and performance of activities of daily living during the assessment. The DHS RN assesses a participant's preferences, risks, dangers, and supports during the meeting with the participant to develop a person-centered service plan. In addition, the service plan development process includes assessment of risk factors and strategies to mitigate risk conducted in a manner that is sensitive to the waiver participant's preferences and the responsibilities required to reduce risk. The risk mitigation includes factors regarding the participant's functioning ability, ADL performance, support systems in place, risk of falls, environmental factors, and other dangers. This information is included on the person-centered service plan and in the participant's record. Services are started as soon as possible in order to mitigate risk.

The person-centered service plan also includes contact information for emergency care and backup plans. The name of a backup caregiver, or the person responsible for the participant, must be included on the person-centered service plan. Backup caregivers are often family members, neighbors or others familiar with the participant.

Routine monitoring of Living Choices Assisted Living participants also helps to assess and mitigate risk. DHS RNs make at least annual contact with participants and take action to mitigate risks if an issue arises. Targeted Case Managers are required to monitor the participant monthly at a minimum and must follow frequency requirements as described in the Targeted Case Management Medicaid Provider Manual regarding face-to-face or telephone contacts with the participant. Potential risks identified during these monitoring contacts require the Targeted Case Manager to take action to mitigate the risk.

Also, providers, family members and others who have regular contact with participants are required to report any change in participant condition, or perceived risk or other problem concerning the participant. The DHS RNs also re-evaluate potential participant risks during each reassessment and during monitoring visits. DHS RNs and Targeted Case Managers refer any high-risk participants to Adult Protective Services immediately if it is felt that the participant is in danger. DHS RNs also provide patient education on safety issues during the assessment and annual reassessment. The annual contact by the DHS RN is a minimum contact standard. Visits are made as needed during the interim.

Service providers are required to follow all guidelines in the Medicaid Provider manual related to emergencies, including the emergency backup plan process and contact information for emergencies. The provider assures DAABHS all necessary safeguards and precautions have been taken to protect the health and welfare of the participants they serve. Providers agree to operate and provide services in full compliance with all applicable federal, state and local standards including, but not limited to, fire, health, safety and sanitation standards prescribed by law or regulations. Providers assure DAABHS that

conditions or circumstances which place a person, or the household of a person, in imminent danger will be brought to the attention of appropriate officials for follow-up. Providers agree to inform the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or would necessitate a change in the participant's service plan.

Also, participants, family members or the participant's representative may also contact the DHS RN or Targeted Case Manager any time a change is needed or a safety issue arises. Additional monitoring is performed by DMS as part of the validation review, by Office of Medicaid Inspector General audits, and in response to any complaints received.

D-1: (6 of 8) Informed Choice of Providers

The participant must choose a provider for each waiver service selected. When a person-centered service plan is developed, the DHS RN must inform the individual, their representative, or family member of all qualified Living Choices Assisted Living qualified providers in the individual's service delivery area. The participant, representative, or guardian/family member may choose the providers from which to receive services. The name of the providers chosen by the participant, representative, or family member/representative must be included on the person-centered service plan prior to securing the individual's signature. Along with signing the service plan, and the Freedom of Choice form, an up-to-date provider listing from DPSQA must be signed and initialed. If a family member/representative chooses a provider for the participant, the DHS RN must identify the individual who chose the providers on the service plan and on the Freedom of Choice form. Documentation is also included in the participant's record and reviewed during the DHS RN supervisory review process.

For reassessments, the participant or representative must sign the Freedom of Choice form to show that no change in providers was made. The provider listing does not need to be initialed if there are no changes in providers. However, if a participant wishes to change providers at reassessment, both the Freedom of Choice form and provider listing must be signed and initialed indicating this change. Participants may request a change of providers at any time during a waiver year.

The participant chooses the provider. However, the participant may invite his or her family members or representative to participate in the decision-making process. Any decision made by a family member or representative is done at the participant's request and is documented.

DHS RNs and Targeted Case Managers leave contact information with participants at each visit. The participant may contact the DHS RN at any time to find out more information about providers.

Appendix D: Participant -Centered Planning and Service Delivery
D-1: Service Plan Development (7 of 8)

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

All waiver service plans are subject to the review and approval by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) and the Division of Medical Services (DMS) (Medicaid agency).

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval. DMS does review a random sampling of participant

records which includes the service plan. Reviewed service plans are compared to policy guidelines, the functional assessment, and the narrative detailing the participant's living environment, physical and mental limitations, and overall needs. All service plans are subject to the approval of the Medicaid Agency and are made available by the operating agency upon request. DMS randomly reviews service plans through several authorities within the Medicaid Agency, such as Program Integrity and the Quality Assurance unit.

A statistically valid random sample of service plans is determined, using the Raosoft software calculations program, for review monthly by the DHS RN supervisory staff to assess the appropriateness of the service plan, to validate service provision, to ensure that services are meeting the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS RN addresses any needed corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the DPSQA Program Integrity Unit or DPSQA QA Unit.

Each year, DAABHS reports to the DPSQA Waiver Quality Management Administrator the findings of the service plan review process.

In addition, DMS completes a random sampling of participant records and provider files annually. Every nth name is selected. The sample size has a 95% confidence level and a margin of error of +/- 5%. An online calculator determines the sample size.

Information reviewed by both DAABHS and DMS during the record review process includes without limitation: development of an appropriate individualized service plan, completion of updates and revisions to the service plan and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

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

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

X Operating agency

Specify:

The service plan is maintained by the DHS RN in the participant's record and by the Living Choices waiver provider.

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) employs Registered Nurses (DHS RNs) who are responsible for monitoring the implementation of the person-centered service plans (PCSP). When the DHS RN sends the person-centered service plan to the provider for implementation, he/she also sends a start of care form along with the PCSP. The provider is required to document the date the service began and return the form to the DHS RN. If the start of care form is not returned to the DHS RN within 10 business days, the DHS RN contacts the provider about the status of implementation. If the provider is unable to provide the service, the DHS RN contacts the participant and offers other qualified providers for the service. The DHS

RN is only required to have one start of care form per service in the participant record if services remain at the same level by the same provider when reassessed. If the amount of service changes or the provider of the service changes a new start of care form is required.

DHS RNs monitor each waiver participant's status on an as-needed basis for changes in service need, reassessment, if necessary, and reporting any participant complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant may invite anyone they choose to participate in the visit. Most often this is the participant's legal representative, guardian or family member.

At each assessment and reassessment, the DHS RN provides the participant with their business card with contact information, an Adult Protective Services (APS) brochure to provide information and the toll-free APS hotline for reporting abuse, maltreatment or exploitation. This information may be utilized by the participant or guardians/family members to report any issues they deem necessary, so that DAABHS can ensure prompt follow-up to problems.

INFORMATION EXCHANGE:

Both DMS and DAABHS perform regular reviews to support proper implementation and monitoring of the service plan. Record reviews are thorough and include a review of all required documentation regarding compliance with the service plan development assurance. Reviews include, but are not limited to, completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services; consideration of participants in the service plan development process; clarity and consistency; and, compliance with program policy regarding all aspects of the service plan development, changes and renewal.

The Division of Medical Services QA review reflects internal review of the billing process by Living Choices Medicaid providers. DMS QA conducts a record review on a monthly basis to monitor accuracy and completeness of the record, service plan implementation, service delivery, and the health and welfare of the participant. As a part of the review process, the DMS QA unit surveys respective Living Choices participants to verify service delivery, service plan compliance and participant satisfaction. The review completes a systematic random sampling of the active case population whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached. The DMS sample is pulled annually, and then divided by twelve for monthly monitoring over the course of the year.

Appendix D: Participant-Centered Planning and Service Delivery
Quality Improvement: Service Plan

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

i. Sub-Assurances

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

Performance Measures:

Number and percent of participants reviewed who had service plans that were adequate and appropriate to their needs as indicated by the

assessment(s). Numerator: Number of participants with service plans that address needs; Denominator: Number of records reviewed.
Number and percent of participants reviewed who had service plans that addressed risk factors. Numerator: Number of participants' service plans that address risk factors; Denominator: Number of records reviewed.
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

b. Sub-Assurance: The State monitors service plan development in accordance with its policies and procedures.
Performance Measures:
Number and percent of service plan development procedures that are completed as described in the waiver application. Numerator: Number of participants' service plans completed according to waiver procedures; Denominator: Number of records reviewed.
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

c. Sub-Assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
Performance Measures:
Number and percent of service plans that were reviewed and updated by the DHS RN according to changes in participants' needs before the waiver participants' annual review date. Numerator: Number of participants' service plans that were reviewed and revised by the DHS RN before annual review date; Denominator: Number of records reviewed.
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

d.*Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.* Performance Measures:
Number and percent of participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan. Numerator: Number of participants' service plans who received services specified in the service plan; Denominator: Number of records reviewed.
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

Performance Measures:

Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed.

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

Appeals are the responsibility of the Department of Human Services Appeals and Hearings section. Waiver applicants are advised on the DCO-707 (Notice of Action) or the system-generated Notice of Action by the County Office of their right to request a fair hearing when adverse action is taken to deny, suspend or terminate eligibility for Living Choices. The notice is issued by the LTSS caseworker, and explains the participant's right to a fair hearing, how to file for a hearing and the participant's right to representation. Notices of adverse actions and the opportunity to request a fair hearing are kept in the participant's case record. Applicants must make their request for an appeal no later than 30 days from the date on the DCO-707.

The DCO-707 Notice of Action is kept in the participant's county office case record. If the DCO-707 is a request for information only, the form may be discarded when all the needed information is received. If the information requested is not received, the form may be discarded five years from the month of origin. Otherwise, the DCO-700 will be retained for five years from the date of last approval, closure or denial.

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

Living Choices participants have the option of continuing Medicaid eligibility and services during the appeal process. They are informed of their options when notified by the DHS county office of the pending

adverse action. If the findings of the appeal are not in the participant's favor, and the participant has elected the continuation of benefits, the participant is liable for payment to the provider. If Medicaid has paid the provider, DHS will consider the services that were provided during the period of ineligibility a Medicaid overpayment and will seek reimbursement from the participant.

Participants have the right to appeal if they were not provided a choice in institutional care or waiver services, or a choice of providers.

The assisted living facility and the Department of Human Services county office inform the participant of their potential payment liability if a participant has been denied eligibility for the program and if an appeal of a denial is not in the participant's favor.

During the assessment and service plan development process, the DHS RN explains these rights to the participant, family member or representative. Signatures on the service plan verify that the choice between waiver services or institutional care was exercised. Also, during this process, participants choose a provider from a list provided by the DHS RN. Choices of provider are documented on the Freedom of Choice form, and the participant signs the list of providers showing that the choice was made. At reassessments, if no change in provider is requested, the provider list is not signed by the participant.

Appendix F-3: State Grievance/Complaint System

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Division of Aging, Adult, and Behavioral Health Services

c. Description of System: Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAABHS Central Office or their DHS RN. When a DHS RN is contacted regarding a complaint or dissatisfaction, the DHS RN explains the complaint process to the participant, and completes the HCBS Complaint Intake Report (AAS-9505). Any DAABHS staff receiving a complaint must complete the HCBS Complaint Intake Report.

The HCBS Complaint Intake Report (AAS-9505), along with the complaint database, is used to track any dissatisfaction or complaint, including complaints against DAABHS staff and DPSQA providers. The record of complaint includes the date the complaint was filed.

The complaint database was designed to register different types of complaints. Based on the data entered, the complaint can be tracked by type of complaint (service, provider, DAABHS, etc.) and complaint source (participant, county office, family, etc.), and monitored for trends, action taken to address the complaint, access, quality of care, health and welfare. The complaint database provides a means to address any type complaint filed by any source. The complaint database also tracks resolution.

Information entered into the database includes the complaint source and contact information, participant information, person or provider for whom the complaint is being made against, the person who received the complaint, the person to whom the complaint is assigned for investigation, the complaint being made, and the action taken relative to investigation findings. Complaints concerning abuse and neglect are routed to Adult Protective Services immediately for appropriate action.

The HCBS Complaint Intake Report (AAS-9505) must be completed within five working days of receiving the complaint. Complaints must be resolved within 30 days from the date the complaint was received. If a complaint cannot be resolved by an RN supervisor, the information is forwarded to the DAABHS central office administrative staff to resolve.

DHS RNs and RN supervisors work to resolve any complaints. This involves contacting all parties involved to obtain all sides of the issue, a participant home visit and a review of the participant's service plan, if necessary. The Nurse Manager at the DAABHS central office may also be asked to assist. Based on the nature of the complaint, the Nurse Manager will use their professional judgment on issues that must be resolved more quickly, such as instances where the participant's health and safety are at risk. Compliance with this policy is tracked and reported through the database. This issue continues to be tracked and reviewed by the RN Supervisors and the Medicaid Quality Assurance staff during the chart review process.

A follow-up call or correspondence is made to the reporter, if appropriate, to discuss how the issue was resolved without violating confidentiality rules. The participant or representative is informed of the right to appeal any decision and that filing a complaint is not a prerequisite or substitute for a fair hearing.

If a participant is dissatisfied with the resolution of a complaint, a fair hearing request may be made at the local DHS county office. The DHS RN explains the hearings and appeals process to the participant at this time.

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

A complaint received on a DHS RN is reported to his or her supervisor, who investigates the complaint.

The Complaint Intake Report must be completed within five working days from when DAABHS staff receives the complaint. Complaints must be resolved within 30 days. To ensure that participants are safe during these time frames, the DHS RN may put in place the backup plan on the participant's service plan or report the situation to Adult Protective Services, if needed.

Appendix G: Participant Safeguards
Appendix G-1: Response to Critical Events or Incidents

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

Arkansas state law requires that suspected abuse, neglect, and exploitation of endangered and impaired adults be reported to the Adult Maltreatment Hotline for investigation. The method of reporting is primarily by phone to the Hotline; written reports of allegations will be entered into the Adult Protective Services system or routed to the appropriate investigative department.

Ark. Code Ann. § 12-12-1708(a) specifies mandatory reporters who are required to report suspected adult maltreatment, including abuse, exploitation, neglect, or self-neglect of endangered or impaired adults. Mandated reporters include all physicians, nurses, social workers, case managers, home health workers, DHS employees, facility administrators or owners, employees of facilities, and any employee or volunteer of a program or organization funded partially or wholly by DHS who enters the home of, or has contact with an elderly person. Living Choices waiver staff, providers, and DAABHS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

According to the statute, adult abuse includes intentional acts to an endangered or impaired adult which result in physical harm or psychological injury; or credible threats to inflict pain of injury which provoke fear or alarm; or unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Exploitation includes illegal or unauthorized use of the

person's funds or property; or use of the person's power of attorney or guardianship for the profit of one's own self; or improper acts or process that deprive the person of rightful access to benefits, resources, belongings and assets. Neglect is an act or omission by the endangered or impaired person (self-neglect), or an act or omission by the person's caregiver (caregiver neglect) constituting failure to provide necessary treatment, care, food, clothing, shelter, supervision or medical services; failure to report health problems and changes in health condition to appropriate medical personnel; or failure to carry out a prescribed treatment plan.

Reporting requirements for providers:

In addition to statutory requirements, the Division of Provider Services and Quality Assurance, the licensing and certification agency, requires home and community-based services (HCBS)/non-institutional providers to report the following incident types:

(a) Abuse
(b) Neglect
(c) Exploitation or Misappropriation of Property
(d) Unnatural Death
(e) Unauthorized use of restrictive interventions
(f) Significant Medication Error
(g) Elopement/Missing Person
(h) Other: Includes without limitation abandonment, serious bodily injury, incidents that require notification to police or fire department.

In accordance with DPSQA Policy 1001, the above events must be reported to the Division of Provider Services and Quality Assurance by facsimile transmission to telephone number 501-682-8551 of the completed Incident & Accident Intake Form (Form DPSQA-731) no later than 11:00 a.m. on the next business day following discovery by the provider. In addition to the requirement of a facsimile report by the next business day, the provider must conduct a thorough investigation of the alleged or suspected incident and complete an investigation report and submit it to DPSQA on Form DPSQA-742 within five working days.

Reporting requirements for DHS employees and contractors:

DHS employees and contractors are required to report incidents in accordance with DHS Policy 1090 (Incident Reporting). Under this policy, any incident requiring a report to the DHS Communications Director must be reported by telephone within one hour of the incident. All other reports must be filed with the Division Director or Designee and the DHS Client Advocate no later than the end of the second business day following the incident. Any employee not filing reports within the specified time is subject to disciplinary action unless the employee can show that it was not physically possible to make the report within the required time.

Telephone notifications and informational e-mails to Division Directors or Designees, the DHS Client Advocate and other parties as appropriate for early reporting of unusual or sensitive information are welcomed. All such reports must be followed with completion and submission of Form DHS-1910.

If the incident alleges maltreatment by a hospital, a copy of the report will be sent to the Arkansas Department of Health by the Division Director or Designee, who should note the notification in the appropriate space on the Form DHS-1910, and forward the information to the DHS Client Advocate as a follow up Incident Report.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The DHS RN provides waiver applicants and their families with an Adult Protective Services (APS) brochure when initial contact is made. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including to the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DHS RNs review this information with participants and family members at the initial assessment and at each annual reassessment. In addition, providers are required to post information about how to report a complaint to APS and the Adult Maltreatment Hotline in a visible area on their premises.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

For incidents involving alleged abuse, neglect, and exploitation regarding adult clients, Adult Protective Services (APS) receives, investigates, evaluates, and resolves reports. Additionally, all incidents defined in DPSQA Policy 1001 must be reported to Division of Provider Services and Quality Assurance (DPSQA). These include alleged abuse, neglect, and exploitation, unnatural death, unauthorized use of restrictive interventions, significant medication error, elopement/missing person, abandonment, serious bodily injury, and incidents requiring notification to the police or fire department.

Adult Protective Services (APS) Responsibilities

APS visits clients within 24 hours for emergency cases or within five working days for non-emergency cases. Emergency cases are instances when immediate medical attention is necessary or when there is imminent danger to health or safety which means a situation in which death or serious bodily harm could reasonably be expected to occur without intervention, according to Ark. Code Ann. § 12-12-1703(8). Non-emergency cases refer to situations when allegations do not meet the definition of imminent danger to health or safety.

As required by law, investigations are completed and an investigative determination entered within 60 days. APS notifies the client and other relevant parties, including the offender, of the determination.

APS communicates with the waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation. Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.

APS communicates with the Living Choices waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. DPSQA and Living Choices staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

Division of Provider Services and Quality Assurance (DPSQA) Responsibilities

DPSQA receives and triages incidents to appropriate divisions for investigation. DPSQA will investigate those incidents that relate to providers licensed and/or certified by DPSQA and forwards incidents regarding clients to the Division of Aging, Adult, and Behavioral Health Services.

Reports to DPSQA are entered into a tracking system which DPSQA uses to determine if further investigation is needed in the event of multiple complaints at one provider locations or facility. DPSQA uses this resource to monitor active participants of the waiver for critical incidents.

As required by statute, investigations are completed and an investigative determination entered within 60 days.

Unexpected client deaths must be reported immediately to the DPSQA contact using the DHS Client Unexpected Death Report. The DPSQA contact investigates the report within two days of receiving the notice of the occurrence and prepares a report of the investigation within 30 days of receiving the notice of the occurrence. The investigation includes reviewing a written report of the facts and circumstances of the unexpected death and documentation listing the client's condition, including diagnoses, prescriptions and service plan.

The DPSQA contact will determine the facts and circumstances of the occurrence. DPSQA's role includes performing a thorough investigation, reviewing current policy, making corrections if necessary and identifying patterns during the process. Final results of investigations are electronically made available to the Division of Medical Services (DMS).

All reports to the Adult Maltreatment Hotline and instances of unexpected client deaths are investigated and addressed by DPSQA. Incidents reported to the DHS Incident Reporting Information System (IRIS), a system which enables online submission and transmittal of incident reports, are investigated depending on the type of incident reported.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Division of Provider Services and Quality Assurance assumes responsibility for compiling all incident reports from providers for review and action. Incidents are reported to DPSQA staff through submission of Form DPSQA-731.

DPSQA staff review the reports as incidents occur and identify patterns and make systematic corrections when necessary. Current policy is reviewed at each occurrence and revisions may be made if necessary.

The Adult Protective Services unit tracks APS incidents. Operating agencies and the Medicaid agency, Division of Medical Services (DMS) are informed of the outcomes of incidents reported

to APS applicable to waiver participants. There is a Memorandum of Understanding between the operating agency waiver units and the APS unit detailing the relationship and activities of each unit, as they relate to the waiver program.

Final results of APS investigations, final results of unexpected death findings, and results of incident reports are electronically made available to the Medicaid agency, Division of Medical Services (DMS).

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

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

X The state does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restraints or seclusion. This oversight is conducted through incident reports received and monitoring of the participant by the DHS RN, if needed.

Quality Improvement: Health and Welfare

a. Methods for Discovery: Health and Welfare

i. Sub-Assurances

a. *Sub-Assurance:* *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.* (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures:

Number and percent of critical incidents reviews/investigations that were initiated and completed according program policy and state law. Numerator: Number of critical incident investigations initiated/completed according to policy/law; Denominator: Number of critical incidents reviewed.

Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up; Denominator: Number of critical incidents reviewed.

Number and percent of participant records reviewed where the participant and/or family or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents as specified in the waiver application. Numerator: Number of participants receiving information on abuse, neglect, exploitation and critical incidents; Denominator: Number of records reviewed.

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

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

Arkansas addresses this assurance with a three-step process that involves record review, ongoing communication with Adult Protective Services (APS) and Division of Medical Services (DMS) audits of waiver participants' records. Monthly record reviews are performed by DHS RN supervisors to assure that DHS RNs report incidences of abuse or neglect, and that safety and protection are addressed at each assessment and reassessment and reported in the Record Review Summary Report. APS reports specific cases of abuse and neglect affecting waiver participants to DAABHS waiver staff. Findings are reported to the DPSQA QA Unit.

DAABHS staff are required to review the APS information with participants and other interested parties at each assessment and reassessment. This must include providing APS brochures, as well as information on how to identify possible abuse and neglect and a toll-free number for reporting abuse. Compliance with this requirement is documented in the participant record and reviewed by RN supervisors during each record review. Compliance is a part of the record review and annual reporting process.

Policy requires compliance and mandates the DHS RN to report alleged abuse to APS and/or the Office of Long Term Care (OLTC). All reports of alleged abuse, follow-ups and actions taken to investigate the alleged abuse, along with all reports to APS or OLTC must be documented in the nurse narrative. Record reviews include verification of this requirement and are included on the annual report.

The process for reporting abuse as established in Ark. Code Ann. § 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult Maltreatment Hotline refers the matter immediately to the appropriate investigating agency. Under this statute, a resident of an assisted living facility is identified as a long-term care facility resident, and for the purposes of the statute is presumed to be an impaired person. A report for a long-term care facility resident is to be made immediately to the local law enforcement agency for the jurisdiction in which the long-term care facility is located, and to OLTC under the regulations of that office. DHS has jurisdiction to investigate all cases of suspected maltreatment of an endangered person or an impaired person. The APS unit of DHS shall investigate all cases of suspected adult maltreatment if the act or omission occurs in a place other than a long-term care facility; and all cases of suspected adult maltreatment if a family member of the adult person is named as the suspected offender, regardless of whether or not the adult is a long-term care facility resident. The OLTC unit of DHS shall investigate all cases of suspected maltreatment of a long-term care facility resident.

The DPSQA QA audit reflects internal review of the billing process by Living Choices Medicaid providers. The DPSQA QA audit completes a systematic random sampling of the active case population whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate

sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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, and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems related to participant health and welfare, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to participant health and welfare for the waiver.

DAABHS's remediation efforts in cases where participants or their family members or legal guardians have not received information about how to report abuse, neglect, exploitation or critical incidents include providing the appropriate information to the participant and family member/legal guardian upon discovery that this information was not provided, providing additional training for DHS RNs and considering this remediation as part of RNs' performance evaluations.

In cases where critical incidents were not reported within required time frames, DAABHS provides remediation, including reporting the critical incident immediately upon discovery, and providing additional training and counseling to staff.
If critical incident reviews and investigations are not initiated and completed according to program policy and state law, DAABHS's remediation includes initiating and completing the investigation immediately upon discovery, and providing additional training and counseling to staff. When appropriate follow-up to critical incidents is not conducted according to methods discussed in the waiver application, DAABHS provides immediate follow-up to the incident and staff training as remediation.

DAABHS provides remediation in cases of investigation and review of unexplained, suspicious and untimely deaths that did not result in identification of preventable and unpreventable causes to include staff and provider training, implementing additional services and imposing provider sanctions. The Unexpected Death Report ensures that remediation of preventable deaths is captured and that remediation data is collected appropriately.

The DAABHS complaint database collects complaints, the outcomes and the resolution for substantiated complaints. Remediation for complaints that were not addressed during the required time frame includes DAABHS addressing the complaint immediately upon discovery, and providing additional staff training and counseling.

All substantiated incidents are investigated by the DAABHS Deputy Director or his/her designee. DAABHS plans to continue this process and reviewing remediation plans remains in development.

Appendix H: Quality Improvement Strategy (2 of 2)
H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DPSQA analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DPSQA will meet with the operating agency (DAABHS) to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue, etc.), complexity of the solution (does it require an amendment to the waiver application), and the financial impact. If it is determined that a system change is needed, a computer service request will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DPSQA and a priority status is assigned. MMIP prioritizes system changes to MMIS and coordinates implementation with the state fiscal agent. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. The MMIP Unit and the DPSQA QA Unit monitor the system changes.

As a result of the discovery processes:

The interagency agreements were revised to provide a more visible product to clarify roles and responsibilities between the Division of Medical Services (Medicaid agency) and the Division of Aging, Adult, and Behavioral Health Services (operating agency).

The agreement between the two divisions has been modified and is updated at least annually.

Medicaid related issues are documented by DAABHS waiver staff and reviewed by DPSQA QA staff, and recorded on a monthly report to identify, capture and resolve billing and claims submission problems. Error reports are worked and billing issues are resolved by the DPSQA QA staff. DPSQA QA staff reviews reports for proper resolution. These activities occur on a daily basis, and reviews occur monthly by DPSQA QA staff.

A separate Quality Assurance Unit was formed within DPSQA to monitor and advise the operating agency for Home and Community-Based Waiver Programs.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of Provider Services and Quality Assurance (DPSQA) both employ staff to assist in system design. When an issue arises that requires development of a Computer Service Request (CSR), meetings with the DHS information technology consultants, DPSQA Program Development and Quality Assurance staff, DPSQA Program Integrity staff, and DAABHS waiver staff are held to address needs and resolve issues, including

developing new elements and testing system changes. Meetings are scheduled on an as-needed basis with the assigned DHS information technology consulting firm, the Medicaid program's fiscal agent, the DAABHS Deputy Director, DPSQA QA staff and others as may be appropriate depending on the issue for discussion.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DAABHS and DPSQA monitor the Quality Improvement Strategy on an ongoing basis and review the Quality Improvement Strategy annually. A review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systematic issues found through discovery and notating desired outcomes. When change in the strategy is indicated, a collaborative effort between DPSQA and DAABHS is set in motion to complete a revision to the Quality Improvement Strategy which may include submission of a waiver amendment. DPSQA QA staff utilizes the Quality Improvement Strategy during all levels of QA reviews.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In accordance with waiver participants' service plans, sampling is pulled on a random basis as described in the waiver.

An independent audit is required annually of the provider agency when:

- State expenditures are $100,000 or more;
- Federal expenditures are $300,000 or more; or
- The contract the Department of Human Services (DHS) has with the provider agency requires an independent audit, regardless of funding level.

If the federal expenditures are $300,000 or more, the audit must be performed in accordance with OMB Circular A133, which implemented the Single Audit Act as amended. A Government Auditing Standards (GAS) audit must be performed if DHS funding provided is $100,000 or more of federal, state, or federal and state combined.

The DHS Office of Chief Counsel, Audit Section is responsible for reviewing all independent audits. The provider's audit report is reviewed by the Audit Section to determine whether requirements of applicable authorities and those contained in agency policy were met; material weaknesses in internal control exist; material noncompliance with the provision of grants, contracts, and agreements occurred; and the report included findings, recommendations, and responses thereto by management.

Material weaknesses and non-compliance, other findings, recommendations and responses are recorded and communicated to the DAABHS Deputy Director, who will take appropriate action to resolve audit findings within 90 days of the referral of the finding from the Audit Section.

If applicable, through audit requirements regarding provider organizations and thresholds of funding, the DHS Office of Quality Assurance (OQA) maintains a database of audit due dates. Each provider selects an independent auditor. The auditor completes a report and submits the report to the provider and to the DHS OQA. The DHS OQA submits a monthly report indicating findings to the DHS Executive Staff.

DPSQA Quality Assurances also reviews the services billed compared to the services listed on a participant's service plan. DPSQA record reviews include a review of the billing by LCAL providers. A systematic random sampling of the active case population is drawn whereby every nth name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the nth integer, the sample is divided by the population. Those names are drawn until the sample size is reached. DAABHS receives a report from DPSQA on a monthly basis with overpayments. DAABHS verifies all overbilling and sends out for recoupment. DAABHS also receives a quarterly overlapping report and no service report. DAABHS reviews and verifies the report for overlapping of services or no services being billed within 30 days.

Quality Improvement: Financial Accountability

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, and Behavioral Health Services (DAABHS) (operating agency) and the Division of Medical Services (DMS) (Medicaid agency) participate in regular team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAABHS and DPSQA have a Memorandum of Understanding (MOU) that includes measures related to financial accountability for the waiver.

The performance measure for number and percent of waiver claims paid using the correct rate specified in the waiver application will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate. DAABHS's remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discovery, making system changes and training staff. DAABHS's remediation for claims for services not specified in the participant's service plan includes revising the participant's plan of care if necessary, recouping payment to the provider, imposing provider sanctions, training providers and conducting a participant monitoring visit to possibly reconsider consumer direction.

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description

are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Assisted Living Facility Rate Determination Methods: This amended waiver reforms the payment rate determination method for assisted living facilities (ALFs) serving waiver participants. For purposes of this waiver, "assisted living facility" means a Medicaid-certified and enrolled assisted living facility with a Level II license.

Methods Employed to Determine Rates: To establish the new assisted living facility payment methodology, the State employed two methods:

1. An actuarial analysis by the Arkansas Medicaid program's contracted actuaries. This included a cost survey of assisted living facilities and consideration of other states' federally-approved rate methods and rate levels, direct care cost factors (e.g., direct care work wages and benefits, direct care-related supervision and overhead), Arkansas labor market wage levels, rate scenarios, and Arkansas' minimum and prevailing assisted living facility staffing levels. The actuary's report is available to CMS upon request through the Division of Aging, Adult, and Behavioral Health Services (DAABHS).

2. Negotiations with representatives of the State's participating assisted living facilities.

The rate methodology excludes reimbursement of room and board costs.

The new methodology and resulting new per diem rates provide for payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough assisted living facility providers, as required under 42 U.S.C. 1396a(a)30(A) and 42 CFR §447.200-205.

Uniform, Statewide Rate Methodology: The rate methodology is uniform and applies statewide to all Level II licensed assisted living facilities serving waiver participants.

Opportunities for Public Comment: Before submitting this amended waiver to CMS for federal review and approval, DHS engaged in various opportunities for public comment and consultations with assisted living facility providers and other interested stakeholders. This includes webinars and regional public meetings. These are in addition to the public comment process for this amended waiver and the revised provider manual. Further, both the amended waiver and the revised provider manual undergo prior review by Arkansas legislative committees.

Entities Responsible for Rate Determination and Oversight of Rate Determination Process: The assisted living facility rate methodology is determined by the Division of Aging, Adult, and Behavioral Health Services (DAABHS), in consultation with the Division of Provider Services and Quality Assurance (DPSQA) and the contracted actuaries, and with oversight by the Division of Medical Services (DMS). As the Medicaid agency, DMS is responsible for oversight of all Medicaid rate determinations and for ensuring that provider payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers. DAABHS (as the operating agency responsible for day-to-day waiver administration, service planning, and access and care delivery in the waiver) and DPSQA (as the operating agency responsible for ALF licensure, ALF Medicaid certification, provider accountability, quality of care, inspections, and auditing) jointly monitor to ensure that assisted living facility payments are consistent with the requirements of 42 U.S.C. § 1396a(a)30(A) and 42 CFR § 447.200-205.

Implementation of New Assisted Living Facility Rates:

Effective on January 1, 2019, assisted living facilities are reimbursed on a fee-for-service basis according to a new single statewide per diem rate, determined by DAABHS according to the rate determination methods (actuarial analysis and negotiations) described in this Appendix.

On the effective date of this amended waiver, the four-tier payment model provided for under the current waiver is discontinued. Thereafter, assisted living facilities will be reimbursed according to the new single, statewide per diem rate method. For purposes of assisted living facility payments, waiver participants will no longer be assigned a rate tier level. The discontinued four-tier payment model was initially developed in 2002 prior to the use of comprehensive assessment instruments, is inconsistent with the new assessment system, is administratively cumbersome and unnecessary, and may foster unintentional incentives misaligned with the objectives of appropriate access and service use, facility efficiency, active and independent living, and optimal medication therapy management.

DAABHS will review the rate methodology on a triennial basis, with the next review in CY 2021. During the last two years of the current 5-year waiver term (CY 2019-2020), as data from the new Arkansas Independent Assessment (ARIA) system and use of the Task and Hour Standards for personal care-type services are accumulated and assessed, DAABHS will consider whether an acuity-adjusted methodology is appropriate. If a methodology change is determined appropriate, it will be addressed in a subsequent waiver amendment or the waiver renewal application.

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DPSQA staff verifies services were provided according to the person-centered service plan through an internal monthly monitoring system. Adjustments are made or cases referred to the Office of Medicaid Inspector General when claims are paid incorrectly.

All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable.

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	20112.22	2249.00	22361.22	40826.00	2249.00	43075.00	20713.78
2	20119.88	2316.00	22435.88	42046.00	2316.00	44362.00	21926.12
3	20127.91	2385.00	22512.91	43303.00	2385.00	45688.00	23175.09
4	16132.58	2457.00	18589.58	44598.00	2457.00	47055.00	28465.42
5	16142.25	2530.00	18672.25	45931.00	2530.00	48461.00	29788.75

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:						**93000.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	100	15.00	62.00	**93000.00**	
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:						26145883.35
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20112.22

Average Length of Stay on the Waiver:	255

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
Extended Medicaid State Plan Prescription Drugs Total:						**102960.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	104	15.00	66.00	**102960.00**	
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:	**87698432.4**					26155843.35
Total Estimated Unduplicated Participants:	**11350**					1300
Factor D (Divide total by number of participants):	**7726.73**					20119.88
Average Length of Stay on the Waiver:						255

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:						**113400.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	108	15.00	70.00	**113400.00**	

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:						26166283.35
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20127.91
Average Length of Stay on the Waiver:						255

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:						**124320.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	112	15.00	74.00	**124320.00**	
Living Choices Assisted Living Services Total:						**20848035.00**
Living Choices Assisted Living	1 Day	1300	255.00	62.89	**20848035.00**	
GRAND TOTAL:						20972355
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						16132.58
Average Length of Stay on the Waiver:						255

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:						**136890.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	117	15.00	78.00	**136890.00**	
Living Choices Assisted Living Services Total:						**20848035.00**
Living Choices Assisted Living	1 Day	1300	255.00	62.89	**20848035.00**	
GRAND TOTAL:						20984925
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						16142.25
Average Length of Stay on the Waiver:						255

200.100 Qualifying Criteria for Living Choices Assisted Living Providers 1-1-13

Living Choices providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the criteria below to be eligible to participate in the Arkansas Medicaid Program.

A. Assisted living facilities (ALF) are licensed and regulated by the Office of Long Term Care in the Division of Medical Services (DMS), which is the division of the Arkansas Department of Human Services (DHS) that administers the Arkansas Medicaid Program. Licensed Level II ALF are qualified to enroll with Medicaid as Living Choices Assisted Living Facilities—Direct Services Providers, if all other requirements for enrollment are met.

B. Home health agencies in Arkansas are licensed and regulated by the Arkansas Department of Health. Licensed Class A home health agencies may contract with Level II ALF to provide the bundled services covered in the Living Choices Program. In such an arrangement, federal regulations permit Medicaid to cover the services only if the home health agency, instead of the ALF, is the Living Choices provider.

Living Choices Assisted Living Waiver Services providers must meet the Provider Participation and enrollment requirements detailed in the Medicaid provider manual.

A licensed home health agency may qualify for Living Choices waiver services provider enrollment only by first contracting with a licensed Level II ALF to provide Living Choices bundled services to Living Choices beneficiaries who reside in the ALF.

C. All Living Choice providers must be certified by the Division of Provider Services and Quality Assurance (DPSQA).

D. Option to Temporarily Limit Certification and Enrollment of New Assisted Living Facilities: Consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the concurrence of the federal Centers for Medicare and Medicaid Services (CMS), DPSQA may temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers in the Living Choices HCBS waiver program. Such temporary caps, limits, or moratoria on the certification and enrollment of new assisted living facility providers shall be initially limited to no more than six months, may be extended in 6-month increments subject to DPSQA and CMS approval, and may be applied on a regional or another geographic basis. If DPSQA determines temporary caps, limits, or moratoria are appropriate and would not adversely impact beneficiaries' access to assisted living facility services, it will initiate the process through filing a Request for State Implemented Moratorium (Form CMS–10628) with CMS.

200.105 Provider Assurances 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.~~** The Provider must immediately report changes in a beneficiary's condition to the DHS registered nurse (DHS RN) via Form AAS 9511 (Change of Status).

C. Code of Ethics

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

1. No consumption of the beneficiary's food or drink;

2. No use of the beneficiary's telephone for personal calls;

3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;

4. No acceptance of gifts or tips from the beneficiary or their caregiver;

5. No friends or relatives of the employee or unauthorized individuals are to accompany the employee to the beneficiary's assisted living facility apartment unit;

6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery nor in the beneficiary's assisted living facility apartment unit;

7. No smoking in the beneficiary's assisted living facility apartment unit;

8. No solicitation of money or goods from the beneficiary;

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

D. Home and Community Based Services (HCBS) Settings

All Level II Assisted Living Facilities licensed by the OLTC and participating in the Arkansas Medicaid waiver must meet the following Home and Community Based Services

(HCBS) Settings regulations as established by CMS. The federal regulations for the new rule is 42 CFR 441.301(c) (4)-(5). Facilities who enroll in the waiver on or after the date of this policy change must meet these HCBS settings requirements prior to certification. Those facilities already enrolled in the waiver before this policy change must comply with the HCBS settings requirements under the timeframe established by the HCBS settings transition plan.

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

HCBS settings must have the following characteristics:

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

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

i. Identify a specific and individualized assessed need.

ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

iii. Document less intrusive methods of meeting the need that have been tried but did not work.

iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

200.110 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Facilities 1-1-13

Level II ALF located within the state of Arkansas, licensed ~~by the Arkansas Division of Medical Services, Office of Long Term Care,~~ and certified by the Office of Long Term Care, DPSQA, are eligible to apply for Medicaid enrollment as Living Choices providers. Qualified Level II Assisted Living Facility providers contract with Medicaid as Living Choices Assisted Living Facility providers to provide and claim reimbursement for Living Choices bundled services instead of contracting with another entity (e.g., a licensed home health agency) that is enrolled with Medicaid to provide and receive payment for those services. Living Choices includes provisions for alternative methods of delivering services because assisted living facilities have different business and staffing arrangements and the Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service. Additional details in this regard are provided in this manual.

200.120 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Agencies 1-1-13

Within their licensing regulations, Level II ALF may contract with home health agencies and other entities and individuals to provide required and optional services for residents of the ALF. In the Living Choices Program, an ALF that chooses not to be the Medicaid-enrolled provider of Living Choices services may contract only with a licensed home health agency to furnish Living Choices bundled services. The Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service.

A Licensed Class A Home Health Agency is eligible to enroll in the Arkansas Medicaid Program as an Assisted Living Agency provider only if it has a contract with a Level II Assisted Living Facility to deliver all Living Choices bundled services furnished in that facility. A home health agency must have a separate Medicaid provider number for each ALF in which it is the Living Choices provider.

To enroll as a Living Choices Assisted Living Agency, the agency must comply with certain procedures and criteria. This section describes those criteria and procedures, as well as the actions DMS takes to facilitate enrollment.

A. The provider must be licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.

B. The provider must submit to the Medicaid program's Provider Enrollment Unit and to DPSQA the following items, in addition to the other documentation required in this section.

1. A copy of its contract with the ALF (financial details may be omitted). The contract must describe in detail the agency's contractual obligations to provide Living Choices bundled services to the ALF's Living Choices beneficiaries.

2. Copies of contracts (financial details may be omitted) with any entities or individuals the agency has sub-contracted with to provide components of Living Choices bundled services.

202.100 Records that Living Choices Assisted Living Facilities and Agencies Must Keep 2-1-15

A. Living Choices Assisted Living facility and agency providers must maintain required personal care aide training program documentation as specified in this manual.

B. A provider must also maintain the following items in each Living Choices beneficiary's file.

1. The beneficiary's attending or primary care physician's name, office address, telephone number and after-hours contact information.

2. A copy of the beneficiary's current plan of care (form AAS-9503).

3. Written instructions to the facility's attendant care staff.

4. Documentation of limited nursing services performed by the provider's nursing staff in accordance with the beneficiary's plan of care. Records must include:

   a. Nursing service or services performed,

   b. The date and time of day that nursing services (exclusive of attendant care services) are performed,

   c. Progress or other notes regarding the resident's health status and

   d. The signature or initials and the title of the person performing the services.

5. Documentation of periodic nursing evaluations performed by the ALF nursing staff in accordance with the beneficiary's plan of care.

6. Records of attendant care services as described in this manual.

7. Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the beneficiary's condition to the ~~DAAS~~DHS RN, who is the only authorized individual who may adjust a beneficiary's plan of care. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by ~~DAAS~~DAABHS; to notify the ~~DAAS~~DHS RN immediately of any change in the beneficiary's physical, mental or environmental needs the provider observes or is made aware of that may affect the beneficiary's eligibility or necessitate a change in the beneficiary's plan of care; to continually monitor beneficiary satisfaction and quality of service ~~delivery and to record their findings every 90 days by completing the Quarterly Monitoring Form (AAS-9506)~~; and to notify the ~~DAAS~~DHS RN in writing within one week of services being

terminated, documenting the termination effective date and the reason for termination.

210.000 PROGRAM COVERAGE 1-1-13

Living Choices Assisted Living is a home and community-based services waiver program that is administered jointly by the Division of Medical Services (DMS, the state Medicaid agency) and the ~~Division of Aging and Adult Services (DAAS)~~ Division of Aging, Adult, and Behavioral Health Services (DAABHS), under the waiver authority of Section 1915(c) of the Social Security Act. Home and community-based services waiver programs cover services designed to allow specific populations of individuals to live in their own homes or in certain types of congregate settings. The Living Choices Assisted Living waiver program serves persons aged 65 and older and persons aged 21 through 64 who are determined to be individuals with physical disabilities by the Social Security Administration or the Arkansas DHS Medical Review Team (MRT), and who are eligible for nursing home admission at the intermediate level of care.

The rules and regulations for licensure of Level II Assisted Living Facilities (ALF) are administered by the Office of Long Term Care within DMS. As agencies of the Arkansas Department of Human Services (DHS), ~~DAAS~~DAABHS, DMS and the Division of County Operations (DCO) administer the policies and procedures and the rules and regulations governing provider and beneficiary participation in the Living Choices Program.

Individuals found eligible for the Living Choices Program may participate in the program when residing in a licensed Level II ALF that is enrolled as a Living Choices waiver provider in the Arkansas Medicaid Program.

211.000 Scope of the Program 1-1-13

The *Level II Assisted Living Facilities Rules and Regulations* manual defines assisted living as: "Housing, meals, laundry, social activities, transportation (assistance with and arranging for transportation), one or more personal services, direct care services, health care services, 24-hour supervision and care, and limited nursing services." Medicaid, by federal law, may not cover beneficiaries' room and board except in nursing and intermediate care facilities. Medicaid covers some services only under certain conditions. This home and community-based services waiver program permits Medicaid coverage of assisted living services as described in this manual.

Individuals participating in the Living Choices Program reside in apartment-style living units in licensed Level II ALF and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes residents' self-direction and personal decision-making while protecting their health and safety.

Assisted living includes 24-hour on-site response staff to assist with residents' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living provider staff perform their duties and conduct themselves in a manner that fosters and promotes residents' dignity and independence. Supervision, safety and security are required components of the assisted living environment. Living Choices includes therapeutic social and recreational activities suitable to residents' abilities, interests and needs.

Services are provided on a regular basis in accordance with individualized plans of care that are signed by a ~~DAAS~~DHS registered nurse. Assisted living beneficiaries reside in their own living units, which are separate and distinct from all others. Laundry and meal preparation and service

are in a congregate setting for beneficiaries who choose not to perform those activities themselves.

211.100 Eligibility for the Living Choices Assisted Living Program 1-1-13

A. To qualify for the Living Choices Program, an individual must meet the targeted population as described in this manual and must be found to require a nursing facility intermediate level of care. Individuals meeting the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the Living Choices Assisted Living Program.

~~The beneficiary intake and assessment process for the Living Choices Program includes a level of care determination, the development of a plan of care and the beneficiary's notification of his or her choice between home- and community-based services and institutional services.~~

The Living Choices Program processes for beneficiary intake, assessment, and service plan development include:

1. Determination of categorical eligibility;
2. Determination of financial eligibility;
3. Determination of nursing facility level of care;
4. Development of a person-centered service plan (PCSP); and
5. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services.

B. Candidates for participation in the program (or their representatives) must make application for services at the DHS office in the county in which the Level II ALF is located. Medicaid eligibility is determined by the DHS County Office and is based on non-medical and medical criteria. Income and resources comprise the non-medical criteria. Medically, the candidate must be an individual with a functional disability.

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

1. The individual is unable to perform either of the following:
   a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon, another person; or
   b. At least 2 of the 3 ADLs of transferring/locomotion, eating or toileting without limited assistance from another person; or
2. ~~Medical assessment results in a score of three or more on Cognitive Performance Scale~~ The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,
3. ~~Medical assessment results in a Changes in Health, End-Stage Disease and Symptoms and Signs (CHESS) score of three or more.~~ The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

D. Individuals who require a skilled level of care as defined in Department of Human Services regulations are not eligible for the Living Choices waiver.

E. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment. The tiers are intended to help inform waiver program oversight and administration and person-centered service planning. The tiers do not replace the Level of Care criteria described in Section C above, waiver eligibility determinations, or the person-centered service plan process.

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

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

3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and therefore is not eligible for the Living Choices waiver program.

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

For more information on ARIA, please see the ARIA Manual.

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

~~F~~G. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.

~~G~~H. Eligibility for the Living Choices waiver program is determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the plan of care is signed by the ~~DAAS~~DHS RN and beneficiary. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.)

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

1. Each Living Choices application will be accepted and medical and financial eligibility will be determined.

2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled, and that the applicant is number X in line for an available slot.

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

   a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;

   b. Waiver application determination date for persons being discharged from a nursing facility after a 90-day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;

   c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);

   d. Waiver application determination date for all other persons.

211.150 Level of Care Determination 1-1-13

A prospective Living Choices beneficiary must require a nursing facility intermediate level of care.

The intermediate level of care determination is made by medical staff with the Department of Human Services (DHS), Office of Long Term Care. The determination is based on the assessment performed by the ~~DAAS~~ Independent Assessment Contractor RN, using standard criteria for functional disability in evaluating an individual's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance with nursing home admission criteria, must be completed and the individual deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving Living Choices services.

The ~~DAAS~~Independent Assessment Contractor RN performs an assessment periodically (at least annually), and the Office of Long Term Care re-determines level of care annually. The results of the level of care determination and the re-evaluation are documented on form DHS-704, Decision for Nursing Home Placement.

NOTE: While federal guidelines require level of care reassessment at least annually, ~~DAAS~~ the Independent Assessment Contractor may reassess a beneficiary's level of care and/or need any time it is deemed appropriate by the ~~DAAS~~DHS RN to ensure that a beneficiary is appropriately placed in the Living Choices Assisted Living Program and is receiving services suitable to his or her needs.

211.200 Plan of Care 2-1-14

A. Each beneficiary in the Living Choices Assisted Living Program must have a person-centered service plan, also referred to as an individualized Living Choices Plan of Care (AAS-9503). The authority to develop a Living Choices plan of care is given to the Medicaid State agency's designee, the ~~Division of Aging and Adult Services Registered Nurse (DAAS~~DHS RN~~)~~. The Living Choices plan of care developed by the ~~DAAS~~DHS RN includes~~, but is not limited to~~ without limitation:

1. Beneficiary identification and contact information to include full name and address, phone number, date of birth, Medicaid number and the effective date of Living Choices Assisted Living waiver eligibility;

2. Primary and secondary diagnosis;

3. ~~Tier Level;~~

~~4.~~ Contact person;

~~45~~. Physician's name and address;

~~56~~. The amount, frequency and duration of required Living Choices services and the name of the service provider chosen by the beneficiary or representative to provide the services;

~~67~~. Other services outside the Living Choices services, regardless of payment source identified and/or ordered to meet the beneficiary's needs. Living Choices providers are not required to provide these services, but they may not impede their delivery.

~~78~~. The election of community services by the waiver beneficiary; and

~~89~~. The name and title of the ~~DAAS~~DHS RN responsible for the development of the plan of care.

~~910~~. Each beneficiary, or his or her representative, has the right to choose the provider of each non-waiver service. Non-waiver services are the services listed on the plan of care that are not included in the bundled services of the Living Choices Program (e.g., medical equipment rental). The plan of care names the provider that the beneficiary (or the beneficiary's representative) has chosen to provide each service.

B. A copy of the plan of care signed by the ~~DAAS~~DHS RN and the waiver beneficiary will be forwarded to the beneficiary and the Living Choices service provider(s) chosen by the beneficiary or representative, if waiver eligibility is approved by the DHS County Office. Each provider is responsible for developing an implementation plan in accordance with the beneficiary plan of care. The original plan of care will be maintained by the ~~DAAS~~DHS RN.

The implementation plan must be designed to ensure that services are:

1. Individualized to the beneficiary's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the beneficiary's welfare;
4. Monitored and adjusted as needed, based on changes to the waiver plan of care, as reported by the ~~DAAS~~DHS RN;
5. Provided within a system that safeguards the beneficiary's rights; and
6. Documented carefully, with assurance that appropriate records will be maintained.

NOTE: Each service included on the Living Choices plan of care must be justified by the ~~DAAS~~DHS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the ~~DAAS~~DHS RN.

Living Choices services must be provided according to the beneficiary plan of care. Providers may bill only for services in the amount and frequency that is authorized in the plan of care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

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

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

C. The assisted living provider employs or contracts with a Registered Nurse (the "assisted living provider RN") who implements and coordinates plans of care, supervises nursing and direct care staff and monitors beneficiaries' status. At least once every three months, the assisted living provider RN must evaluate each Living Choices beneficiary.

D. The ~~DAAS~~DHS RN must reevaluate a beneficiary's medical condition within fourteen days of being notified of any significant change in the beneficiary's condition. The assisted living RN is responsible for immediately notifying the ~~DAAS~~DHS RN regarding beneficiaries whose status or condition has changed and who need reevaluation and reassessment.

REVISIONS TO A BENEFICIARY PLAN OF CARE MAY ONLY BE MADE BY THE ~~DAAS~~DHS RN.

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

E. An individual may be served in a Level II Assisted Living Facility under a provisional plan of care developed by the beneficiary and the ~~DAAS~~DHS RN and signed by the beneficiary or the beneficiary's representative and the ~~DAAS~~DHS RN, if the beneficiary and the provider accept the risk of possible ineligibility.

1. A provisional plan of care may be effective for no more than 60 days.
2. If approved by the Division of County Operations, eligibility for the program will be determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the provisional plan of care is signed by the ~~DAAS~~DHS RN and the beneficiary, and a plan of care will be sent to the provider.

NOTE: No provisional plans of care will be developed if the waiting list process is in effect.

Once a Living Choices eligibility application has been approved, waiver services must be provided in order for eligibility to continue. Medicaid covers Living Choices services on a daily, all-inclusive basis, rather than on an itemized per-service basis. With the exception explained in the NOTE below, a day is a covered date of service when a beneficiary receives any of the services described as a covered ALF service in this manual, when the service is received between midnight on a given day and midnight of the following day. A day is not a covered date of service when a beneficiary does not receive any Living Choices services between midnight of that day and midnight of the following day.

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

Living Choices waiver services are not allowed on the same day as an individual is admitted to an inpatient facility, regardless of the time of day. If the inpatient facility (hospital, rehab hospital, nursing facility or ICF/IID) is

reimbursed by Medicaid on any given day, the ALF waiver provider is not allowed reimbursement for Living Choices service on the same day.

For example: If a waiver beneficiary is taken and admitted to the hospital on 6/10/12 at 10 a.m. and discharged on 6/13/12 at 10:00 p.m., the hospital will be reimbursed by Medicaid for that date of admission, 6/10/12, but will not be reimbursed for the date of discharge, 6/13/12. In this scenario, the individual left the ALF II facility, was admitted to the hospital, and was returned to the ALF II facility after 3 days of hospitalization.

Date of Admission – 6/10/12 at 10:00 a.m. – Reimbursement to the hospital

6/11/12 – Reimbursement to the hospital

6/12/12 – Reimbursement to the hospital

Date of Discharge – 6/13/12 at 10:00 p.m. – Reimbursement to the ALF facility

The time of admission and the time of discharge are not relevant. Payment is made to the two facilities based on the dates of service.

A. Basic Living Choices Assisted Living direct care services are:

1. Attendant care services,
2. Therapeutic social and recreational activities,
3. Periodic nursing evaluations,
4. Limited nursing services,
5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing,
6. Medication oversight to the extent permitted under Arkansas law and
7. Assistance obtaining non-medical transportation specified in the plan of care.

B. Living Choices participants are eligible for pharmacist consultant services. Level II ALFs are required by their licensing regulations to engage a Consultant Pharmacist in Charge.

NOTE: The removal of Pharmacy Consultant Services as a waiver service does not change the provision of the service, as required under the Level II ALF licensing regulations.

Living Choices waiver beneficiaries are eligible for the same prescription drug benefits of regular Medicaid, plus three (3) additional prescriptions for a total of nine (9) per month. No prior authorization is required for the three additional prescriptions. Living Choices waiver beneficiaries who are dual eligible (receiving both Medicare and Medicaid) must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

212.200 Periodic Nursing Evaluations 1-1-13

The assisted living provider RN must evaluate each Living Choices Program beneficiary at least every three months, more often if necessary. The assisted living provider RN must alert the

~~DAAS~~DHS RN to any indication that a beneficiary's direct care services needs are changing or have changed, so that the ~~DAAS~~DHS RN can reassess the individual.

Each Living Choices beneficiary will be evaluated at least annually by a ~~DAAS~~DHS RN. The ~~DAAS~~DHS RN evaluates the resident to determine whether a nursing home intermediate level of care is still appropriate and whether the plan of care should continue unchanged or be revised. Re-evaluations and subsequent plan of care revisions must be made within fourteen days of any significant change in the beneficiary's status.

215.000 Living Choices Forms 1-1-13

Living Choices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging and Adult Services. These forms include ~~but are not limited to~~ without limitation:

A. Plan of Care – AAS-9503

~~B, Quarterly Monitoring AAS-9506~~

B.~~C.~~ Start Services – AAS-9510

C.~~D.~~ Beneficiary Change of Status – AAS-9511

Providers may request form~~s AAS-9506 and~~ AAS-9511 by writing to the Division of Aging, Adult and Behavioral Health ~~and Adult~~ Services. **View or print the Division of Aging, Adult, and Behavioral Health ~~and Adult~~ Services contact information.**

Forms AAS-9503 and AAS-9510 will be mailed to the provider by the DHS RN.

Instructions for completion and retention are included with each form. If there are questions regarding any waiver form, providers may contact the DHS RN in your area.

216.260 In-Service Training 1-1-13

Medicaid requires personal care aides to participate in least twelve (12) hours of in-service training every twelve (12) months after achieving Personal Care Aide certification.

A. Each in-service training session must be at least 1 hour in length.

1. When appropriate, in-service training may occur at an assisted living facility when the aide is furnishing services.

2. In-service training while serving a Living Choices beneficiary may occur only if the beneficiary or the beneficiary's representative has given prior written consent for training activities to occur concurrently with the beneficiary's care.

B. The Living Choices provider and the personal care aide must maintain documentation that they are meeting the in-service training requirement.

C. Providers are required to attend at least one in-service per calendar year. Required in-services are co-sponsored by DMS and ~~DAAS~~DAABHS.

250.100 Reimbursement of Living Choices Assisted Living Facilities and Agencies 1-1-13

Medicaid reimbursement to Living Choices assisted living facility and agency providers is based on a statewide daily (per diem) rate, as determined by DMS and specified in the Fee Schedule under Section 250.210. ~~that corresponds to the tier of need in which the DAASDHS RN places a beneficiary. The determination of the tier of need is based on the comprehensive assessment. There are four tiers of need.~~ The daily rate pays for all direct care services in the beneficiary's plan of care. Reimbursement is for direct care services only; room and board are to be paid by the beneficiary or his or her legal representative.

A day is a covered date of service when a Living Choices beneficiary receives any of the services described in Sections 212.100 through 212.500 between midnight of that day and midnight of the following day.

262.100 Living Choices Assisted Living Procedure Codes 1-1-13

Procedure Code	Modifier	Description
T2031	~~U1~~	Living Choices Assisted Living ~~Tier 1~~
~~T2031~~	~~U2~~	~~Living Choices Assisted Living Tier 2~~
~~T2031~~	~~U3~~	~~Living Choices Assisted Living Tier 3~~
~~T2031~~	~~U4~~	~~Living Choices Assisted Living Tier 4~~

SECTION II - PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

CONTENTS

201.100 PACE Provider Enrollment Requirements 5-1-08

To ensure quality and continuity of care, all PACE providers approved to receive Medicaid reimbursement for services provided must meet specific qualifications. PACE providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of

this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. PACE providers must be certified by the ~~Division of Aging and Adult Services (DAAS)~~ Division of Provider Services and Quality Assurance (DPSQA) as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

Certification by the ~~Division of Aging and Adult Services Division of Aging and Adult Services (DAAS)~~ Division of Provider Services and Quality Assurance (DPSQA) does not guarantee enrollment in the Medicaid program.

All providers must maintain their provider files at the Provider Enrollment Unit by submitting current certification, licensure, etc., all ~~DAAS~~DPSQA-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider.

Copies of certifications and renewals required by ~~DAAS~~DPSQA must be maintained by ~~DAAS~~DPSQA to avoid loss of provider certification.

B. A PACE provider application must be approved by the Centers for Medicare and Medicaid Services (CMS) and ~~DAAS~~ the Division of Aging, Adult, and Behavioral Health Services (DAABHS). Failure to submit a PACE provider application to DAABHS at the same time or prior to submitting the application to CMS shall constitute grounds for DAABHS denying or delaying approval of the application.

C. A three-way Provider Agreement must be signed by ~~the DAAS~~ DAABHS, CMS, and the provider.

D. The PACE Organization must be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance ~~Long Term Care Section~~, as an Adult Day Health Care.

204.200 Medical Criteria 1-1-13

PACE participants must meet one of the following criteria:

The individual is unable to perform either of the following:

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

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

C. ~~Medical assessment results in a score of three or more on Cognitive Performance Scale~~ The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or

D. ~~Medical assessment results in a Changes in Health, End-Stage Disease and Symptoms and Signs (CHESS) score of three or more.~~ The individual has a diagnosed medical

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

E. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the Program of All-Inclusive Care for the Elderly unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.

212.100 PACE Enrollment 5-1-08

Participant enrollment into the PACE Program is voluntary. Prospective PACE beneficiaries may apply for PACE services through their local DHS county offices. Applicants may apply by referral from the PACE provider, by referral from a DHS RN, or without a referral from any source. Regardless of the origin of the inquiry, the prospective participant must meet the medical and financial eligibility criteria.

If the prospective PACE beneficiary makes the initial inquiry with the PACE provider or the DHS-RN, the provider or RN will instruct the applicant to make application at the local DHS county office for a determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for the medical assessment.

The ~~Division of Aging and Adult Services (DAAS~~Office of Long Term Care, Division of Provider Services and Quality Assurance, of the Department of Human Services must determine, based on the functional assessment conducted by the Independent Assessment Contractor, that ~~assess~~ the potential enrollee ~~and agree that he or she~~ meets the requirements for nursing facility care prior to enrollment. The Department of Human Services (DHS)-RN must certify that an assessment has been completed and that it is safe for the participant to live in the community. The DHS-RN will notify the local DHS county office and the Provider Organization (PO) that all requirements have been met.

The PACE provider must explain to the potential enrollee that enrollment in PACE results in disenrollment in any other Medicare or Medicaid plan and the provider is required to complete an intensive assessment that includes a minimum of one home visit and one visit by the potential enrollee to the PACE center unless otherwise approved by CMS.

212.200 Disenrollment 5-1-08

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

A. Participant's failure to pay if he or she has a payment responsibility

B. Participant's disruptive or threatening behavior

C. Participant moves out of the PACE service delivery area

D. Participant no longer meets the nursing facility level of care requirement

E. The PACE program agreement with the Centers for Medicare and Medicaid Services (CMS) and the state is not renewed

F. The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of the Department of Human Services. The request to disenroll a participant and documentation to support the request must be sent to the DHS-RN. The DHS- RN will review the request and corresponding documentation and will make a recommendation to the DHS- RN Supervisor and DHS PACE Program Manager regarding whether the PACE Organization should proceed with the involuntary disenrollment. The DHS-RN Supervisor, in consultation with PACE Program management will make a final determination regarding the appropriateness of the involuntary disenrollment and will notify the PACE Organization and the DHS-RN.

The PACE Organization may request an administrative reconsideration pursuant to Section 190.003. A request for administrative reconsideration must be directed to the ~~Division of Aging and Adult Services (DAAS)~~ Division for Aging, Adult, and Behavioral Health Services (~~DAAS~~DAABHS).

215.000 Interdisciplinary Teams 4-1-06

The PACE interdisciplinary team must meet regularly as indicated in the Provider Agreement between the PO, CMS, and ~~DAAS~~DAABHS to provide overall assessment of care needs and subsequent management, supervision and provision of care for eligible individuals.

215.200 Assessment/Treatment Plan 1-1-13

An interdisciplinary team is responsible for assessment, treatment planning and care delivery after the Independent Assessment Contractor has completed an initial assessment using the ARIA assessment instrument to determine the individual's functional needs and eligibility for nursing facility level of care ~~DHS-RN has completed the initial eligibility assessment for nursing facility level of care~~. The team must meet the following assessment requirements:

A. An initial in-person comprehensive assessment must be completed promptly following enrollment by the:

1. Primary care physician,
2. Registered nurse,
3. Master's-level social worker,
4. Physical therapist,
5. Occupational therapist,
6. Recreational therapist or activity coordinator,
7. Dietitian and
8. Home care coordinator.

B. At least semi-annually, an in-person assessment and treatment plan must be completed by the:

1. Primary care physician,
2. Registered nurse,
3. Master's-level social worker and
4. Recreational therapist/activity coordinator.

C. Annually, an in-person assessment and treatment plan must be completed by the:

1. Physical therapist,
2. Occupational therapist
3. Dietitian and
4. Home care coordinator.

PACE organizations consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the interdisciplinary team. The consolidated plan is then discussed and finalized with the PACE participant and/or his or her significant others.

Reassessments and treatment plan changes are completed when the health or psychosocial situation of the participant changes.

220.100 Monitoring by the Office of Long Term Care 1-1-13

Due to the requirement that PACE Organizations be licensed as Arkansas Adult Day Health Care Centers, the ~~Office of Long Term Care~~Division of Provider Services and Quality Assurance (DPSQA) will be conducting monitoring and oversight of the PACE Center operations.

~~220.300 Monitoring by RN Supervisor~~ ~~1-1-13~~

~~The DHS RN Supervisor attends the PACE organization's weekly Interdisciplinary Team Meetings (IDT). The DHS RN Supervisor contributes to the IDT meetings as necessary to ensure the health, welfare and safety needs of the beneficiaries are met.~~

220.400 Monitoring by the Centers for Medicare and Medicaid Services (CMS) and the State Administering Agency (SAA) 1-1-13

In compliance with federal requirements, each PACE Organization will enter required information for nine (9) key indicators into the Health Plan Management System (HPMS), or any successor data elements or data system on a quarterly basis. Both CMS and the State Administering Agency (SAA) will use the data entered into HPMS or its successor system to monitor the ongoing operations of the PACE Organization and identify potential problems or unusual events that may be the first indication of problems in patient care, site operations or financial solvency. These reviews will also be used to determine if further onsite monitoring will be necessary.

A. The nine (9) key indicators are as follows:

1. Routine Pneumococcal Immunizations
2. Grievances & Appeals
3. Enrollments
4. Disenrollments
5. Prospective Enrollees
6. Unscheduled Hospitalizations
7. Emergency (Unscheduled) Care
8. Unusual Incidents for participants and the PACE site (such as falls, attempted suicides, staff criminal records, infectious diseases, food poisoning, participant injury, Medication errors, lawsuits, any type of restraint use, etc.)

9. Participant Deaths

~~B. Other Required DHS Monitoring Reports:~~

~~1. 45 day report - tracks all applications pending more than 45 days~~

~~2. Monthly Reports - tracks all assessments, reassessments, monitoring contacts, mileage associated with home visits, and pending applications~~

~~3. Average Days for Assessment Completion - tracks statewide average and each RNs length of time between receiving referral and completing home visit.~~

SECTION II - PERSONAL CARE

CONTENTS

200.100 Arkansas Medicaid Participation Requirements for Personal Care Providers 1-1-18

Numerous agencies, organizations and other entities may qualify for enrollment in the Arkansas Medicaid Personal Care Program. Participation requirements vary among these different types of providers. Sections 200.110 through 200.160 outline the participation requirements specific to each type of personal care provider. Section 201.000 describes the procedures required to enroll in the Medicaid Program. Sections 201.010 through 201.050 set forth the licensing, certification and other requirements specific to each type of personal care provider.

All owners, principals, employees, and contract staff of a personal care provider must have ~~comply with~~ national and state criminal background checks according to Arkansas ~~State Law at~~ Code Annotated §§ 20-33-213 and 20-38-101 *et seq*. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

200.140 Assisted Living Facilities

A. Only one type of assisted living facility, a Level 1 Assisted Living Facility (ALF), may enroll as a personal care provider. ~~There are three types of assisted living facilities (ALFs). These three types are: Residential Care Facilities (RCFs), Level I Assisted Living Facilities (Level I ALFs), and Level II Assisted Living Facilities (Level II ALFs).~~

B. The ~~Arkansas Office of Long Term Care (OLTC)~~ Division of Provider Services and Quality Assurance (DPSQA) certifies, licenses and regulates certain institutions, including ALFs.

C. Each ALF has a separate license, regardless of which type it is and regardless of its location or proprietorship.

D. Each ALF that provides personal care for Medicaid beneficiaries and that desires Medicaid reimbursement for those services must enroll separately in the Arkansas Medicaid Personal Care Program, effective for dates of service on and after March 1, 2005.

1. Some providers operate multiple ALF facilities, sometimes on the same property or in the same complex and sometimes in multiple locations.

   a. Effective for dates of service before March 1, 2005, Medicaid covers personal care services provided by enrolled RCFs for residents of Level I ALFs ~~and Level II ALFs~~ under the same proprietorship as the enrolled RCF.

   b. Level I ~~and Level II~~ ALFs that are not under the same proprietorship as a Medicaid-enrolled RCF may not contract for Medicaid-covered personal care with an enrolled RCF owned by another entity.

   c. Except under the conditions described in part a above, personal care in any assisted living facility may be provided only by the facility itself, if it is enrolled in the Arkansas Medicaid Personal Care Program, or by

(1). A private care agency that is enrolled as a Personal Care provider or

(2). A Class A or Class B home health agency that is enrolled as a Personal Care provider.

2. Several provider files may share the same Federal Employer Identification Number (FEIN). For example: A corporate entity that has one FEIN owns an RCF and a Level I ALF and enrolls them as Personal Care Program providers.

   a. Each facility is assigned a unique Arkansas Medicaid provider number.

   b. Each facility's Arkansas Medicaid Personal Care provider number is linked to its unique license number.

   c. Each facility's Arkansas Medicaid Personal Care provider number is linked to the corporate entity's single FEIN.

~~E. For dates of service before March 1, 2005, RCFs are the only assisted living facilities that may participate in the Personal Care Program.~~

~~F~~E. Sections 200.141~~,~~ and 200.142 ~~and 200.143~~ outline Arkansas Medicaid Personal Care Program participation requirements for RCFs~~,~~ and Level I ALFs. ~~and Level II ALFs~~.

~~G~~F. ~~In addition to the Personal Care Program,~~ Level II ALFs may participate in the Living Choices Assisted Living Program.

1. Living Choices is a home- and community-based program established for certain nursing home-eligible individuals who, without a program like Living Choices, would not be able to live in a dwelling of their own or would be able to do so only with great difficulty and with significant risk to their health and safety.

2. Providers may obtain Living Choices Program participation requirements by downloading the Living Choices Assisted Living Provider Manual from the Arkansas Medicaid website, ~~www.medicaid.state.ar.us~~.https://medicaid.mmis.arkansas.gov.

3. Living Choices services are not covered for beneficiaries receiving services through the Personal Care Program, and Personal Care Program services are not covered for ~~beneficiarys~~ beneficiaries in the Living Choices Program.

200.141 Residential Care Facilities 3-1-05

A residential care facility applying for enrollment as a personal care provider must be licensed as a residential care facility by the ~~OLTC~~ Division of Provider Services and Quality Assurance (DPSQA).

200.142 Level I Assisted Living Facilities 3-1-05

A Level I ALF applying for enrollment as a personal care provider must be licensed as a Level I ALF by the ~~Arkansas Office of Long Term Care (OLTC)~~ Division of Provider Services and Quality Assurance (DPSQA).

~~200.143 Level II Assisted Living Facilities~~ ~~3-1-05~~

~~A Level II ALF applying for enrollment as a personal care provider must be licensed as a Level II ALF by the OLTC.~~

~~200.150 Division of Developmental Disabilities Services Community Providers~~ ~~8-1-04~~

~~A Division of Developmental Disabilities Services Community Provider facility applying for enrollment as a personal care provider must hold a current license from the Arkansas Division of Developmental Disabilities Services.~~

201.110 Class A and Class B Home Health Agencies 3-1-05

Class A and Class B Home Health Agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current Class A or Class B license. In addition, certification by DPSQA is required for Medicaid provider enrollment.

201.120 Private Care Agencies 1-1-18

A. Private care agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current license from the Arkansas Department of Health. In addition, certification by DPSQA is required for Medicaid provider enrollment.

B. Private care agencies must ensure that there is on file with the Provider Enrollment Unit proof of liability insurance coverage of not less than one million dollars ($1,000,000.00), covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.

C. Annually, private care agency providers must ensure that there is on file with the Provider Enrollment Unit proof that the agency's required liability insurance remains in force and has remained in force at a level of coverage no less than the required minimum since the provider's previous report.

201.131 Residential Care Facilities 3-1-05

A residential care facility applying for enrollment as a personal care provider must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of its current license from the ~~Arkansas Office of Long Term Care (OLTC)~~ Division of Provider Services and Quality Assurance (DPSQA). In addition, certification by DPSQA is required for Medicaid provider enrollment.

201.132 Level I Assisted Living Facilities 3-1-05

A Level I Assisted Living Facility (ALF) applying to enroll as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the ~~Arkansas Office of Long Term Care (OLTC)~~ Division of Provider Services and Quality Assurance (DPSQA). In addition, certification by DPSQA is required for Medicaid provider enrollment.

~~201.133 Level II Assisted Living Facilities~~ ~~3-1-05~~

~~A Level II ALF applying to enroll as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the OLTC.~~

~~201.140 Division of Developmental Disabilities Services Community Providers~~ ~~3-1-05~~

~~A Developmental Disabilities Services Community Provider facility applying for enrollment as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the Arkansas Division of Developmental Disabilities Services.~~

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202.210 Out-of-State Limited Services Personal Care Providers 3-1-11

A. Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and they have a claim or claims to file with Arkansas Medicaid.

1. To enroll, providers must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View Medicaid Provider Enrollment Unit contact information.**
2. Out of state providers must also be certified by DPSQA.
3. Enrollment as a limited services provider automatically expires after a year unless the provider provides and bills for subsequent services for Arkansas Medicaid beneficiaries during the year. See part B below.

B. Out-of-state limited services providers remain enrolled for one year.

1. If an out-of-state limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

213.000 Scope of the Program 1-1-18

A. Personal care services are primarily based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Hands-on assistance in at least one of these areas, based on the ARIA assessment results, is required. This type of assistance is provided by a personal care aide based on a beneficiary's physical dependency needs (as opposed to purely housekeeping services). ~~A~~ An individualized plan of care is developed based on the ARIA assessment results and information in the form designated by DHS that is submitted by the provider, ~~through the independent assessment process~~ and is based on a beneficiary's assessed dependency in at least one of the above-listed activities of daily living. While not a part of the eligibility criteria, the need for assistance with other tasks and IADLs (Instrumental Activities of Daily Living) are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized. Routines or IADLs include meal preparation, incidental housekeeping, laundry, medication assistance, etc. These tasks are also defined and described in this section of this provider manual and are defined in the Arkansas State Board of Nursing Position Statement 97-2.

B. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the beneficiary were in a hospital or nursing facility.

C. Personal care services may be similar to or overlap some services that home health aides furnish.

1. Home health aides may provide personal care services in the home under the home health benefit.
2. Skilled services that only a health professional may perform are not considered personal care services.

D. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, Level II assisted living facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State, e.g., ARChoices, IndependentChoices;
2. Furnished in the beneficiary's home, and at the State's option, in another location.
3. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family".

E. Personal care for Medicaid-eligible individuals requires prior authorization. See Sections 240.000 through 246.000.

F. Only Class-A Home Health agencies, Class-B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, and education service cooperatives ~~and DDS facilities~~ may provide personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the beneficiary's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

213.120 Non-Inpatient, Non-Institutionalized Status 10-13-03

A. Personal care services are services furnished to an individual who is not an inpatient or a resident of:

1. A hospital,
2. A nursing facility,
3. A Level II assisted living facility
4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or
5. An institution for mental diseases (IMD).

B. Individuals who are inpatients or residents of the foregoing institutions or facilities are ineligible for Personal Care Program services.

1. Under applicable federal statutory and regulatory provisions, the institutional status of an individual controls the individual's exclusion from service eligibility.
2. The location of the personal care service delivery site is not a determinant of the institutionalized individual's ineligibility for services.

213.200 Physical Dependency Need Criteria for Service Eligibility 1-1-18

A. The terms "routines," "activities of daily living" and "service" have particular definitions that apply to the Personal Care Program. See Sections 216.100 through 216.140 for definitions of these and other terms employed in this manual.

B. Personal care services, described in Sections 216.000 through 216.330, must be medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS.

C. Personal care services are individually designed to assist with a beneficiary's assessed physical dependency needs related to the following routine activities of daily living and instrumental activities of daily living:

1. Bathing
2. Bladder and bowel requirements
3. Dressing
4. Eating
5. Incidental housekeeping
6. Laundry
7. Personal hygiene
8. Shopping for personal maintenance items
9. Taking medications*
10. Mobility and Ambulation

* Assistance with medications is a personal care service only to the extent that it is permitted by the Arkansas Nurse Practice Act, ~~and~~ implementing regulations permit a personal care aide to perform the service, and Arkansas State Board of Nursing Position Statement 97-2.

D. A number of conditions may cause "physical dependency needs."

1. Particular disabilities or conditions may or may not be pertinent to specific needs for individual assistance.
2. In assessing an individual's need for personal care, the question to pursue is whether the individual is unable to perform tasks covered by this program without assistance from someone else.
3. The need for individual assistance indicates whether to consider personal care.

213.310 IndependentChoices Program, Title XIX State Plan Program 1-1-13

IndependentChoices is operated by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ and operates under the authority of the Title XIX State Plan with the Division of Medical Services responsible for administrative and financial authority.

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly (age 65 and older) to direct their personal care. The beneficiary chooses a cash allowance in lieu of agency personal care services. IndependentChoices provides qualifying beneficiaries with counseling and training to assist them with information to fulfill their role as an employer. The beneficiary as the employer will hire, train, supervise and, if necessary, terminate the services of their employee. In addition to hiring an employee, the beneficiary may use part of their budget to purchase goods and services that lessen their physical dependency needs. In addition to counseling support services, ~~beneficiarys~~ beneficiaries may receive Financial Management Services (FMS) from a DMS contracted provider. The FMS provider will assist the beneficiary by processing timesheets, withholding and reporting State and Federal taxes, issuing a W-2 to all employees who meet the tax threshold and refunding taxes to the beneficiary and the employee when the threshold was not met. The

FMS provider also coordinates the accuracy and coordination of the forms used to establish the Medicaid beneficiary as an employer and to employ a worker. The FMS provider representing the Medicaid beneficiary will obtain permissions and execute an IRS Form 2678 to act as the beneficiary's agent.

NOTE: The IndependentChoices Program is required to follow the rules and regulations of the State Plan approved Personal Care Program, unless stated otherwise in this manual.

213.500 Personal Care Service Locations 3-1-05

A. Arkansas Medicaid covers personal care in a beneficiary's home and, at the state's option, in another location, for beneficiaries of all ages.

1. A beneficiary's home is the beneficiary's residence, subject to the exclusions in part B, below.
2. Service locations outside the beneficiary's home must be included in the service plan. (If shopping or assistance with shopping is included in the service plan, it is understood that the actual activity occurs at a store. The place of service—for billing purposes—remains the beneficiary's home.)
3. The beneficiary's assessment and service plan must justify the medical necessity for personal care in a location other than the beneficiary's residence. For example: A beneficiary's service plan includes assistance with dressing. This particular beneficiary regularly (by PCP referral or a physician's order) goes to a clinic or other site for a therapy, such as aqua therapy, that involves changing clothes. If, at the therapy site, assistance with dressing and/or changing is not included with the therapy service, the personal care service plan may include an aide's assistance. However, in such a situation, only the time the aide spends performing the service is covered.

B. Medicaid does not cover personal care services in the following locations:

1. A hospital,
2. A nursing facility,
3. A Level II assisted living facility,
4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or
5. An institution for mental diseases (IMD).

C. All individuals residing in locations listed above in part B are ineligible for Medicaid-covered personal care.

D. Individuals who are inpatients or residents of the facilities and institutions listed in part B are not eligible for Medicaid-covered personal care services in any location.

~~213.510 Personal Care in Division of Developmental Disabilities Services (DDS) Community Provider Facilities~~ ~~3-1-05~~

~~A. Medically necessary personal care is covered in a DDS community provider facility.~~

~~B. Medicaid Program requirements are the same as for personal care services delivered in a beneficiary's home.~~

~~C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid programs, through which the beneficiary receives services.~~

~~D. Individuals enrolled in DDS community provider facilities may receive a number of services in accordance with an Individualized Plan (IP), an Individualized Family Services Plan (IFSP) or an Individualized Habilitation Plan (IHP).~~

~~1. None of these plans may supersede or substitute for the personal care service plan.~~

~~2. The Personal Care Program requires a distinct and separate assessment and service plan.~~

213.540 Employment-related Personal Care Outside the Home 1-1-18

No condition of this section alters or adversely affects the status of individuals who are furnished personal care in sheltered workshops or similarly authorized habilitative environments. There may be a few beneficiaries working in sheltered workshops solely or primarily because they have access to personal care in that setting. This expansion of personal care outside the home may enable some of those individuals to move or attempt to move into an integrated work setting.

A. Personal care may be provided outside the home when the requirements in subparts A1 through A5 are met and the services are necessary to assist an individual with a disability to obtain or retain employment.

1. The beneficiary must have an authorized, individualized personal care service plan that includes the covered personal care services necessary to and appropriate for an employed individual or for an individual seeking employment.
2. The beneficiary must be aged 16 or older.
3. The beneficiary's disability must meet the Social Security/SSI disability definition.
    a A beneficiary's disability may be confirmed by verifying his or her eligibility for SSI, Social Security disability benefits or a Medicaid disability aid category, such as Working Disabled or DDS Alternative Community Services waiver.
    b. If uncertain whether a beneficiary qualifies under this disability provision, contact the Department of Human Services local office in the county in which the beneficiary resides.
4. One of the following two conditions must be met.
    a. The beneficiary must work at least 40 hours per month in an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability).
    b. Alternatively, the beneficiary must be actively seeking employment that requires a minimum of 40 hours of work per month in an integrated setting.
5. The beneficiary must earn at least minimum wage or be actively seeking employment that pays at least minimum wage.

B. Personal care aides may assist beneficiaries with personal care needs in a beneficiary's workplace and at employment-related locations, such as human resource offices, employment agencies or job interview sites.

C. Employment-related personal care associated with transportation is covered as follows.

1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking.
2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; see Section 215.300, part F) in the service plan and all pertinent service documentation.

3. Medicaid does not cover mileage associated with any personal care service.

4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is ~~neither subject to nor included in the eight-hour per month benefit limit that applies to shopping for personal care items and transportation to stores to shop for personal care items, but it is~~ included in the 64-hour per month personal care benefit limit for beneficiaries aged 21 and older.

D. All personal care for beneficiaries requires prior authorization.

E. Providers furnishing both employment-related personal care outside the home and non-employment related personal care at home or elsewhere for the same beneficiary must comply with the applicable rules at Sections 215.350, 215.351 and 262.100.

213.600 In-State and Out-of-State Limited Services Secondary Personal Care Providers 1-1-18

On rare occasions, a personal care beneficiary might have urgent cause to travel to a locality outside his or her personal care provider's service area. If DHS professional staff or contractor(s) designated by DHS authorizes personal care during the beneficiary's stay in that locality, the beneficiary may choose a personal care provider agency in the service area to which he or she is traveling.

A. In-State and Out-of-State Limited Services Secondary Personal Care Provider

If the selected provider is an in-state provider, the selected provider's services may be covered if all the following requirements are met:

1. The beneficiary's personal care provider (the "primary" provider) must request in writing that the selected provider (the "secondary" provider) assume the beneficiary's service for the specified duration of the beneficiary's stay.

2. The primary provider must forward to the secondary provider a copy of the beneficiary's current service plan and service documentation, including logs, for a minimum service-period of sixty days prior to the request.

3. If the secondary provider requests additional information or documentation, the primary provider must forward the requested materials immediately.

4. The secondary provider must execute a written agreement to assume the beneficiary's care on behalf of the primary provider.

5. The secondary provider must submit its service documentation to the primary provider within ten working days of the beneficiary's departure from the temporary locality.

B. Out-of-State Limited Services Secondary Personal Care Provider

If the provider is an out-of-state provider, the provider must also download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application and contract to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).**

The selected provider must also submit to the ~~Medical Services, Utilization Review Section,~~ contractor designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff a written request for prior authorization accompanied with copies of the provider's license, Medicare certification, beneficiary's identifying information and the beneficiary's service plan. ~~**View or print Division of Medical Services, Utilization Review Section contact information**~~.

C. All documentation exchanged between the primary and secondary providers must satisfy all Medicaid requirements.

213.610 Personal Care/Hospice Policy Clarification 1-1-13

Medicaid beneficiaries are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice and homemaker services.

A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in home providers.

B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aid and homemaker services necessary for the treatment of the terminal condition.

C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the IndependentChoices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

~~Extension of benefits for personal care for beneficiaries receiving both hospice services and personal care services will be considered based on the individual beneficiary's physical dependency needs. Requests for increased personal care hours will be reviewed for medical necessity; duplication of services will be adjusted accordingly.~~

NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice-care in the home that provides the amount of services required to meet the needs of the beneficiary, the amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the hospice and personal care records must explain the need for both and be supported by the policy in this section.

214.200 Service Plan Review and Renewal 1-1-18

A. A personal care service plan terminates one (1) year after its initial or revised beginning date of service, unless described otherwise in this section. ~~See **NOTE** below.~~

~~1.~~ DHS professional staff or contractor(s) designated by DHS must review the service plan no less often than once per year, unless described otherwise in this section. See **NOTE** below.

~~2. Upon completion of the six-month review, DHS professional staff or contractor(s) designated by DHS may authorize continued personal care services, either unchanged or with modifications, or may order that services cease.~~

B. Personal care services may not continue past the one-year anniversary of an initial or revised beginning date of service until DHS professional staff or contractor(s) designated by DHS authorizes a revised service plan or renews the authorization of an existing service plan.

214.300 Authorization of ARChoices ~~Plan of Care~~ Person-Centered Service Plan and Personal Care Individualized Service Plan 1-1-18

The ~~DAAS~~DHS RN is responsible for developing an ARChoices ~~Plan of Care~~ Person-Centered Service Plan (PCSP) that includes both waiver and non-waiver services. Once developed, the ~~Plan of Care~~ PCSP is signed by the ~~DAAS~~DHS RN authorizing the services listed.

The signed ARChoices ~~Plan of Care~~ PCSP will suffice as the "Personal Care Authorization" for services required in the Personal Care Program. ~~The signature of the DAAS RN on the ARChoices Plan of Care simply replaces the need for the prior authorization of personal care services.~~ The personal care individualized service plan, developed by the Personal Care provider, is still required.

As the ARChoices ~~Plan of Care~~ PCSP is effective for one year, once signed by the ~~DAAS~~DHS RN; the authorization for personal care services, when included on the ARChoices ~~Plan of Care~~ PCSP, will be for one year from the date of the ~~DAAS~~DHS RN's signature, unless revised by the ~~DAAS~~DHS RN or the personal care individualized service plan needs to be revised, whichever occurs first. ~~If personal care services continue unchanged as authorized on the ARChoices Plan of Care, a new service plan is not required at the 6-month interval.~~

NOTE: For ARChoices ~~beneficiarys~~ beneficiaries who receive personal care through traditional agency services or have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices ~~plan of care~~ PCSP, signed by a ~~DAAS~~DHS RN, will serve as the authorization for personal care services for one year from the date of the ~~DAAS~~DHS RN's signature, as described above.

The responsibility of developing a personal care individualized service plan is not placed with the ~~DAAS~~DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

The Arkansas Medicaid Program waives no other Personal Care Program requirements with regard to personal care individualized service plan authorizations obtained by ~~DAAS~~DHS RNs.

214.310 Development of ARChoices ~~Plan of Care~~ Person-Centered Service Plan 1-1-16

If personal care services are not currently being provided when the ~~DAAS~~DHS RN develops the ARChoices ~~Plan of Care~~ Person-Centered Service Plan (PCSP), the ~~DAAS~~DHS RN will determine if personal care services are needed. If so, the service, amount, frequency, duration and the beneficiary's provider of choice will be included on the ARChoices ~~Plan of Care~~ PCSP. A copy of the ARChoices ~~Plan of Care~~ PCSP and a Start of Care form (AAS-9510) will be forwarded to the personal care provider, as is current practice for waiver services. The Start of Care form must be returned to the ~~DAAS~~DHS RN within 10 working days from mailing or action may be taken by the ~~DAAS~~DHS RN to secure another personal care provider or modify the ARChoices ~~Plan of Care~~ PCSP. (The ARChoices ~~Plan of Care~~ PCSP is dated the date it is mailed.) Before taking action to secure another provider or modifying the ~~Plan of Care~~ PCSP,

the applicant and/or family members will be contacted to discuss possible alternatives. ~~Communications related to participation in the IndependentChoices program will be conveyed electronically through "tasks" communicated through Med Compass software, a new data system used to help manage waiver and IndependentChoices services.~~

This ~~Plan of Care~~ PCSP supersedes any other ~~Plan of Care~~ care plan that may have been previously developed by another Medicaid provider for the applicant. The ARChoices ~~Plan of Care~~ PCSP must include all appropriate ARChoices services and certain non-waiver services appropriate for the applicant, such as Personal Care.

An agency providing services to an ARChoices beneficiary must report these services to the ~~DAAS~~DHS RN. The services being provided to the ARChoices beneficiary must be included on the ARChoices ~~Plan of Care~~ PCSP. Prior to beginning services or revising services provided to an ARChoices beneficiary, contact the ~~DAAS~~DHS RN so the ~~Plan of Care~~ PCSP is properly revised and approved. Please report all changes in services and changes in the ARChoices beneficiary's circumstances to the ~~DAAS~~DHS RN immediately upon learning of the change. Certain services provided to an ARChoices beneficiary that are not included on the ARChoices ~~Plan of Care~~ PCSP may be subject to recoupment by the Medicaid Program.

~~If the DAAS RN is aware that personal care services are currently being provided when the ARChoices Plan of Care is developed, the DAAS RN will contact the personal care provider to verify the current order and amount of personal care services in place. If requested verbally, the request must be documented in the ARChoices nurse narrative. It is the personal care provider's responsibility to provide the requested information to the DAAS RN immediately upon receipt of the request. If a copy is not received within 10 working days of the request, the DAAS RN will process the ARChoices Plan of Care, as developed by the DAAS RN.~~

NOTE: It is the IndependentChoices employer or personal care provider's responsibility to place information regarding their presence in the home in a prominent location so that the ~~DAAS~~DHS RN will be aware that they are serving the beneficiary. Preferably, the provider will place the information on the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will place the information in a location satisfactory to the applicant, as long as it is readily available and easily accessible by the ~~DAAS~~DHS RN.

The personal care individualized service plan developed by the personal care provider must meet all requirements as detailed in the personal care provider manual. This includes, but is not limited to, the amount of personal care services, personal care tasks, frequency and duration. ~~The DAAS RN will not alter the current number of personal care units, unless a waiver Plan of Care cannot be developed without duplicating services. If personal care units must be altered, the DAAS RN will contact the personal care provider to discuss available alternatives prior to making any revisions.~~ The ARChoices ~~Plan of Care~~ PCSP and the required justification for each service remains the responsibility of the ~~DAAS~~DHS RN. Therefore, final decisions regarding services included on the ARChoices ~~Plan of Care~~ PCSP rest with the ~~DAAS~~DHS RN.

NOTE: For ARChoices waiver beneficiaries participating in the IndependentChoices program, services are effective on the date of the ~~DAAS~~ DHS RN's signature on ~~assessment tool or~~ the ARChoices waiver PCSP ~~plan of care, whichever is the latter of the two~~.

~~214.320 Revisions to the ARChoices Plan of Care~~ ~~1-1-18~~

~~Requested changes to the personal care services included on the ARChoices Plan of Care may originate with the personal care RN or the DAAS RN, based on the beneficiary's circumstances. Unless requested by an IndependentChoices beneficiary, the individual or agency requesting revisions to the Personal Care services on the ARChoices Plan of Care is responsible for securing any required signatures authorizing the change prior to the ARChoices Plan of Care being revised. The DAAS RN will obtain electronic signatures for dates of service on or after January 1, 2013.~~

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

214.330 Medicaid Audit Requirements for the ARChoices ~~Plan of Care~~ Person-Centered Service Plan 1-1-16

When the Medicaid Program, as authorized by the ARChoices ~~Plan of Care~~ Person-Centered Service Plan (PCSP), reimburses for Personal Care services, all Medicaid audits will be performed based on that authorization. Therefore, all documentation by the Personal Care provider must tie services rendered to services authorized as reflected on the ARChoices ~~Plan of Care~~ PCSP.

215.000 Personal Care Assessment and Individualized Service Plan

215.100 IndependentChoices Assessment and Service Plan Formats 1-1-18

~~A. The Division of Medical Services (DMS), in some circumstances and for certain specified providers, requires exclusive use of form DMS-618 (**View or print form DMS-618.**) to satisfy particular Program documentation requirements.~~

~~1. Whether Medicaid does or does not require exclusive use of form DMS-618, all documentation required by the Personal Care Program must meet or exceed DMS regulations as stated in this manual and other official communications.~~

~~2. When using form DMS-618, attachments may be necessary to complete assessments and service plans and/or to comply with other rules.~~

~~a. An assessing Registered Nurse (RN) must sign or initial and date each attachment he or she adds to a required personal care document.~~

~~B. The Division of Medical Services requires Residential Care Facility (RCF) Personal Care providers to use exclusively form DMS-618 and to comply with all rules applicable to RCFs regarding the use of form DMS-618.~~

~~C. For assessments completed on individuals participating in the IndependentChoices Program, the following applies:~~

~~For IndependentChoices beneficiarys, the form DMS-618 is not required. Only the DAAS RN will use the results of the AR PathARIA assessment and additional questions that the DAAS RN will ask of Independent Choices beneficiarys. will be used by the DAASRN.~~

For IndependentChoices beneficiaries who are also active waiver beneficiaries in the ARChoices Program, the assessment tool used for waiver level of care determination and the waiver ~~plan of care~~ Person-Centered Service Plan (PCSP) will suffice to support authorization for personal care services, if signed by the ~~DAAS~~DHS RN. Eligibility for personal care services is based on the same criteria as state plan personal care services. Services are effective on the date of the ~~DAAS RN's signature on the waiver assessment tool or the~~ waiver PCSP ~~plan of care, whichever is the latter of the two~~. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver ~~plan of care~~ PCSP must include, at least, the information included on the form ~~DMS-618~~ designated by DHS that is utilized to support the medical necessity, eligibility and amount of personal care services provided through IndependentChoices or agency personal care services. This information is required in

documentation ~~whether or not an extension of benefits is requested~~ for each beneficiary. As with all required documentation, this information must be available in the beneficiary's chart or electronic record and available for audit and Quality Management Strategy reviews.

215.200 Personal Care Provider's ~~Assessment~~ Proposed Individualized Service Plan 10-13-03

~~A. A physician's order to assess a beneficiary for personal care is a recommendation to evaluate the beneficiary's physical dependency needs with regard to necessary routines and activities of daily living. The assessment helps the physician and the personal care provider:~~

~~1. To decide whether personal care is an option for the beneficiary and if so, to~~

~~2. Determine the type, amount, frequency and duration of services the beneficiary requires.~~

~~B. Initiation of a personal care assessment does not require a physician's order.~~

~~C. A physician's referral, order or request to assess a beneficiary for personal care services is neither a prescription nor an authorization for personal care services.~~

A. As part of each prior authorization request, each provider shall submit a complete and accurate form designated by DHS. The form must be prepared, certified, and signed by an Arkansas licensed registered nurse.

B. The completed form designated by DHS shall include all information required on the form applicable to the individual beneficiary, including:

1. Beneficiary and provider information;

2. Detailed information concerning physician-diagnosed physical and Behavioral Health Services conditions, identified physical dependency needs, and mental/cognitive status; and

3. For each physical dependency need identified, written descriptions including:

~~D. The provider's assessment of a beneficiary's need for personal care services must include a written description of each physical dependency need. The identification of each physical dependency need must include:~~

a. The extent to which the beneficiary can personally perform individual task components of routines and activities of daily living;

~~2. The extent beyond which the beneficiary cannot personally perform individual task components of routines and activities of daily living and~~

b. The type and amount of assistance the beneficiary may need with each task thus identified, including the frequency (per day, week, or month, as applicable) of each task with which the beneficiary needs assistance and for which other sources of assistance are not available; and

c. The extent beyond which the beneficiary cannot personally perform individual task components of routines and activities of daily living;

4. Detailed information on all personal assistance available to the beneficiary through other sources, including informal caregivers (e.g., family, friends), community organizations (e.g., Meals on Wheels), Medicare (e.g., Medicare home health aide services), or the beneficiary's Medicare Advantage health plan;

5. A proposed service plan, with proposed hours/minutes and frequency of needed tasks consistent with the Task and Hour Standards (as described in Section 240.100); and

6. The signed approval of the beneficiary or the beneficiary's legal representative.

~~E. A registered nurse must perform the assessment.~~

~~F.~~ C. When a beneficiary has two or more personal care providers, the providers should cooperate in the ~~assessment and service plan development processes~~ required nursing evaluation and the preparation and submission of the prior authorization request and completed form designated by DHS on behalf of the beneficiary.

~~G.~~ D. When an individual will receive some or all of his or her services in a congregate setting, the assessment must reflect the RN's determination that the individual is an appropriate candidate for services delivered in that setting. See Section 216.201 and Sections 220.110 through 220.112.

215.210 Alternative Resources for Assistance ~~10-13-03~~

A. The following requirements regarding alternative resources for assistance do not apply, or apply only insofar as they are legal, practical and practicable when the identifiable resources are prohibited from assisting the beneficiary by law or by a facility's or organization's rules or bylaws. For example, a relative of the beneficiary is an alternative resource in the beneficiary's home or the relative's home but not in the public school.

B. The form designated by DHS that is submitted by the provider to DHS or the contractor designated by DHS ~~personal care assessment~~ must include written evidence that the beneficiary or the beneficiary's representative and the provider have considered alternative resources available to assist or partially assist the beneficiary with physical dependency needs identified in the assessment.

1. The provider must determine whether voluntary third-party resources are available and if so, the extent of the third party's willingness to devote time to the benefit of the beneficiary. The provider must:

   a. Consider other members of the beneficiary's household as well as nearby relatives and friends,

   b. Indicate the usual times of their availability to assist the beneficiary and the frequency and duration of their assistance, and

   c. Explain the circumstances of any individual household member's inability to provide any assistance or to provide less than complete assistance with the beneficiary's physical dependency needs.

2. The provider must also consider such alternative community resources as public and private community agencies and organizations, whether secular or religious, paid or volunteer.

   a. Consider entities that provide not only in-home services, but also such services as adult day care or caregiver respite.

   b. List the approximate number of hours per week the beneficiary receives (or will receive) services from each such community resource.

C. The provider must make reasonable efforts to determine the nature, scope, frequency and duration of other services the individual receives, particularly in-home services.

D. The provider's case record documentation must include the certification that the beneficiary's individualized service plan does not duplicate any other in-home services of which the provider is aware.

215.300 Individualized Service Plan 1-1-18

A beneficiary must receive services in accordance with an individualized service plan.

A. The plan must be acceptable to the beneficiary or the beneficiary's representative.

B. A registered nurse and other appropriate personnel of the personal care provider agency, in concert with the beneficiary or the beneficiary's representative, must design the individualized service plan to correlate with the physical dependency needs identified in the assessment.

C. The individualized service plan must be limited to assistance with the beneficiary's individual physical dependency needs.

D. The service plan must clearly identify which of the beneficiary's physical dependency needs will be met by each task performed by a personal care aide.

1. This requirement does not necessarily mandate writing a unique statement for each task or task component. Indexing the assessment may expedite documentation by permitting one to reference the relevant section of the assessment for the explanatory detail. For example:
   a. "Task 1 (corresponds to) Physical Dependency 2."
   b. "Task 6 (corresponds to) Physical Dependency 3."
2. In addition to establishing its correspondence to the assessment (e.g., designing individualized services for a beneficiary's physical dependency needs); the service plan must describe for each routine or activity listed:
   a. The individual tasks the aide is to perform for the beneficiary,
   b. The individual tasks with which the aide is to assist the beneficiary and
   c. The frequency and duration of service of each routine and activity, including:
      (1). The number of days per week each routine or activity will be accomplished and
      (2). The maximum and minimum estimated aggregate ~~time~~ minutes the aide should spend on all authorized tasks each service day.

E. The service plan must include written instructions for the personal care aide specifying how and when to execute or assist with the beneficiary's routines or activities including:

1. The number of days per week to accomplish each routine or activity (as well as which days when relevant) and
2. The time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.

F. The service plan must include written instructions describing whether and to what extent the aide's function in individual task components of each routine or activity is:

1. To assist the beneficiary to perform the task,
2. To perform the task for the beneficiary or
3. To observe the beneficiary perform the task.

G. The service plan must require the beneficiary to perform all tasks within the beneficiary's capability. Medicaid does not cover assistance with any task a beneficiary can perform unless DHS professional staff or contractor(s) designated by DHS have authorized the assistance. For example:

1. A beneficiary can manage his own laundry but he cannot extract wet items from the washer while leaning over the machine.

a. The assessment notes that he needs assistance with the task of removing wet items from the washing machine.

b. The service plan describes the assistance designed for his individual physical dependency need with his laundry.

c. The registered nurse instructs the aide to perform the task(s) constituting the service.

2. Loading the washer, emptying the dryer, folding and ironing clothing and linens are not covered tasks for this particular beneficiary.

3. Removing laundry from the washer and loading it in the dryer are covered tasks for this beneficiary if those tasks are described in his service plan and authorized by DHS professional staff or contractor(s) designated by DHS.

H. The form designated by DHS that is submitted by the provider must support the service plan and the provider's RN's instructions to the aide(s) regarding the delivery of services. The plan must reflect whether the individual is receiving services in more than one setting. If a beneficiary is receiving services in more than one setting, it must be clear in which setting a beneficiary receives a particular service or assistance. See part G of Section 215.200, Section 216.201 and Sections 220.110 through 220.112.

I. ~~The provider must revise a service plan if a beneficiary's average daily service time consistently varies from the service plan's maximum or minimum estimated service time by ten percent (10%) or more over a period exceeding or expected to exceed thirty days.~~

~~1. During brief periods (less than 30 days duration) of service interruption or service time variation, the provider must document any extenuating circumstances and explain each service plan deviation for each day of the period of service interruption or service alteration.~~

See Section 215.330 for information about ~~more~~ service plan revision requirements.

215.310 Identifying Individual Physical Dependency Needs 1-1-18

A. A personal care provider must identify and describe (*assess*) a beneficiary's need for assistance (*physical dependency need*) with individual task components of routines and activities of daily living in the form designated by DHS.

B. The provider must describe the type, amount, frequency and duration of assistance required for each task thus identified (*individualized service plan*) in the form designated by DHS.

C. A personal care aide furnishes assistance (*service*) with the individual task components of routines and activities of daily living, in accordance with the individualized service plan authorized by DHS professional staff or contractor(s) designated by DHS.

D. The following examples illustrate how to facilitate service plan development and service documentation by assessing the beneficiary at the level of individual task performance:

E. A beneficiary is unable to pick up slender items, such as spoons and toothbrushes, and sometimes loses his grip on those objects.

1. This condition causes similar physical dependency needs in different routines.

Sample Assessment Entry	
Eating:	The beneficiary needs someone to place eating utensils in his grasp and to retrieve them when he drops them.
Oral hygiene:	The beneficiary needs someone to place his toothbrush in his grasp and to retrieve it when he drops it.

2. The service plan will contain instructions to the aide similar to this Sample Service Plan Entry.

Sample Service Plan Entry	
Eating:	Place the (*object*) in (*beneficiary's name*)'s grasp.
Oral hygiene:	Retrieve the (*object*) when *(beneficiary's name)* drops it and replace the (*object*) in his grasp.

F. Medicaid Program staff reviewing a personal care provider's records must be able to readily observe that the service plan logically follows the assessment, which is possible only if the provider assesses the beneficiary at the individual task performance level.

1. Additionally, the aide's daily service documentation and the registered nurse's case notes must address the requirements and objectives of the service plan.

2. There must be a clear and logical relationship of each component of this documentation to each other component and to the service continuum.

215.330 Service Plan Revisions 1-1-18

NOTE: Subsections (A) (3) and (B) are not applicable to IndependentChoices program.

A. DHS professional staff or contractor(s) designated by DHS must authorize permanent service plan changes before the provider amends service delivery.

1. For purposes of this requirement, a **permanent** service plan change is one expected to last 30 days or more.

2. Service plan revisions must be made if a beneficiary's condition changes to the extent that the personal care provider must modify, add or delete tasks.

3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.

   a. ~~While~~ Changes in the amount, frequency or duration of a service must be documented in the medical record~~, an increase or a reduction of 10% or less in the average **amount** of service (measured in service time) over a period of fewer than 30 days does not in itself require a service plan revision. If the amount of service remains unchanged, but the frequency or duration of a service is modified, documentation of the reason for the change is required, but no DHS/contractor authorization is required~~.

   b. The reasons for the service variances must be written daily in the service documentation.

4. All Service plan revisions require the provider to submit an amended prior authorization request. DHS professional staff or the DHS contractor will review the request and determine, based on application of the Task and Hour Standards described in Section 240.100, the amount of adjustment to make in prior authorized minutes. DHS professional staff or the DHS contractor will revise the number of minutes in Interchange.

B. Providers may not reduce a beneficiary's services without prior authorization by DHS professional staff or contractor(s) designated by DHS

C. The personal care provider must document medical reasons for service plan revisions.

D. The new beginning date of service is the date authorized by DHS professional staff or contractor(s) designated by DHS.

F. Service plan revisions and updates since the previous assessment must remain with the service plan. Updates since the previous assessment must include documentation of when and why the change occurred.

216.000 Coverage 1-1-18

A. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, Level II assisted living facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State
2. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family"
3. Prior authorized by DHS professional staff or contractor(s) designated by DHS
4. Provided by an individual who is
   a. Qualified to provide the services,
   b. Supervised by a registered nurse (RN) or (when applicable) a Qualified Intellectual Disabilities ~~Mental Retardation~~ Professional (~~QMRP~~QIDP) and
   c. Not a member of the beneficiary's family OR
   d. Qualified to provide the service according to approved policy in the IndependentChoices Program.
5. Furnished in the beneficiary's home or, at the State's option, in another location

B. Medicaid restricts coverage of personal care to services directly helping a beneficiary with certain specified routines and activities, regardless of the beneficiary's ability or inability to execute other non-covered routines and activities.

216.140 Service 10-13-03

A. A "personal care service" is a covered task or a related group of covered tasks.

B. A "personal care aide service" is a personal care service.

1. "Personal care services" and "personal care aide services" are interchangeable expressions that mean "covered tasks."
2. Only a certified personal care aide, or an individual who meets or exceeds the qualifications of a personal care aide, as defined in Section 222.100, who is also in the employ of a Medicaid-enrolled personal care provider, may provide covered personal care services or personal care aide services as defined in this manual.

C. As a condition of coverage and reimbursement, all personal care services must be:

1. Reasonable and medically necessary, supported by the individual's latest nursing evaluation, and consistent with the individual's service plan;

2. Expressly authorized in the individual's approved personal care services prior authorization;

3. Not available from another source (including, but not limited to, family members, a member of the beneficiary's household, or other unpaid caregivers; another Medicaid State Plan covered service; the Medicare program; the beneficiary's Medicare Advantage plan or Medicare prescription drug plan; or the beneficiary's private long-term care, disability, or supplemental insurance coverage);

4. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services;

5. Provided by qualified, Medicaid-enrolled, DPSQA-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and

6. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

D. Personal care services exclude all of the following:

1. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including, but not limited to, aseptic or sterile procedures, application of dressings, medications administration, injections, observation and assessment of health conditions, insertion, removal, or irrigation of catheters, tube or other enteral feedings, tracheostomy care, oxygen administration, ventilator care, drawing blood, and care and maintenance of any medical equipment;

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

3. Services provided for a person other than the beneficiary, including but limited to a provider, family member, household resident, or neighbor;

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

5. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and

6. Mental health counseling or services.

216.210 Eating (see Section 216.212, Consuming Meals, below)

216.212 Consuming Meals 1-1-18

A. The service related to this routine includes the tasks involved in giving the beneficiary hands-on assistance to consume a meal and fluids. It does not include meal preparation.

B. To receive personal care assistance with this routine, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to execute tasks such as cutting food in bite-size pieces or negotiating food from plate to mouth.

C. The related service is hands-on assistance with the beneficiary's physical dependency needs to accomplish eating. The aide may only assist with or perform functional tasks the beneficiary cannot physically perform, in accordance with the beneficiary's physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following examples.

1. An assessment states, "Beneficiary's arthritis prevents him from gripping slender objects such as eating utensils with either hand." The related task in the service plan is for the aide to "cut items into bite-size pieces and deliver them from plate to mouth for the beneficiary."

2. The same assessment also states, "Effects of a recent stroke cause the beneficiary to choke or to risk choking unless food is pureed."

a. The related task in the service plan is for the aide to "puree food items for the beneficiary."

b. A separate statement, "The aide will deliver spoonfuls from plate to mouth for the beneficiary," addresses the arthritic condition.

E. Observing a beneficiary eat is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the beneficiary's eating places the beneficiary at risk of injury or harm.

216.240 Personal Hygiene 1-1-18

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's personal hygiene. "Personal hygiene" means grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene.

1. An aide's time spent reminding a beneficiary to perform personal hygiene tasks is not a covered service unless the beneficiary's service plan includes hands-on assistance with personal hygiene.

2. An aide's time spent observing a beneficiary perform personal hygiene tasks is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the activity places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency preventing or substantially impairing their ability to perform hair and skin care and grooming, oral hygiene, shaving and nail care.

C. The aide's service in regard to this routine is hands-on assistance with personal hygiene tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.260 Medication 10-13-03

A. Personal care aide services regarding medication routines are covered only to the extent that they are permitted by the Arkansas Nurse Practice Act and implementing rules and regulations.

B. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's medications.

C. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability to safely and correctly dispense and ingest orally administered prescription medications.

D. The aide's service in regard to the beneficiary's medication routines is hands-on assistance with tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment, as described in the Arkansas State Board of Nursing Position Statement 97.2.

E. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.270 Mobility and Ambulation 10-13-03

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's mobility and ambulation. "Mobility and ambulation" mean functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive equipment.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To turn themselves in bed,
2. To move from bed to chair (including wheelchair or motorized chair),
3. To walk (alone or with a device) or
4. To operate a push wheelchair or a motorized chair.

C. The aide's service in this routine is hands-on assistance with ambulation and mobility tasks the beneficiary cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.310 Incidental Housekeeping 10-13-03

A. "Incidental housekeeping" means cleaning of the floor, ~~and~~ furniture, and areas that are directly used by the beneficiary. ~~only in the area of the service delivery location occupied by the beneficiary. For example, if the beneficiary occupies only one room, the service is limited to cleaning only that room.~~

B. The aide's service in regard to incidental housekeeping is hands-on assistance with covered tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

C. The assessment must describe the impairments that prevent or impede the beneficiary's ability to move freely and safely about their living area and clean the floor and furniture in the area they occupy.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.330 Shopping 10-13-03

"Shopping" means services to address the beneficiary's physical dependency need by assisting the beneficiary with shopping or by shopping for the beneficiary.

A. Assisting a beneficiary with shopping is a covered service only when the beneficiary is purchasing items that are necessary for the beneficiary's health and maintenance in the home (such as food, clothing, and other essential items) and that are used primarily by the beneficiary or, are used primarily by the beneficiary and other Personal Care Program beneficiaries who reside in the same service delivery location, and whose service plans include assistance with shopping.

1. The aide's service in regard to shopping is hands-on assistance with covered shopping tasks the beneficiary cannot physically perform, according to the beneficiary's physical dependency needs detailed in the assessment.
2. The assessment must describe the impairment(s) that prevent or impede the beneficiary's ability to move freely and safely in stores and perform some or all of the shopping tasks necessary to maintain his or her health and comfort.
3. The service plan must correlate each required task with the beneficiary's corresponding physical dependency need. See Sections 215.300 and 215.310.

B. If the service plan requires the aide to shop for the beneficiary:

1. The beneficiary, or the beneficiary's representative, has freedom of choice to describe the items to be purchased (within the constraints stated herein) for the beneficiary's maintenance in the home.
2. The beneficiary has freedom of choice to designate the individual stores at which to purchase the items.
   a. If the designated stores are within the beneficiary's normal retail service area the service plan need not identify the specific stores.
   b. If the designated stores are outside the normal retail service area for residents of the beneficiary's locale, the service plan must include the stores' names and locations.
3. ~~Whether the service plan requires the aide to assist the beneficiary at shopping or to shop for the beneficiary, Medicaid covers only eight hours per month per beneficiary for shopping and travel time related to shopping.~~

C. If there are other members of the beneficiary's household, the service plan must not include shopping, or assistance with shopping, unless the assessment fully documents all reasons each household member can neither:

1. Assist with or do the beneficiary's shopping, nor
2. Arrange for someone else to assist with or to do the beneficiary's shopping.

D. Medicaid provides no additional coverage for an aide's mileage incurred performing shopping tasks.

216.400 Personal Care Aide Service and Documentation Responsibility 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

It is the responsibility of the personal care aide to accomplish the following:

A. Perform authorized tasks as instructed by the supervising RN or QIDP~~QMRP~~.

B. Maintain a service log.

1. The service log must be completed at the time services are delivered.
2. If the service log is not completed concurrently with service delivery, coverage may be denied.
3. Refer to Sections 220.110 through 220.112 for service log requirements.

C. Provide necessary documentation showing the date, time, nature and scope of authorized services delivered.

D. Provide necessary documentation showing the date, time, nature and scope of emergency services delivered.

1. If an emergency requires the personal care aide to perform a personal care service task not included on the personal care service plan, the personal care aide must receive when possible, prior approval from the supervising registered nurse or QIDP~~QMRP~~ to perform the task.
2. When prior approval is not possible, the personal care aide may perform the emergency service task, but she or he must receive post-service approval from the supervising registered nurse or QIDP~~QMRP~~.
3. Document the circumstances in detail, describing:
   a. The nature of the emergency,
   b. The action or task required to resolve the emergency and
   c. The justification for the unscheduled service.

E. If a personal care aide does not perform a particular task scheduled on the service plan, the personal care aide must document why she or he did not perform the task that day.

217.000 Benefit Limits 10-1-12

~~Effective for dates of service on and after March 1, 2008, Arkansas Medicaid does not grant to beneficiaries whose residence is an RCF or ALF, extension of the personal care benefit for personal care provided at the RCF or ALF by the RCF or ALF Personal Care provider.~~

A. Medicaid imposes a 64-hour benefit limit, per month, per beneficiary, on personal care aide services for beneficiaries aged 21 and older.

B. The 64-hour limitation applies to the monthly aggregated hours of personal care aide services. ~~at all authorized locations except RCFs and ALFs.~~

C. This 64-hour limit on personal care services for beneficiaries aged 21 and older is a firm cap for which there will be no extensions or exceptions. ~~Providers may request extensions of this benefit for reasons of medical necessity. Submit written requests for benefit extensions to the Division of Medical Services, Utilization Review Section.~~ **~~View or print Division of Medical Services, Utilization Review Section contact information.~~**

D. The hour limit does not apply to beneficiaries under age 21.

217.100 Benefit Extension Requests for Beneficiaries Aged 21 and Older 1-1-18

A. Submit to DMS:

1. A completed form DMS-618 (all pages), including the current new or revised prior authorization for personal care services, signed by the beneficiary or the beneficiary's representative, and the assessing registered nurse. View or print form DMS-618.

2. The supervising RN's or QMRP's case documentation, as described in Section 220.100, for the ninety days preceding the new beginning date of service established in the service plan that generated the benefit extension request. This documentation is not required if the service plan is the beneficiary's initial service plan for personal care services.

3. The personal care aide's service log and documentation, as described in Sections 216.400 and 220.110 through 220.112, of the ninety days preceding the new beginning date of service established in the service plan generating the benefit extension request. This documentation is not required if the service plan is the beneficiary's initial service plan for personal care services.

B. Subsequent to a benefit extension approval, if the need arises for additional personal care service, revise the service plan and initiate the extension request process, whether or not the previously approved period of extended benefits has expired.

217.110 Provider Notification of Benefit Extension Determinations 7-1-04

A. DMS will approve or deny the request – or ask for additional information – within two weeks.

B. DMS reviewers will advise the provider of their decision by means of the Provider Notification page of form DMS-618. View or print form DMS-618.

1. Notification of benefit extension approval includes:

a. The procedure code approved,

b. The total number of units approved for the procedure code,

c. The benefit extension control number and

d. The approved beginning and ending dates of service.

2. The DMS reviewers who approved or denied the request sign and date the notification.

217.120 Duration of Benefit Extension 1-1-18

A. Benefit extensions are granted for six months or the life of the service plan, whichever is shorter.

B. When the beneficiary's diagnosis indicates a permanent disability or a CHRONIC CONDITION that will not improve within the next six (6) months, DHS professional staff or contractor(s) designated by DHS may authorize services for one year. For individuals with permanent disabilities, benefit extension requests will be necessary only once every 12 months unless the service plan changes.

1. If there is a service plan revision, the provider must submit a benefit extension request for the number of hours being requested.

2. Upon approval of the requested extension, the updated benefit extension approval file is valid for 12 months from the beginning of the month in which the revised service plan takes effect.

~~3. If there is a service plan revision before 12 months have passed, the provider must initiate the benefit extension approval process again.~~

220.100 Service Supervision 10-1-12

Effective for dates of service on and after March 1, 2008, RNs supervising RCF and ALF I Personal Care providers' personal care aides shall write, in a designated area on form DMS-873, instructions to aides and comments regarding the beneficiary and/or the aide.

A. The provider must assure that the delivery of personal care services by personal care aides is supervised.

1. Supervision must be performed by a registered nurse (RN).
2. Alternatively, a Qualified Intellectual Disabilities ~~Mental Retardation~~ Professional (~~QMRP~~QIDP) may fulfill the RN supervision requirement for personal care services to beneficiaries residing in alternative living situations or alternative family homes, ~~authorized or~~ licensed ~~by the Division of Developmental Disabilities Services~~ and certified by DPSQA as personal care providers.

B. The supervisor has the following responsibilities.

1. The supervisor must instruct the personal care aide in
   a. Which routines, activities and tasks to perform in executing a beneficiary's service plan,
   b. The minimum frequency of each routine or activity and
   c. The maximum number of hours per month of personal care service delivery, as authorized in the service plan.
2. At least once a month, the supervisor must
   a. Review the aide's records,
   b. Document the record review and
   c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
3. At least three times every 183 days (six months) at intervals no greater than 62 days, the supervisor must visit the beneficiary at the service delivery location to conduct on-site evaluation.
   a. Medicaid requires that at least one of these supervisory visits must be when the aide is not present.
   b. At least one visit must be while the aide is present and furnishing services.
4. When the aide is present during the visit the supervising RN or QIDP~~QMRP~~ must
   a. Observe and document
      (1) The condition of the beneficiary,
      (2) The type and quality of the personal care aide's service provision and
      (3) The interaction and relationship between the beneficiary and the aide;
   b. Modify the service plan, if necessary, based on the observations and findings from the visit and
   c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
5. When the aide is not present during the visit, the supervising RN or QIDP~~QMRP~~ must
   a. Observe and document the condition of the beneficiary,

b. Observe and document, from available evidence, the type and quality of the personal care aide's service provision, and

c. Query the beneficiary or the beneficiary's representative and document pertinent information regarding the beneficiary's opinion of

(1) The type and quality of the aide's service,

(2) The aide's conduct and

(3) The adequacy of the working relationship of the beneficiary and the aide;

d. Modify the service plan, if necessary, based on observations and findings from the visit, and

e. Further instruct the aide, if necessary, and document the nature of and the reasons for further instructions.

C. The provider must review the service plan and the aide's records as necessary, but no less often than every 62 days. The review will ensure that the daily aggregate time estimate in the service plan accurately reflects the actual average time the aide spends delivering personal care aide services to a beneficiary.

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220.111 Service Log for Multiple Beneficiaries 10-1-12

Effective for dates of service on and after March 1, 2008, the rules in this section do not apply to RCF and ALF Personal Care providers.

An aide delivering services to two or more beneficiaries at the same service location, during the same period (discontinuing or interrupting a beneficiary's service plan required tasks to begin or resume service plan required tasks for another beneficiary, or performing an authorized service simultaneously for two or more beneficiaries (for example, cleaning a living space used by more than one beneficiary or preparing a meal that will be eaten by more than one beneficiary), must comply with the applicable instructions in parts A or B below:

A. If providing services for only two beneficiaries, the aide must record in each beneficiary's service log

1. The name of each individual for whom they are simultaneously performing personal care service; ~~and~~

2. The beginning and ending times of service for each beneficiary and the beginning and ending times of each interruption and of each resumption of service; ~~and~~

3. Which services or services were performed simultaneously for more than one beneficiary.

B. If services are performed in a congregate setting (more than two beneficiaries) the service log must state

1. The actual time of day (clock-time) that the congregate services begin and end; ~~and~~

2. The number of individuals, and the name of each individual, both Medicaid-eligible and non-Medicaid eligible, who received the documented congregate services during that period; ~~and~~

3. Which services or services were performed simultaneously for more than one beneficiary.

C. For services performed simultaneously for more than one beneficiary, the provider must split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took 20 minutes, the aide would document only half of that time - 10 minutes - for each beneficiary for the task).

D. If the beneficiaries have different providers and different aides, both providers may not bill for cleaning a shared living space (e.g., a bathroom) or performing another task that benefits both beneficiaries (e.g., preparing a meal for both). The providers must determine which of their aides will be responsible for performing the task. The provider whose aide did not perform the task may not bill for it.

E. A provider who knowingly bills twice for the same service or for a service that has been billed by another provider is committing a fraudulent act and may be referred by DHS to the Medicaid Fraud Control Unit.

221.000 Documentation 1-1-18

NOTE: This section is not applicable to the IndependentChoices program.

Rule D in this section is effective for dates of service on and after March 1, 2008.

The personal care provider must keep and make available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services and its authorized agents or officials; records including:

A. If applicable, certification by the Home Health State Survey Agency as a beneficiary in the Title XVIII Program. Agencies that provided Medicaid personal care services before July 1, 1986 are exempt from this requirement.

B. When applicable, copies of pertinent residential care facility license(s) issued by the Office of Long Term Care.

C. Medicaid contract.

D. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers will be required, when requested by DHS, to provide payroll records to validate service plans and service logs.

E. Documents signed by the supervising RN or QIDP~~QMRP~~, including:

1. The initial and all subsequent assessments.
2. Instructions to the personal care aide regarding:
   a. The tasks the aide is to perform,
   b. The frequency of each task and
   c. The maximum number of hours and minutes per month of aide service authorized by DHS professional staff or contractor(s) designated by DHS.
3. Notes arising from the supervisor's visits to the service delivery location, regarding:
   a. The condition of the beneficiary,
   b. Evaluation of the aide's service performance,
   c. The beneficiary's evaluation of the aide's service performance and
   d. Difficulties the aide encounters performing any tasks.
4. The service plan and service plan revisions:
   a. The justifications for service plan revisions,
   b. Justification for emergency, unscheduled tasks and
   c. Documentation of prior or post approval of unscheduled tasks.

F. Any additional or special documentation required to satisfy or to resolve questions arising during, from or out of an investigation or audit. "Additional or special documentation," refers to notes, correspondence, written or transcribed consultations with or by other healthcare professionals (i.e., material in the beneficiary's or provider's records relevant to the beneficiary's personal care services, but not necessarily specifically mentioned in the foregoing requirements). "Additional or special documentation," is not a generic designation for inadvertent omissions from program policy. It does not imply and one should not infer from it that, the State may arbitrarily demand media, material, records or documentation irrelevant or unrelated to Medicaid Program policy as stated in this manual and in official program correspondence.

G. The personal care aide's training records, including:

1. Examination results,
2. Skills test results and
3. Personal care aide certification.

H. The personal care aide's daily service notes for each beneficiary, reflecting:

1. The date of service,
2. The routines performed on that date of service, noted to affirm completion of each task.
3. The time of day the aide began performing the first service-plan-required task for the beneficiary;
4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function;
5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks and
6. The time of day the aide completed the last service-plan-required task for the day for that beneficiary.

I. Notes, orders and records reflecting the activities of the physician, the supervising RN or QIDP~~QMRP~~, the aide and the beneficiary or the beneficiary's representative; as those activities affect delivering personal care services.

222.100 Personal Care Aide Selection, Training and Continuing Education 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

A. When personal care services are delivered through a home health agency or private care agency, the person providing the direct care who works for the agency may not:

1. Reside (permanently, seasonally, or occasionally) in the same premises as the beneficiary;
2. Have a business partnership or financial or fiduciary relationship of any kind with the beneficiary or the beneficiary's legal representative; or
3. Be related to the beneficiary by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

B. ~~The beneficiary must receive Medicaid Personal Care services from a certified personal care aide who is not a member of the beneficiary's family. The Medicaid agency defines, "a member of the beneficiary's family" as~~: Under no circumstances may Medicaid payment be made for Personal Care services rendered by the waiver beneficiary's:

~~1. A spouse.~~

~~2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent.~~

~~1~~3. Legal guardian of the person;

~~2~~4. Attorney-in-fact granted authority to direct the beneficiary's care.

~~B~~C. Personal care aides must be selected on the basis of such factors as:

1. A sympathetic attitude toward the care of the sick,
2. An ability to read, write and carry out directions and
3. Maturity and ability to deal effectively with the demands of the job.

~~C~~D. The personal care provider is responsible for ensuring that personal care aides in its employ are:

1. Certified as personal care aides,
2. Participate in all required in-service training and
3. Maintain at least "satisfactory" competency evaluations from their supervisors in all personal care tasks they perform.

~~D~~E. DMS will deem valid the Certified Personal Care Aide status of an individual with

1. Personal Care Aide Certification conferred before April 1, 1998, and
2. Documentation of ongoing compliance with Personal Care Program policies in effect before April 1, 1998, regarding continuing education and competency requirements.
3. The deemed status will be effective for dates of service on and after April 1, 1998, conditional upon the certified aide's continuing compliance with program policies.

~~E~~F. A qualified training program (see Section 222.110) may waive the training component of personal care aide certification requirements for individuals who can document previous experience as personal care aides, nurse's aides or similar occupations requiring the same skills needed by personal care aides.

1. The qualified training program must verify the individual's previous experience.
2. The individual must pass the personal care aide examinations and skills tests.

~~F~~G. Certified Nursing Assistants with current valid credentials are deemed qualified personal care aides.

~~G~~H. Certified Home Health Aides with current valid credentials are deemed qualified personal care aides.

222.120 Personal Care Aide Training Subject Areas 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

A. Correct conduct toward beneficiaries, including respect for the beneficiary, the beneficiary's privacy and the beneficiary's property.

B. Understanding and following spoken and written instructions.

C. Communications skills, especially the skills needed to:

1. Interact with beneficiaries,
2. Report relevant and required information to supervisors and

3. Report events accurately to public safety personnel and to emergency and medical personnel.

D. Record-keeping, including:

1. The role and importance of record keeping and documentation.
2. Service documentation requirements and procedures, especially all documentation Medicaid requires of personal care aides, as described in Medicaid Personal Care Program policy statements current at the time of the aide's training.
3. Reporting and documenting non-medical observations of beneficiary status.
4. Reporting and documenting, when pertinent, the beneficiary's observations regarding their own status.

E. Recognizing and reporting, to the supervising RN or QIDP~~QRMP~~, when changes in the beneficiary's condition or status require the aide to perform tasks differently than instructed.

F. State law regarding delegation of nursing tasks to unlicensed personnel as designated by the Arkansas State Board of Nursing.

G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.

H. Safe transfer techniques and ambulation.

I. Normal range of motion and positioning.

J. Recognizing emergencies and knowledge of emergency procedures.

K. Basic household safety and fire prevention.

L. Maintaining a clean, safe and healthy environment.

M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the beneficiary with:

1. Bed bath
2. Sponge, tub or shower bath
3. Shampoo; sink, tub or bed
4. Nail and skin care
5. Oral hygiene
6. Toileting and elimination
7. Shaving
8. Assistance with eating
9. Assistance with dressing
10. Efficient, safe and sanitary meal preparation
11. Dishwashing
12. Basic housekeeping procedures
13. Laundry skills

222.140 In-Service Training 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

Medicaid requires personal care aides to participate in at least twelve (12) hours of in-service training every twelve (12) months after achieving Personal Care Aide certification.

A. Each in-service training session must be at least 1 hour in length.

1. When appropriate, in-service training may occur at a personal care service delivery location when the aide is furnishing personal care services.

2. In-service training at a service delivery site may occur only if the beneficiary or the beneficiary's representative has given prior written consent for training activities to occur concurrently with the beneficiary's care.

B. The Personal Care Program provider agency and the personal care aide must maintain documentation that they are meeting the in-service training requirement.

240.000 PRIOR AUTHORIZATION 1-1-18

A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries, including beneficiaries participating in the IndependentChoices Program.

B. Prior authorization does not guarantee payment for the service.

1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.

2. The provider must follow the billing procedures in this manual.

C. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the DHS Independent Assessment Contractor to collect information used in determining the beneficiary's physical dependency needs for "hands-on" services with activities of daily living (ADL), and in calculating the number of personal care hours that can be authorized for the beneficiary. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each beneficiary is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment.

1. Tier 0 (zero) indicates the individual's assessed needs, if any, do not support the need for personal care services.

2. Tiers 1 (one), 2 (two), or 3 (three) indicate the individual's assessed needs do support the need for personal care services.

D. The Task and Hour Standards will be used by DHS RNs and DHS contractors to calculate the number of personal care hours that can be authorized for the beneficiary.

240.100 Task and Hour Standards (THS)

1. Background on THS

The Task and Hour Standards (THS) is the written methodology used by the DHS RNs and DHS contractor RNs to calculate the number of personal care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

The current DAABHS approved THS is located on the web at [insert website address]

The THS includes the following four components, described in a grid format:

a. The beneficiary's Needs Intensity Score (0, 1, 2, or 3) for each task;

b. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;

c. The frequency with which a task is necessary and reasonably performed; and

d. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary attendant care services hours, with the minute ranges and frequencies, providing the ability to adjust service plans based on unique factors related to a given beneficiary's needs, preferences, and risks.

The number of attendant care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN or by the contractor(s) designated by DHS consistent with the THS grid and based on:

a. Responses by the beneficiary and their representatives to certain relevant questions in the ARIA assessment instrument, and

b. As appropriate, information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representatives or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

2. Needs Intensity Score:

For each task, the DHS RN or the contractor(s) designated by DHS will assign a Needs Intensity Score to the beneficiary based on the beneficiary's and/or representative's responses to questions during the ARIA assessment and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS. The four Needs Intensity Scores are defined as follows:

Impairment Score 0 – The beneficiary has no functional impairment with regard to the task and can perform it without assistance.

Impairment Score 1 (Mild): Minimal/mild functional impairment. The beneficiary is able to conduct activities with minimal difficulty and needs minimal assistance.

Impairment Score 2 (Severe): Extensive/severe functional impairment. The beneficiary has extensive difficulty carrying out activities and needs extensive assistance.

Impairment Score 3 (Total): The beneficiary is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

3. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN or contractor(s) designated by DHS will determine the number of minutes within the range that are appropriate for the beneficiary based on conditions specific to the beneficiary.

For example, if a beneficiary has cognitive or behavioral issues, the maximum number of minutes in the range for bathing may be warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a beneficiary who is bald.

If the beneficiary has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN or designated contractor RN must obtain supervisory approval. For supervisory approval, the RN must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the personal care prior authorization or ARChoices PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the personal care prior authorization or PCSP.

4. The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

5. The amount of assistance with ADLs and IADLs provided by other sources

Personal care services are not available for assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then personal care services are not necessary and no time for that task is included. When another source is available to provide some instances of a needed ADL or IADL task, the frequency and time associated with these other sources are adjusted to correspond with the remaining assessed needs.

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task (e.g., the beneficiary's daughter bathes her mother once a week and prepares all meals on weekends). For example, where a needed meal is supplied by Meals on Wheels, minutes for meal preparation may not be necessary and should be adjusted.

6. Calculation of total hours of personal care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of personal care hours approved for the beneficiary for a month.

A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization of personal care services for beneficiaries.

B. DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's completed form designated by DHS ~~request~~ and submitted documentation for personal care services. Based on the information in the ARIA assessment and the form designated by DHS, ~~For approved services,~~ they authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.

C. DHS professional staff or contractor(s) designated by DHS have a right to review the beneficiary's medical information.

242.000 Personal Care PA Request Procedure 1-1-18

A. Providers must use ~~pages 1 through 6 of form DMS-618~~ the form designated by DHS to request PA. **View or print ~~form DMS-618~~ (English) the form designated by DHS.** **View or print ~~form DMS-618~~ the form designated by DHS (Spanish).**

B. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals for beneficiaries who are assessed at Tier 1, 2, or 3 will be retroactive to the beginning date of service if the request is received within the 30-day time frame. There will be no prior authorization, including any retroactive prior authorization, if the beneficiary is assessed at Tier 0.

C. ~~Mail or fax the required documents~~ Providers should submit prior authorization forms to ~~DHS professional staff or~~ the contractor(s) designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff.

243.000 Provider Notification Procedure 1-1-18

Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

A. For approved cases, an approval letter will be mailed to the requesting provider, detailing the procedure codes approved, total number of service time increments, beginning and ending dates and the authorization number.

B. For denied or partially denied cases, a denial letter with reason for denial will be mailed to the beneficiary and the requesting provider. The letter shall specify why the prior authorization request was denied or partially denied and shall give the beneficiary notice of the right to file a request for a fair hearing and where to file the request. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation.

244.000 Duration of PA 1-1-18

A. Personal Care PAs are generally assigned for 12 ~~six~~ months or for the life of the service plan, whichever is shorter, unless the beneficiary has a change in condition.

~~B. DHS professional staff or contractor(s) designated by DHS may validate a PA for one year if the provider requests an extended PA because the beneficiary has a permanent disability or a CHRONIC CONDITION that will not improve within the next six (6) months.~~

~~1. A one-year PA remains valid only if the service plan and services remain unchanged and the provider meets all Personal Care Program requirements.~~

~~2. Providers receiving extended PAs for individuals with a permanent disability must continue to follow Personal Care Program policy regarding regular assessments and service plan renewals and revisions.~~

245.000 Provider Process for Reconsideration of PA Determination 7-1-15

Reconsideration of a denial may be requested within thirty calendar days of the denial date. Reconsideration requests must be made in writing to ~~the contracted Quality Improvement Organization~~ DHS professional staff or the contractor(s) designated by DHS and must include additional documentation to substantiate the medical necessity of the requested services.

If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, ~~the QIO~~ DHS professional staff or the contractor(s) designated by DHS issues a written notification of the decision to the beneficiary and provider. **View or print contractor contact information.**

246.000 Beneficiary Process for Appeal of PA Determination 10-1-08

When the beneficiary receives an adverse decision concerning a request for PA determination ~~is received from the reviewing QIO~~, the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter from ~~the QIO~~ DHS professional staff or contractor(s) designated by DHS explaining the denial. Appeal requests must be submitted to the Department of Human Services, Appeals and Hearings Section. **View or print the Department of Human Services, Appeals and Hearings Section contact information**.

250.000 REIMBURSEMENT

250.100 Reimbursement Methods 10-1-12

A. Reimbursement for personal care services is the lesser of the billed amount per unit of service or Medicaid's maximum allowable fee (herein also referred to as "rate" or "the rate") per unit.

B. Reimbursement for Arkansas Medicaid Personal Care services is based on a 15-minute unit of service.

C. ~~Effective for dates of service on and after March 1, 2008,~~ RCF Personal Care provider reimbursement is in accordance with a multi-hour daily service rate system, employing Medicaid maximum allowable fees (Daily Service Rates) determined by individual beneficiaries' ~~Levels of Care~~ Payment Levels.

D. ~~Effective for dates of service on or after October 1, 2012,~~ ALF Personal Care provider reimbursement is in accordance with a multi-hour daily service rate system, employing Medicaid maximum allowable fees (Daily Service Rates) determined by individual beneficiaries' ~~Levels of Care~~ Payment Levels. This excludes the Living Choices Assisted Living waiver beneficiaries.

250.200 RCF and ALF Personal Care Reimbursement Methodology 10-1-12

A. The RCF and ALF Personal Care reimbursement methodology is designed with the intent that reimbursement under the multi-hour Daily Service Rate system closely approximates what reimbursement would have been if the providers were to have billed by units of service furnished.

B. Whenever the unit rate (i.e., the maximum allowable amount per fifteen minutes service) for personal care services changes, Daily Service Rates under the RCF and ALF

methodology are correspondingly adjusted in accordance with the initial methodology by which they were established and which is described in detail in the following sections.

C. The Daily Service Rate paid for personal care services is based on a ~~Level of Care~~ Payment Level determined from the resident's service plan.

250.210 ~~Level of Care~~ Payment Level 10-1-12

There are 10 ~~Levels of Care~~ Payment Levels, each based on the average number of 15-minute units of service per month required to fulfill a beneficiary's service plan.

A. Level 1 includes RCF and ALF Personal Care beneficiaries whose service plans comprise 100 units or less per month of medically necessary personal care.

B. Level 10 includes RCF and ALF Personal Care beneficiaries whose service plans comprise 256 or more units per month of medically necessary personal care.

C. Level 2 through Level 9 were established in equal increments between 101 and 255 units per month.

250.211 ~~Level of Care~~ Payment Level Determination 10-1-12

A. The average of a service plan's monthly units of service is used to determine each beneficiary's ~~Level of Care~~ Payment Level.

B. Calculate a beneficiary's average number of monthly units of personal care as follows.

1. Add the ~~minimum and maximum hourly~~ Weekly Minute Totals from the prior authorization approved by DHS using the Task and Hour Standards. ~~a completed form DMS-618, "Personal Care Assessment and Service Plan," and divide the sum by **2** to obtain average weekly hours of service.~~

~~2. Convert the average obtained in step 1 to minutes by multiplying it by **60**.~~

2~~3~~. Divide the minutes by **15** (*15 minutes equals one unit of service*) to calculate weekly average units of service.

3~~4~~. Multiply the weekly average units from step 2~~3~~ by **52** (*Weeks in a year*) and divide the product by **12** (*Months in a year*) to calculate monthly average units of service.

4~~5~~. Consult the "RCF and ALF Personal Care Service Rate Schedule" on the Arkansas Medicaid Personal Care Fee Schedule to find the applicable Daily Multi-Hour Service Rate for each ~~Level of Care~~ Payment Level. Procedure code T1020 is the applicable code for RCF and ALF Personal Care providers.

250.212 Rate Development 3-1-08

A. The Level 1 Daily Service Rate was calculated as follows.

1. Multiplied **100** (*15-minute units*) by **12** (*Months in a year*)
2. Divided units per year calculated in step 1 by **365** (*The average number of days in a year*) to calculate average units per day
3. Multiplied average units (*Unrounded*) per day obtained in step 2 by the current Personal Care maximum allowable fee per unit and rounded the product to the nearest 100th to calculate the Level I Daily Service Rate

B. The Level 10 Daily Service Rate was calculated as follows.

1. Multiplied **256** (*Maximum monthly units)* by **12** (*Months per year*)
2. Divided the product calculated in step 1 by **365** (*The average number of days in a year*) to calculate average maximum units per day
3. Multiplied average maximum units per day from step 2 by the current Personal Care maximum allowable fee per unit and rounded the product to the nearest 100th to calculate the Level 10 Daily Service Rate

C. The Daily Service Rates for Level 2 through Level 9 were calculated as follows.

1. The difference between 255 and 101 (154) was divided into eight equal increments that then were designated ~~Levels of Care~~ Payment Levels ("Levels") 2 through 9.
2. The sum of the beginning and ending values within each ~~Level of Care~~ Payment Level was divided by **2** to calculate the Level's average units per month.
3. The average units per month was multiplied by **12** (*Months per year*) to calculate average annual units.
4. The average annual units calculated in step 3 was divided by **365** (*The average number of days in a year*) to arrive at average units per day.
5. The average units per day calculated in step 4 was multiplied by the current Personal Care maximum allowable fee per unit and the product was rounded to the nearest 100th.

~~**251.110 IDEA Responsibilities of Developmental Disabilities Services Community Provider Facilities** 8-1-04~~

~~Developmental Disabilities Services Community Provider Facilities, when enrolled as Arkansas Medicaid Personal Care providers, are deemed the provider of service.~~

~~A. As such, the facilities must provide, under the guidelines of the Arkansas Medicaid Personal Care Provider Manual, the Medicaid covered services that are included in a beneficiary's Individualized Family Services Plan (IFSP), Individualized Program Plan (IPP) or Individualized Habilitation Plan (IHP).~~

~~1. An IFSP is an individualized plan for beneficiaries aged from birth through 2 years who are enrolled in a facility's Early Intervention program.~~

~~2. An IPP is an individualized plan for beneficiaries aged 3 through 4 years whose parents have elected to enroll them in the facility's preschool program.~~

~~3. An IHP is an individualized plan for beneficiaries aged 18 and older~~

~~B. With respect to Medicaid beneficiaries whose participation in the facility's services are subject to the IDEA, their parents or guardians may independently select an enrolled Medicaid provider ("other provider") other than the DDS community provider facility. This exception requires the existence of each of the following conditions:~~

~~1. Neither the facility nor anyone acting on behalf of the facility may refer the beneficiary, or the beneficiary's parent or guardian, to the other provider.~~

~~2. There is no arrangement by the facility or persons or entities in privity with the facility, for the other provider to furnish the services.~~

~~3. The other provider does not, either directly or through another person or entity, have a contract with the facility or persons or entities in privity with the facility for referrals, consulting or the provision of Medicaid-covered services.~~

~~4. The other provider is not under control or supervision of the facility or persons or entities in privity with the facility.~~

~~C. For purposes of this rule, "privity" means a derivative interest growing out of a contract, mutuality of interest, or common ownership or control.~~

251.121 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov** ~~**https://www.medicaid.state.ar.us**~~ under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

262.101 Personal Care for a Beneficiary Aged 21 or Older (Non-RCF) 3-1-08

Procedure Code	Modifier	Service Description
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older, per 15 minutes (requires prior authorization)

262.104 Personal Care in an RCF or ALF 10-1-12

A. To bill for RCF or ALF Personal Care, use HCPCS procedure code **T1020** and the modifier corresponding to the beneficiary's ~~Level of Care~~ Payment Level in effect for the date(s) of service being billed.

B. The ~~Level of Care~~ Payment Level that a provider bills must be consistent with the beneficiary's service plan in effect on the day that the provider furnished the personal care services billed.

~~Level of Care~~ Payment Level Specifications and Modifiers for Procedure Code T1020

Payment Levels ~~Levels of Care~~	Minimum Service Units	Maximum Service Units	Modifier
Level 1	Less than 100	100	U1
Level 2	101	119	U2
Level 3	120	139	U3
Level 4	140	158	U4
Level 5	159	177	U5
Level 6	178	196	U6
Level 7	197	216	U7
Level 8	217	235	U8
Level 9	236	255	U9
Level 10	256	256	UA

262.105 Employment-Related Personal Care Outside the Home 10-1-07

Procedure Code	Modifier	Service Description
T1019	U5	Employment-related personal care outside the home, beneficiary aged 16 or older, per 15 minutes. ~~This service requires prior authorization for beneficiaries under age 21~~ All personal care services require prior authorization.

262.410 Completing a CMS-1500 Claim Form for Personal Care 1-1-18

When a provider must bill on a paper claim, the fiscal agent accepts only red-lined, sensor-coded CMS-1500 claim forms. Claim photocopies and claim forms that are not sensor-coded cannot be processed.

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid or ARKids First-A identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the individual's Medicaid or ARKids First-A identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary resides.
	STATE	Two-letter postal code for the state in which the beneficiary resides.
	ZIP CODE	Five-digit ZIP code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/ emergency telephone
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if the insured's address is different from the patient's address.
	CITY	
	STATE	

Field Name and Number		Instructions for Completion
	ZIP CODE TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9a and d are required. Name of the insured individual's employer and/or school.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
	a. INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
	b. OTHER CLAIM ID NUMBER	Not required.
	c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.

Field Name and Number	Instructions for Completion
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a, 9c and 9d.Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: lLLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness ; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of the referral source.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not applicable.
19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER	Insert LEA number.
20. OUTSIDE LAB?	Not required.

Field Name and Number		Instructions for Completion
	$ CHARGES	Not required.
21.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22.	RESUBMISSION CODE	Reserved for future use.
	ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23.	PRIOR AUTHORIZATION NUMBER	The prior authorization ~~or benefit extension control~~ number ~~when applicable~~.
24A.	DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. A provider may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the date sequence. 3. RCFs may bill for a date span of any length within the same calendar month, provided the beneficiary was present every day of the date span and all services provided within the date span were at the same ~~Level of Care~~ Payment Level.
B.	PLACE OF SERVICE	Two-digit national standard place of service code.
C.	EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D.	PROCEDURES, SERVICES, OR SUPPLIES	
	CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
	MODIFIER	Modifier(s) when applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the services totaled in the detail. This charge must be the usual charge to any beneficiary patient, or other recipient of the provider's services. RCFs' charges should equal no less than the product of the number of units (days) times the beneficiary's Daily Service Rate. If the charge is less, Medicaid will pay the billed charge.
G. DAYS OR UNITS	The units (in whole numbers) of service provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening and referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, advise Provider Enrollment so that the year-end 1099 will be correct and reported correctly.
26. PATIENT'S ACCOUNT NO.	Optional entry for providers' accounting and account-retrieval purposes. Enter up to 16 numeric, alphabetic or alpha-numeric characters. This character set appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum of all charges on the claim.
29. AMOUNT PAID	Enter the total of payments received from other sources on this claim. Do not include amounts previously paid by Medicaid.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PROVIDER	The performing provider or an individual authorized by the performing provider or by an institutional, corporate, business or other provider organization, must sign and date the claim, certifying that the services were furnished by the provider, under (when applicable) the direction of the individual provider or other qualified individual, and in strict and verifiable accordance with all applicable rules of the Medicaid program in which the provider participates. A "provider's signature" is the provider's or authorized individual's personally written signature, a rubber stamp of the signature, an automated signature or a typed signature. The name of a group practice, a facility or institution, a corporation, a business or any other organization will prevent the claim from being processed.
32. SERVICE FACILITY LOCATION INFORMATION	If services were not performed at the beneficiary's home or at the provider's facility (*e.g.*, school, ~~DDS facility~~ etc.) enter the name, street address, city, state and zip code of the facility, workplace etc. where services were performed. If services were furnished at multiple sites (for instance, when job-seeking), indicate "multiple locations" or leave blank.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

26. Personal Care

A. Personal care services are provided by a personal care aide to assist with a client's physical dependency needs. The personal care aide must have at least 24 hours classroom training and a minimum of supervised practical training of 16 hours provided by or under the supervision of a registered nurse for a total of no less than 40 hours.

B. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease that are –

1. Authorized for the individual in accordance with a service plan approved by the State;
2. Provided by an individual who is qualified to provide such services; and
3. Furnished in a home, and at the State's option, in another location, including licensed residential care facilities and licensed assisted living facilities.

C. **When personal care services are delivered through a home health agency or private care agency, the person providing the direct care who works for the agency may not:**

1. Reside (permanently, seasonally, or occasionally) in the same premises as the client;

2. Have a business partnership or financial or fiduciary relationship of any kind with the client or the client's legal representative; or

3. Be related to the client by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

D. Under no circumstances may Medicaid reimbursement be made for personal care services rendered by the client's:

1. Legal guardian; or
2. Attorney-in-fact granted authority to direct the client's care.

E. Personal care services are covered for categorically needy individuals only.

F. Personal care services are medically necessary, prescribed services to assist clients with their physical dependency needs.

1. Personal care services involve "hands-on" assistance, by a personal care aide, with a client's physical dependency needs (as opposed to purely housekeeping services**). Personal care services also include employment-related personal care associated with transportation.**
2. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the client were in a hospital or nursing facility.

G. Prior authorization is required for personal care pursuant to the Independent Assessment for all beneficiaries. **Personal care services for adults 21 years of age or older are limited to a maximum of 64 hours per calendar month.**

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

iii. Payment Methodology (Continued)

B. __X__ The State will use a different reimbursement methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

A. __X__ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. _____ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

When the participant voluntarily elects to discontinue participation in IndependentChoices, ~~the counselor~~**DHS professional staff** will discuss with the individual the reason for disenrollment and assist the individual in resolving any barriers or problems that may exist in preventing continuation. If the participant wishes to continue with the option to disenroll, ~~the counselor~~**DHS professional staff** will assist by informing the participant of traditional agency personal care providers in the participant's area. ~~The counselor~~ **DHS professional staff** will assist with the coordination of agency services to the degree requested by the participant.

IndependentChoices can continue until agency services are established or the participant may elect to use informal supports until agency services are established.

The timeframes discussed under involuntary disenrollment do not apply to voluntary disenrollment. The request of the participant will be honored whether they ask to be disenrolled immediately or at anytime in the future. ~~The counselor~~**DHS professional staff** will coordinate the participant's wishes to the degree requested by the participant. This may include self-advocation by the participant and asking ~~the counselor~~ **DHS professional staff** to coordinate agency services with the participant's preferred provider. In some instances the participant may wish to forego agency personal assistance services and choose to rely on family or friends. If the participant requests that ~~the counselor~~ **DHS professional staff** coordinate the agency services, ~~the counselor~~ **DHS staff** will ascertain when services can be started. ~~The counselor~~ **DHS staff** will then close the IndependentChoices case the day before agency services begin. Regardless of the situation, the State will assure that there will not be an interruption in delivering necessary services unless it is the preference of the participant to depend on informal supports.

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to traditional service delivery model are noted below.

Participants may be disenrolled for the following reasons:

1. Health and Welfare: Any time ~~DAAS~~**DPSQA** feels the health and welfare of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program. Prior to this point ~~the counselor~~ **counseling entity's support coordinator** has worked with the participant offering suggestions, identifying or changing representatives or employees to better meet the needs of the consumer, making in-home visits as needed by APS or HCBS RNs, and working to resolve these concerns. If no resolution is available, meeting the participant's health and well-being needs is of most importance; including referral back to the traditional model.

2. Change in Condition: Should the participant's cognitive ability to direct his/her own care diminish to a point where the participant can no longer self-direct and there is no responsible representative available to direct the care the ~~counselor~~ **counseling entity's support coordinator** will seek out sources of support. If no resources are available, the IndependentChoices case will be closed. The participant will be informed of the pending closure by letter. The letter will include a list of traditional personal care agencies serving the participant's area. If the participant is also a 1915(c) waiver recipient, an e-mail will be auto generated to the HCBS RN or targeted case manager. The e-mail to the HCBS RN or targeted case manager is auto generated and populated with the appropriate names once a closure date is entered in the database. The e-mail will inform the HCBS RN or targeted case manager of the pending closure of the IndependentChoices case necessitating a change in the HCBS service plan. Within five days of sending the letter the ~~counselor~~ **counseling entity's support coordinator** will follow up with the participant to determine which agency the participant may wish to choose. The ~~counselor~~ **counseling entity's support coordinator** will coordinate the referral with the agency provider. However, if the participant declines agency services, the ~~counselor~~ **counseling entity's support coordinator** will respect the choice made by the participant. The participant may choose to have their needs met by informal caregivers.

3. Misuse of Allowance: A notice will be issued should the participant or the representative who manages their cash allowance: 1) fail to pay related state and federal payroll taxes; 2) use the allowance to purchase items unrelated to personal care needs; 3) fail to pay the salary of a personal assistant; or 4) misrepresent payment of a personal assistant's salary. The ~~counselor~~ **counseling entity's support coordinator** will discuss the violations with the participant and allow the participant to take corrective action including restitution if applicable. The participant will be permitted to remain in the program, but will be assigned to the fiscal intermediary, who will provide maximum bookkeeping support and services. The participant

or representative will be notified that further failure to follow the expenditure plan will result in disenrollment and a report filed with Office of Medicaid Inspector General when applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment (Continued)

Should an unapproved expenditure or oversight occur a second time, the participant/ representative will be notified that their IndependentChoices case is being closed and the participant is being returned to traditional personal care. Office of Medicaid Inspector General is informed of situations as required. The State will assure interruption of services will not occur while the participant is transitioning from IndependentChoices to traditional services.

4. Underutilization of Allowance: The fiscal intermediary is responsible for monitoring the use of Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using the allowance according to their cash expenditure plan, the fiscal intermediary will inform the counseling entities through quarterly reports and monthly reports upon request. The ~~counselor~~ **counseling entity's support coordinator** will discuss problems that are occurring with the participant and their support network. Together the parties will resolve the underutilization. The ~~counselor~~ **counseling entity's support coordinator** will continue to monitor the participant's use of their allowance through both reviewing of reports and personal contact with the participant. If a pattern of underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADLs even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days upon disenrollment. Funds accrued in the absence of a savings plan will be returned to the Arkansas Medicaid program within a twelve month filing deadline. Exceptions to involuntary disenrollment may be considered if the participant has been hospitalized for an extended period of time or has had a brief visit out of state with approval by the participant's physician. Person-centered planning allows the flexibility of decision making based on individual needs that best meet the needs of the participant.

5. Failure to Assume Employer Authority: Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Participants who fail in their employer responsibilities but do not have a representative will be given the opportunity to select a representative who can assume employer responsibilities on behalf of the participant. Disenrollment will not occur without guidance and counseling by the ~~counselor~~ **counseling entity's support coordinator** or by the fiscal intermediary. When this occurs, the ~~counselor~~ **counseling entity's support coordinator** will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the ~~counselor~~ **counseling entity's support coordinator**, ask the ~~counselor~~ **counseling entity's support coordinator** to coordinate, or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.

A. The State will provide the following safeguards to ensure continuity of services and assure participant health, safety and welfare during the period of transition between self-directed and traditional service delivery models.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment (Continued)

When a participant is involuntarily disenrolled, a notice of intent to close the IndependentChoices case will be mailed to the participant. The notice will allow a minimum of 10 days but no more than 30 days before IndependentChoices enrollment will be discontinued, depending on the situation. During the transition period, the ~~counselor~~ **counseling entity's support coordinator** will work with the participant/representative to assure services are provided to help the individual transition to the most appropriate personal care services available.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

There are no additional restrictions on living arrangements.

viii. Geographic Limitations and Comparability

A. __X__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. ____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. ____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. __X__ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Age 18 and older.

E. ____ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. __X__ The State elects to provide self-directed personal assistance services to 7500 participants, at any given time.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Not applicable. The state will not allow entities who provide other Medicaid State Plan services to be responsible for developing the self-directed service plan.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

ii. The system performance measures, outcome measures and satisfaction measures that the State will monitor and evaluate.

Many activities evaluate the overall performance of the IndependentChoices program such as:

- The IndependentChoices program uses a database to track a wide array of data, and uses all of the data it stores. Data entry drives end user functionality through form and e-mail generation, field calculation, data cross-referencing, and notices and reports. The reporting capabilities can help to monitor every element of operations such as: case particulars, work reports and management and operational tools. Use of the database supports discovery, remediation, and quality improvements.
- Using a ~~DMS~~ **DHS**-approved assessment tool to determine the resources in time required to provide care in the home.
- Reports received from Financial Management Services provider received on a quarterly basis used by ~~counselors~~ **DHS Independent Choices QA staff** to determine why underutilization of the Cash Expenditure Plan occurs and how underutilization can be resolved.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

All individual facets of the program work in a continuum to identify, remediate and improve the quality of services and the satisfaction of program participants while improving the overall performance of the program. Each phase of the program is described, detailing how assurances are met through the Arkansas Quality Assurance and Improvement Plan described below.

Monitoring and Oversight

The Division of Medical Services (DMS) retains responsibility for the administration and oversight of all Medicaid programs. The Division of ~~Aging and Adult Services (DAAS)~~**Provider Services and Quality Assurance (DPSQA)** is the operating agency for the IndependentChoices program and responsible for the day-to-day operations. Both Divisions are part of the Arkansas Department of Human Services. ~~DAAS~~**DPSQA** will be responsible for executing the Quality Assurance and Improvement Plan with monitoring and oversight by DMS.

~~DAAS~~**DPSQA** will provide DMS with a monthly report comparing status of current data to previous year data. Examples included in the report may include but are not limited to the following:

- Enrollment activities
- ~~Extension of Benefits results~~
- Status of pending applications
- Status of active case load
- Participants who also receive home and community based services (HCBS)
- Medicaid Cost for IndependentChoices including participant-directed cost for HCBS services
- Detailed information for cost data for the most current month including cost of participant's budget and support services.
- Year in Progress, count of participants, contact notes, home visits, new enrollments for the current month, year to date and accumulative prior year experiences.

Lines of communication between the two Divisions are established and utilized to discuss additional needs and concerns that either Division may have.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

The IndependentChoices database is designed in such a way that discovery and remediation go hand in hand; not only for the ~~counselors~~**DHS Independent Choices QA staff**, nurses and contractors, but also for management staff. By design, the efficiency of the database enhances the ~~counselor's~~ **DHS Independent Choices QA staff's** ability to ~~provide good customer service~~ **monitor the program without being** ~~and not be~~ overly burdened ~~with~~ **by** paperwork. Examples on the following pages may include but are not limited to:

The database quantifies:

- referrals received during the month,
- persons disenrolling,
- ~~Extensions of Benefits requested.~~

The database identifies:

- reasons for disenrolling from the program,
- IndependentChoices participants who also receive HCBS waiver services,
- the HCBS RN assigned to the participant,
- the participant's physician,
- physician's fax number,
- date of next reassessment due.

The database tracks and creates exception reports when standards are not met and quantifies results. Some examples of the reports are:

- time between the date of referral, the nurse's home visit, and receipt of the assessment from the ~~HCBS RN~~**DHS Independent Assessment Contractor**,
- ~~time between receiving the assessment, sending the assessment to the physician and receiving the authorization from the physician,~~
- time between the referral and the actual enrollment
- number of home visits made by HCBS RN's within a timeframe.

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Each active and pending record contained within the database only includes data fields that are used in reporting. Each participant record may include the following:

- representative information, if applicable,
- participant's employee,
- participant's back-up worker,
- directions to the participant's home,
- nurse tracking,
- ~~counselor~~ **Independent Choices QA** tracking,
- contact notes,
- HCBS ARChoices service plan for persons receiving both ARChoices and IndependentChoices.

These data elements will assist the ~~counselors~~ **DHS Independent Choices QA staff** and nurses in performing their duties by allowing timely management and monitoring of each participant's case. ~~The HCBS service plan is used to determine if an extension of benefits is warranted, as all community resources are considered when requesting an extension of benefits.~~ The database allows nurses, ~~counselors~~ **DHS Independent Choices QA staff** or contractors to set health risk indicators identifying program participants who may require more frequent monitoring.

The data allows nurses and ~~counselors~~ **DHS Independent Choices QA staff** to run reports from their case load. Automated highlights on specific data elements draw the nurse or ~~counselor's~~ **DHS Independent Choices QA staff** attention to areas that require special attention. Highlighted data fields represent the following:

- assessment performed by the ~~nurse~~ **DHS Independent Assessment Contractor** but not received by ~~DAAS~~**DPSQA**,
- ~~counselor's request for authorization by a physician not received after four or more days,~~
- date enrollment forms sent to a potential enrollee but not returned.

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Reports are available to management to monitor quality of services provided to program participants and performance of staff. The reports identify program strengths and weaknesses or individual areas of concern. Reports compare data elements over periods of time to measure progress of corrective actions. As issues are identified they are addressed with appropriate staff to determine a new course of action through issuing new policy, enacting new procedures, clarifying an existing policy or procedure, or developing additional training. Identified issues continue to be monitored to determine if the corrective action is resolving the concern and is achieving the expected outcomes.

These reports allow flexibility to generate data based on any specified period of time, by a nurse, ~~counselor~~ **DHS Independent Choices QA staff**, contractor or by management. Reporting frequencies range from daily, monthly, or annually. Policy dictates a maximum period of time for completion of specific tasks with the focus on completing necessary tasks that allow the program participant to direct and meet their own health care needs.

Reporting is used to identify and remediate problems, improve program operation and to evaluate staff performance.

The database stores contact notes documenting IndependentChoices **QA** staff and contractors' communication with program participants. Policy requires each contact note to be entered into the participant's record to enhance the ability of management to address concerns expressed by the participant, a legislator, the Governor's Office, etc., with a quick review of the contact notes.

Examples of data elements found in the nurse tracking database portion may include, but is not limited to these data elements describing some of the following characteristics:

- ~~MDS HC RUG~~ **Level of care tier** category
- principal diagnosis,
- secondary diagnoses,
- participant well cared for,
- strong informal supports,
- no concerns noted,
- need for frequent ~~counselor~~ **counseling entity's support coordinator** contact.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Contact notes may include the following:

- person initiating the call,
- person receiving the call,
- date and time of call,
- subject of contact
- description of communication,
- complaint indicator
- whom complaint is directed toward
- date of complaint resolution

Nurses are supported by the Nurse Case Load Report that quantifies the active and pending caseload for each nurse by describing the following:

- by county, the number of active and pending clients with or without home and community-based services ~~and those with extension of benefits~~,
- data is also displayed in the aggregate by nurse per assigned counties.

~~Nurses~~ **The DHS Independent Assessment Contractor uses** ~~use~~ a ~~DMS~~**DHS-**approved assessment tool to define the participant's medical needs relative to the amount of resources required to care for the person in the home. The ~~DMS~~ **DHS-**approved assessment tool is similar to the MDS assessment performed in nursing homes but is specifically designed for the community environment. The assessment results in a ~~Resource Utilization Group (RUG) with an ADL Index~~**level of care tier** defining the degree of functional impairment. These results help define the population served in addition to using a scientifically scaled and validated assessment instrument. The use of this assessment helps to more clearly describe the medical complexities of program participants as they strive to remain in the community and avoid institutionalization.

Monitoring occurs in various other ways such as:

- Underutilization of the allowance could be the first indication that a participant may be experiencing difficulty directing their own care. It could indicate the beginning of a decline in cognitive function, impairing the participant's ability to direct their care, a need for a representative or decision making partner; a loss of worker; or it may be nothing more than not submitting the timesheets in a timely manner. Each ~~counselor~~ **counseling entity's support coordinator** works with his or her participants to determine the cause of the underutilization. The ~~counselor~~ **counseling entity's support coordinator** and participant work together to resolve the problem with the ~~counselor~~ **counseling entity's support coordinator** providing further assistance, as needed, or by the participant meeting his or her responsibilities as an employer. The ~~counselor~~ **counseling entity's support coordinator** follows-up with additional calls to the participant and monitors future underutilization reports for reoccurrences.

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

- Site visits to the contractors are made at a minimum bi-annually and more often if needed. The purpose of the site visit may be to provide an in-service, address concerns, or to evaluate performance. If during an evaluation deficiencies are noted, ~~DAAS~~**DPSQA** may provide additional in-services, require an acceptable corrective action plan, monitor the corrective action plan, withhold payment or terminate the contract.

Participant Feedback

The ~~DAAS~~ **DPSQA** and its counseling and fiscal contractors support and encourage participant communication by provision of a toll-free number. Participants may pose questions and voice concerns using the toll-free number. Incoming calls from participants and outgoing calls from ~~counselors~~ **counseling entity's support coordinators** or contractors are entered into the participant's individual electronic record. If the communication is an expressed complaint the ~~counselor~~ **counseling entity's support coordinator** follows ~~DAAS~~**DPSQA** required reporting procedures for documenting and resolving the complaint. Resolutions may include policy or procedural changes. Monitoring will continue to determine if the change has any impact or if the problem needs additional review.

A DHS appeal process is available for decisions made concerning Medicaid eligibility ~~or extension of benefits~~. An internal appeal process is available for participants when they are in disagreement with the number of hours recommended by the HCBS RN, involuntary disenrollment or if they have disagreements with their ~~counselor~~ **counseling entity's support coordinator** or fiscal agent. The purpose of the internal appeal is to allow the participant a voice in the decision and a way to mediate any misunderstandings between the participant and the IndependentChoices program. Additional supporting information may be shared during this time. ~~DAAS~~ **DPSQA** will issue a letter to the participant within five days from the date the internal appeal is conducted. Most disagreements are resolved prior to a participant initiating a request for a fair hearing and appeal. A formal Medicaid Fair Hearing is available when services are reduced, suspended, eliminated, or upon loss of Medicaid eligibility.

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Information and Assistance

Brochures are available for marketing purposes and are provided to any of the 75 county offices upon request.

Each participant receives a program handbook to convey program guidelines and expectations. Examples of information provided may include any of the following and is subject to additions and deletions as needs arise:

- Overview of the IndependentChoices program
- Overview of support services
- Use of a representative (Decision-Making Partner) ~~or Communications Manager~~
- Eligibility
- Participant rights
- Participant responsibilities
- Personal assistance services
- Other Medicaid services
- Medicaid waiver services
- Expectations from ~~counselor~~ **counseling entity's support coordinator**, nurse, bookkeeper
- Participant's enrollment duties
- Confidentiality
- When participant-direction begins
- Case Expenditure Plan
- Record Keeping
- Payroll
- Timesheets
- Hiring, training, conflict resolution, and termination of personal assistant
- Adult protective services
- Support services monitoring
- Reassessments
- Appeal rights

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1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Participants may also receive in-home visits, newsletters, questionnaires, and contact by phone to support participants wishing to direct their own care.

Participants can speak with their ~~counselor~~ **counseling entity's support coordinator** or the fiscal intermediary from 8:00 a.m. until 4:30 p.m., Monday through Friday, except for legal holidays or during inclement weather. After hours the participant may leave a message; the ~~counselor~~ **counseling entity's support coordinator** will return the call within one working day. Complaints are entered by the receiving party whether that is the ~~counselor~~ **counseling entity's support coordinator** or the fiscal intermediary.

A packet of communication forms is provided to each participant to report a change, to revoke and/or change disclosure of information and to appeal adverse decisions. The ~~counselor~~ **counseling entity's support coordinator** may also verbally take information related to changes in address or phone number.

Health and Welfare

Each participant must have an individual back-up plan to handle situations when the participant's primary employee is unavailable. The participant identifies a person who is willing to assume the tasks of the primary employee. The participant determines the risk involved and how the risk is mitigated based on their own individual needs. Inquiry of the use of the back-up plan occurs during phone communication with the participant. Reports from the IndependentChoices database can identify any program participant without a back-up personal attendant and if there is a conflict regarding a representative serving as a paid back-up personal attendant. The ~~counselor~~ **counseling entity's support coordinator** initiates communications with the participant to begin remediation.

The ~~C~~counseling **entity's support coordinator** and fiscal entities will work closely together to provide information necessary for each entity to perform their duties. Frequent and thorough communication facilitates this good working relationship.

The database assists in addressing health and welfare concerns by allowing monitoring and management of each individual file by:

- identifying a participants representative, employee, physician, back-up worker, directions to the home, results of the ~~nurse's assessment~~**Independent Assessment**, and updates by the ~~counselor~~ **counseling entity's support coordinator** assisting the participant in the IndependentChoices program, and;
- documenting all communications with the program participants.

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Financial Accountability

~~DAAS~~ **DPSQA** assures that payments are made to Medicaid eligible participants by:

- accessing Medicaid eligibility data prior to enrolling a person into IndependentChoices to assure eligibility for Medicaid and the IndependentChoices program;
- IndependentChoices program logic implemented by the Arkansas Medicaid fiscal intermediary, interfaces with the Medicaid Management Information System (MMIS) to edit against creation of an allowance for any participant who is no longer Medicaid eligible or is institutionalized;
- ~~DAAS~~ **DPSQA** maintains the MMIS eligibility file for IndependentChoices. The Arkansas fiscal intermediary reads the MMIS eligibility file to create claims for the IndependentChoices program. ~~DAAS~~ **DPSQA** queries on a weekly basis the Medicaid data warehouse to identify persons who are deceased, entered a nursing home, or have lost Medicaid eligibility. Once identified, the IndependentChoices eligibility segment is closed by ~~an~~ **DHS** Independent Choices **QA staff**~~counselor~~ on a weekly basis. Through contact with the participant or participant's family or representative this information is obtained prior to the update of the MMIS;
- ~~DAAS~~ **DPSQA** also queries the Medicaid data warehouse to identify IndependentChoices participants who have had an acute hospitalization. Once identified, ~~DAAS~~**DPSQA** informs the program participant, FMS provider and the counseling entity by letter that the participant's allowance paid prospectively during the hospitalization must be returned to the Medicaid program. The day of admission and day of discharge are allowable days;
- preventing duplication of agency and consumer-directed services by informing agency provider by fax seven days in advance the date the participant will begin directing their own personal care services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Qualified Providers

IndependentChoices counseling and fiscal providers assist program participants in all phases of program participation. Some of the examples of the work by these providers may include but is not limited to any of the work activities below:

- enrollment of new participants;
- develop and implement participant-directed budget;
- coordinate with FMS provider and ~~DAAS~~**DPSQA**;
- orientation to IndependentChoices and the philosophy of participant direction;
- offer skills training to the degree desired by the participant on how to recruit, interview, hire, evaluate, manage or dismiss assistants;
- participant-directed counseling support services;
- monitoring IndependentChoices participants/representatives;
- monitor over and under expenditures of Cash Expenditure Plan;
- provide quarterly reports to ~~DAAS~~**DPSQA**;
- manage the individual budget on behalf of the participant;
- process payroll and support payment for other qualified services and supports;
- report and pay state and federal income taxes, FICA, Medicare, and state and federal unemployment taxes;
- verify citizenship status of workers;
- serve as the fiscal agent of the participant per IRS rules;
- issues reports to ~~DAAS~~**DPSQA**;
- communicate with ~~counselors~~ **counseling entity's support coordinator** on budget changes;
- inform participants of their individual budget balance.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Qualified Providers (continued)

~~DAAS~~**DPSQA** is responsible for the following activities:

- monitor the counseling and fiscal providers to ensure compliance with the spirit of participant-direction and that appropriate counseling, fiscal and programmatic procedures are maintained;
- serve as the liaison between counseling agency, fiscal provider, Medicaid Management Information System (MMIS), and the Arkansas Medicaid fiscal intermediary;
- monitor the process to reimburse the counseling agency and fiscal provider for services provided to program participants.

Quality assurance measures previously discussed, assist ~~DAAS~~**DPSQA** in discovery and remediation to assure high standards in the offering and management of the participant-directed personal care program. The IndependentChoices program establishes, as its foundation, a person-centered approach that guides not only ~~DAAS~~**DPSQA**, but counseling and fiscal providers as well.

xii Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below:

The HCBS RN or the ~~counselor~~ **counseling entity's support coordinator** is the catalyst for identifying potential risks. In-home visits by either party help to identify risks involved in the current home environment as well as potential risks involved with self-direction. The ~~counselor~~ **counseling entity's support coordinator** or the HCBS RN can identify risks that may be environmental in nature such as throw rugs, uneven floors, etc. or the ~~DMS~~ **DHS-**approved assessment tool may identify potential risks such as not receiving a flu vaccine, etc. Based on the HCBS RN's observation and the ~~DMS~~ **DHS-**approved assessment tool, the HCBS RN after receiving notification from the ~~counselor~~ **counseling entity's support coordinator** will discuss the potential risks identified with the individual. If the HCBS RN determines that a representative is needed, the RN will inform the ~~counselor~~ **counseling entity's support coordinator**.

When the HCBS RN determines that a person is in need of a representative, the nurse will inform the ~~counselor~~ **counseling entity's support coordinator** and the ~~counselor~~ **counseling entity's support coordinator** will work with the participant to determine if there is someone who knows the participant's likes, dislikes, and preferences and is willing to accept the responsibilities to represent the participant in the IndependentChoices program.

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

The ~~counselor~~ **counseling entity's support coordinator** is responsible for working with the participant to determine who can serve as the representative. The ~~counselor~~ **counseling entity's support coordinator** will then work with the representative to teach, educate and work with the proposed representative so that the representative is fully aware of the responsibilities they are accepting in representing a person in a participant-directed program.

If the HCBS RN arrives and the participant is experiencing cognitive impairment and no informal supports are present, the participant will be discouraged from enrolling unless an informal support system can be identified, including someone to act as a representative decision maker. Participation in IndependentChoices requires the participant or their representative to be assertive in their role as employer and accept the risks, rights and responsibilities of directing their own care. If a representative is unavailable and the potential enrollee is incapable of performing these tasks without health and safety risks the person will not be enrolled. Blatant health and welfare concerns will not be compromised if solutions cannot be identified and enacted.

In addition to the HCBS RN's involvement there is communication with other agency providers providing home and community based services, with all parties having a vested interest in the health and welfare of the participant. This communication assists the operating agency to respond to any voiced concern with self-directed care.

The Participant Responsibilities and Agreement Form, which details all the requirements of self-direction, identifies areas where the individual may not be able to meet their responsibilities.

B. The tools or instruments used to mitigate identified risks are described below.

Every opportunity is afforded a participant to direct their own care, but the participant must accept and assume employer responsibility. Counseling support is available to help the participant, but ultimately it is the determination of the participant to succeed that determines whether participant direction will be a successful program for them. The IndependentChoices program requires a participant to make good decisions in order to assure that their personal assistance needs are met. ~~The program allows the use of a Communications Manager for persons who have difficulty with written or oral communication. The Communications Manager acts as the voice of the participant but does not make decisions for the participant. Nor does the Communications Manager hire, train, supervise, or fire the participant's employee.~~

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

When a participant needs a representative, the program allows for appointment of a Decision-Making Partner (DMP) who is willing to act and assume the employer role for the participant. The ~~counselor~~ **counseling entity's support coordinator** is the person responsible for working with the participant or the participant's family in the appointment of ~~either a Communications Manager or~~ a **Representative or** ~~D~~decision-~~M~~making ~~P~~partner. Each time a **Representative or** DMP is appointed the enrollment of the DMP is similar to a new participant enrollment. The **Representative or** DMP must be at least 18 years of age and able and willing to meet the following requirements:

- Possess knowledge of the participant's preferences
- Be willing to meet and uphold all program requirements
- Be willing to sign tax form and verify timesheets,
- Show a strong personal commitment to the participant
- Visit the participant at least weekly
- Uphold all duties without influence by the personal assistant or paid back-up worker
- Obtain approval from the participant and a consensus from other family members of the participant to serve as the DMP
- Be willing to submit to a criminal background check
- Be available to discuss the program hours

~~Whether a participant appoints a Communications Manager or Decision-Making Partner~~**Once the participant has appointed a Representative or DMP**, there are specific forms that must be completed.

If at any time ~~DAAS~~**DPSQA** learns that the participant's personal attendant is not providing the care agreed upon, the counselor will contact the participant/representative to ascertain the ability of the participant/representative to fulfill the role of employer. This discussion is to seek what types of assistance or support the participant or representative may need. A review of recurring instances of noncompliance could be reason for involuntary disenrollment.

When persons affiliated with the IndependentChoices program suspect abuse or neglect causing potential for health and safety risk to the participant by the representative, family members, personal attendant, or others, the participant will be referred to Adult Protective Services.

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State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

The service plan is a result of the assessment and will list any risks identified in the assessment and identify cautionary measures in relation to personal assistance needs with ADLs and IADLs. The service plan will identify any other risks identified through observation that were not identified through the assessment, or risks identified by the participant, representative or interested parties through a participant-centered approach. The HCBS RN makes the ~~counselor~~ **counseling entity's support coordinator** aware of these concerns requiring a plan or actions needed to mitigate the risks and who is responsible for each action. The service plan requires the signature of the participant/ representative.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

HCBS RN's and ~~counselors~~ **counseling entity's support coordinators** are trained to apply a participant-centered approach in developing all plans with the participant. Participants are always encouraged to invite friends and family members who have a personal commitment to the participant but are not acting as an employee to be present in all meetings or communications between the participant and nurse or ~~counselor~~ **counseling entity's support coordinator**. Identified risks will be discussed with the participant/representative and interested parties to determine a plan to mitigate the risk. The ~~counselor~~ **counseling entity's support coordinator** facilitates and guides the discussion and identifies concerns with any discussed approaches to mitigation of risk.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

The service plan is a result of the ~~MDS-HC and/or~~ **Independent Assessment and** ~~DMS-618~~**a form designated by DHS** and will list the risks identified in the assessment. ~~Additionally, each completed MDS-HC identifies Client Assessment Protocols (CAPs) and Triggers which identify cautionary measures in relation to personal assistance needs with ADLs and IADLs. These CAPs and Triggers will be a part of the QA process to assure health and safety.~~ The service plan will also require the nurse to list any other risks identified through observation that was not identified through the ~~MDS-HC and/or~~**Independent Assessment or** ~~DMS-618~~ **form designated by DHS,** or risks identified by the participant, representative or interested parties through a participant-centered approach. The service plan will identify the plan or actions needed to mitigate the risks and who is responsible for each action. The service plan requires the signature of the participant/representative, agreeing to the service plan and what the participant/representative is willing to do to mitigate risk.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

IndependentChoices nurses and ~~counselors~~ **counseling entity's support coordinator** are trained to apply a participant-centered approach in developing all plans with the participant. Participants are always encouraged to invite friends and family members who have a personal commitment to the participant to be present in all meetings between the participant and nurse or ~~counselor~~ **counseling entity's support coordinator**. Identified risks will be discussed with the participant/representative and interested parties to determine a plan to mitigate the risk. The nurse and ~~counselor~~ **counseling entity's support coordinator** are there to facilitate and guide the discussion and identify concerns with any discussed approaches to mitigation of risk.

xiii. Qualifications of Providers of Personal Assistance

A. ____ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

B. __X__ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xiv. Use of Representative

A. __X__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. __X__ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

If the participant has been diagnosed with a mental or cognitively impaired condition such as mental retardation, dementia, Alzheimer, etc., the participant will be required to choose a representative in order to participate or continue to participate in IndependentChoices. If the participant has not been diagnosed with a mental condition, but the ~~DAAS~~**DPSQA** RN and counseling staff determines through the Self-Assessment instrument, discussions with the participant, and sometimes a trial period of self-direction with enhanced counseling, that the individual's cognitive abilities are not sufficient to self-direct, the participant will be required to choose a representative. The counseling staff will work with the participant to establish a representative, using all avenues to find one if necessary. If the participant refuses to select a representative or the participant cannot find anyone who can act in that capacity after all avenues have been exhausted, the ~~counselor~~ **counseling entity's support coordinator** will coordinate with the participant to transition the participant to the traditional personal care provider of choice.

B. ____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. __X__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. _____ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

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

1	2	3	4	5	6	7	8	9	10	11	12
Task / Activity	**Needs Intensity Score 1 Needs and Minute Ranges**	**Minutes Assigned within Range**	**Needs Intensity Score 2 Needs and Minute Ranges**	**Minutes Assigned within Range**	**Needs Intensity Score 3 Needs and Minute Ranges**	**Minutes Assigned within Range**	**Frequency**	**Total Minutes per week**	**Minutes of Assistance with Task Per Week from Another Source**	**Total Minutes/ Hours Per Week Net of Assistance from Another Source**	**Total Net Hours per Month**
Bathing	• Laying out supplies • Drawing water • Standby assistance for safety • Minimal assistance in/out of tub or shower • Reminding, monitoring Minute range: 5-10		• Tub/shower bathing • Sponge bathing • Bed bathing • Drying • Extensive assistance in/out of tub or shower Minute range: 15-30		Total assistance with bathing Minute range: 35-45						
Dressing	• Laying out clothing • May require occasional help with zippers, buttons, putting on socks or shoes • Reminding or monitoring Minute range: 5-10		• Always requires assistance with zippers, buttons, socks, or shoes • Requires assistance getting into and out of garments Minute range: 15-20		Total assistance with dressing Minute range: 25-30						
Feeding	• Verbal reminders & encouragement • Standby assistance • Applying adaptive devices Note: feeding is calculated by # of meals per week, not # of days Minute range: 5-10		• Spoon feeding • Bottle feeding Minute range: 15-20		Total assistance with feeding Minute range: 25-30						

Grooming/Routine hair and skin care	• Laying out supplies • Verbal reminders • Combing/brushing hair • Applying non-prescription lotion to skin Minute range: 10-20		• Shaving • Brushing teeth • Shaving legs, underarms • Caring for nails • Washing hair • Drying hair • Setting/rolling/braiding hair • Washing hands and face • Applying makeup Minute range: 30-50		Total assistance with grooming and routine hair and skin care Minute range: 60-75						
Toileting	• Preparing toileting supplies / equipment • Assisting with clothing during toileting • Occasional help with Cleaning self • Occasional help with catheter or colostomy care • Standby assistance Minute range: 5-10		• Assisting on/off bedpan • Assisting with the use of urinal • Assisting with toileting hygiene • Assisting with feminine hygiene needs • Changing diapers Changing external catheter • Emptying catheter bag • Changing colostomy bag Minute range: 15-20		Total assistance with toileting Minute range: 25-30						
Transferring	• Helping with positioning (adjusting/changing position) • Minimal assistance in rising • Standby assistance Minute range: 5-10		• Non-ambulatory movement from one stationary position to another • Hands-on assistance with rising from a sitting to a standing position • Extensive assistance with positioning or turning Minute range: 15-20		Total assistance with positioning or transferring from bed to chair Minute range: 25-30						

Walking	• Standby assistance with walking • Assistance with putting on and removing leg braces Minute range: 5-10		• Steadying in walking/using steps • Assistance with wheelchair ambulation Minute range: 15-20		Total assistance with wheelchair ambulation Minute range: 25-30						
Cleaning	• Minimal assistance with cleaning • Make bed • Straightening areas Minute range: 60-90		• Cleaning up after personal care tasks • Cleaning floors of living area used by individual • Dusting • Cleaning bathroom • Changing bed linens • Cleaning stove top, counters, washing dishes • Cleaning refrigerator and stove • Emptying and cleaning bedside commode • Carrying out trash, setting out garbage for pickup Minute range: 95-235		Total assistance with cleaning Minute range: 240-300						
Laundry	Individual has no special laundry needs and has: o Washer and dryer – 30-60 o Washer or dryer only – 30-90 o No washer, no dryer – 30-120 Individual has special laundry needs and has: o Washer and dryer - 120 o Washer or dryer only - 180 o No washer, no dryer - 240										

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

Meal preparation	• Warming, cutting, serving prepared food • Meal planning • Helping prepare meals Light Breakfast • Snacks • Cooking full meal. Indicate meals to be cooked. The maximum time per meal is 30 minutes. o Breakfast o Lunch o Supper • Additional time for leftovers. Allow an extra 15 minutes per day for cooking enough for leftovers for the next meal, if needed. • Grinding and pureeing food Minute range: 10-90										
Shopping	• Preparing a shopping list • Picking up extra items Minute range: 10-30		• Going to the store; shopping for all items • Picking up medications • Putting items away Minute range: 35-90		Total assistance with shopping Minute range: 35-90						
Employment-related personal care associated with travel											
										TOTAL Minutes/Hours for All Tasks Per Month	

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

Instructions for Completing the Above Task and Hour Standards Grid

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

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

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

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

1. Identify the beneficiary's Needs Intensity Score (0, 1, 2, or 3) for each task from the ARIA assessment results and from information collected by the DHS RN during the PCSP meeting with the participant. If the Needs Intensity Score for the task is 0, the beneficiary will not be approved for any minutes for that task and THS grid would not be completed for the task. If the beneficiary's Needs Intensity Score is 1, 2, or 3, the grid will be completed for the task and the Needs Intensity Score will determine which minute range (Columns 2, 4, and 6) is applicable for the task.

2. Columns 3, 5, and 7: (Complete only one of these three.) The DHS nurse/contractor will calculate the number of minutes within the minute range for that Needs Intensity Score that are appropriate for the beneficiary based on conditions specific to the beneficiary. For example, if a beneficiary has cognitive or behavioral issues, the nurse may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming for a beneficiary who is bald would probably not be appropriate.

    - In exceptional circumstances and based on documented need, the DHS nurse/contractor may approve minutes in excess of the minute range for the task, so long as the justification of need is documented in writing, the justification is based on the beneficiary's assessed or

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

3. Column 8: Insert the frequency with which the task is performed based on the reasonable needs and preferences of the beneficiary. The frequency with which a given task is performed for a beneficiary will be calculated by the DHS nurse or contractor, drawing upon information from the ARIA assessment results and, as applicable, the information collected by DHS nurses during the PCSP meeting with the beneficiary and/or information submitted by the beneficiary's provider.

4. Column 9: Multiply the total minutes assigned for the task in Columns 3, 5, or 7 by the frequency with which the task is performed (Column 8) to arrive at the total minutes per week. Insert that product in Column 9.

5. Column 10: If the beneficiary is receiving assistance with the task from another source such as (a) informal caregivers (e.g., relatives, neighbors, and friends), (b) community-based agencies such as Meals on Wheels, and/or (c) Medicare or a Medicare Advantage health plan), calculate approximately how many of the assigned minutes for the task are being performed by the other source (e.g., 45 minutes for bathing because the beneficiary's mother needs total assistance and the daughter performs the entire bathing task once a week) and insert in Column 10. The amount of support with ADLs and IADLs provided by other sources is primarily calculated by the DHS nurse or contractor based on ARIA assessment results, during PCSP meetings with the participant, and from information supplied by providers.

6. Column 11: Subtract the number of Minutes of Assistance Per Week from Another Source in Column 10 from the number of Total Minutes Per Week in Column 9. Divide that number by 60 to arrive at the number of hours per week. Enter both minutes and hours per week in this column.

7. Column 12: Multiply the number of hours per week in Column 11 by 4.334 to arrive at the number of hours per month.