

ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**



Secretary of State
John Thurston
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov



For Office

Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Mac E. Golden E-mail Mac.E.Golden@dhs.arkansas.gov Phone 501-563-7634

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: ARChoices 1-20, LCAL 1-20, PERSCARE 3-20, ARChoices and Living Choices Waiver Amendments, and Medical Services Policy C-265, I-630, I-640, and L-120

Intended Effective Date

(Check One)

Date

<input type="checkbox"/> Emergency (ACA 25-15-204)	Legal Notice Published	<u>10/11 -13/2020</u>
<input type="checkbox"/> 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	<u>11/09/2020</u>
<input checked="" type="checkbox"/> Other <u>01/01/21</u> (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	<u>12/18/2020</u>
	Adopted by State Agency	<u>01/01/2021</u>

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Lisa Teague lisa.teague@dhs.arkansas.gov 12/18/20
Contact Person E-mail Address Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

501-320-6270 janet.mann@dhs.arkansas.gov
Phone Number E-mail Address

Director, Division of Medical Services
Title

12/18/20
Date

*TOC not required***212.000 Eligibility for the ARChoices Program 1-1-21**

- A. To qualify for the ARChoices Program, a person must be age twenty-one (21) through sixty-four (64) and have been 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 sixty-five (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 (OLTC), are not eligible for the ARChoices Program.

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, the results of the independent assessment, and the Division of Provider Services and Quality Assurance (DPSQA) 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 (1) of the following three (3) criteria, as determined by a licensed medical professional:
1. 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) ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or,
 2. 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 themselves or others; or,
 3. 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 DHS 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 PCSP. 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 OLTC.

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

- 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 twenty-one (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 twenty-one (21) days.
- 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.
- H. Eligibility for the ARChoices Waiver program begins the date the DHS Division of County Operations 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.)
- 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 (6) 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****1-1-21**

- 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 (PCSP).
- B. ASSESSMENT means the process completed by the independent assessment contractor to collect information used in determining initial functional eligibility for waiver services.
- C. DHS RN means a registered nurse authorized by DHS to develop the person-centered service plan for a participant.
- D. 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.
- E. EVALUATION means the process completed, at a minimum of every three hundred sixty-five (365) days, by the DHS RN to determine continued functional eligibility or a change in medical condition that may impact continued functional eligibility.
- F. 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.
- G. FUNCTIONAL ELIGIBILITY means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one (1) of the following three (3) criteria, as determined by a licensed medical professional:
 - 1. The individual is unable to perform either of the following:
 - a. At least one (1) of the three (3) activities of daily living (ADL's) 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 (ADL's) of transferring/locomotion, eating or toileting without limited assistance from another person; or
 - 2. 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,
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.
 - 3. 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.

- H. 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.
- I. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.
- J. 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.
- K. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.
- L. 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.
- M. PCSP means a person-centered service plan.
- N. REASSESSMENT means the process, completed at the request of DHS, by the independent assessment contractor to collect information used in determining continuing functional eligibility for waiver services.
- O. 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.
- P. 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.
- Q. SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.
- R. 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.
- S. TOTAL DEPENDENCE means the individual needs another person to completely and totally perform the task for the individual.
- T. 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.

212.200 Prospective Individual Services Budget

1-1-21

- 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 the Department of Human Services Registered Nurse (DHS RN) 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 based upon a change of condition.
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 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 one-time 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), 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 sixty (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 sixty (60) days per participant upon written request of the participant (or legal representative) or the participant's personal physician, if:
 - a. 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; or
 - b. 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 upon that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The three (3) ISB Levels are:
 - a. Intensive: The participant requires total dependence or extensive assistance from another person in all three (3) areas of mobility, feeding and toileting.
 - b. Intermediate: The participant requires total dependence or extensive assistance from another person in two (2) of the area of mobility, feeding and 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 for 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 for calendar year 2018.
 - b. In the year following the Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures for 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 the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:
 - i. If the cumulative expenditures are for less than twelve (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 twelve (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;
 - 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.

212.312 Comprehensive Person-Centered Service Plan (PCSP)

1-1-21

Prior to the expiration date of the provisional PCSP, the 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 three hundred sixty-five (365) days from the date of the DHS RN's signature on form AAS-9503, the ARChoices PCSP. Once the renewal is either approved or denied by the DHS Division of County Operations the providers will be notified by the 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.

Prior to the expiration of the three hundred sixty-five (365) days, financial and functional eligibility will be reviewed for renewal of the PCSP. Functional eligibility will be determined by an evaluation done by the DHS RN.

212.500 Reporting Changes in Beneficiary's Status

1-1-21

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 DHS RN or Case Manager. 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 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, providers must immediately report all changes in the beneficiary's status to the 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 evaluation of any beneficiary complaints or change of condition to the DHS RN, or DHS RN Supervisor immediately upon learning of the change. The DHS RN will determine if a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RNs evaluation of the beneficiary.

*TOC not required***211.100 Eligibility for the Living Choices Assisted Living Program 1-1-21**

- 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 Living Choices Program processes for beneficiary intake, assessment, evaluation, 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 (1) of the following three (3) criteria, as determined by a licensed medical professional.
1. 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) ADLs of transferring/locomotion, eating or toileting without limited assistance from another person; or,
 2. 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 that pose serious health or safety hazards to himself or others; or,
 3. The individual has a diagnosed medical condition that 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 required skilled level of care as defined in the 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 reassessment. 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 Bullet 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 Provider Manual.

- 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 twenty-one (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 twenty-one (21) days.
- 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.
- 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 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. If a beneficiary is moving from a Provider-Led Arkansas Shared Savings Entity (PASSE) to the Living Choices waiver program, the eligibility date will be no earlier than the first day following disenrollment from the PASSE.
- 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

- (6) 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.

211.125**Definitions**

1-1-21

- 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 (PCSP).
- B. **ASSESSMENT** means the process completed by the independent assessment contractor to collect information used in determining initial functional eligibility for waiver services.
- C. **DHS RN** means a registered nurse authorized by DHS to develop the person-centered service plan for a participant.
- D. **EVALUATION** means the process completed, at a minimum of every three hundred sixty-five (365) days, by the DHS RN to determine continued functional eligibility or a change in medical condition that may impact continued functional eligibility
- E. **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.
- F. **FUNCTIONAL ELIGIBILITY** means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one (1) of the following three (3) criteria, as determined by a licensed medical professional:
 - 1. The individual is unable to perform either of the following:
 - a. At least one (1) of the three (3) activities of daily living (ADL's) 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 (ADL's) of transferring/locomotion, eating or toileting without limited assistance from another person; or
 - 2. 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. 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.
- G. **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.
- H. **REASSESSMENT** means the process, completed at the request of DHS, by the independent assessment contractor to collect information used in determining continuing functional eligibility for waiver services.
- 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.

211.150 Level of Care Determination

1-1-21

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 Independent Assessment Contractor RN, using standard criteria for functional eligibility 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.

An evaluation is completed annually by the DHS RN to determine continued functional eligibility. Should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment. 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 reevaluation at least annually, the Independent Assessment Contractor may reassess a beneficiary's level of care and/or need any time it is deemed appropriate by the 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

1-1-21

- 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 DHS RN. The Living Choices plan of care developed by the DHS RN includes 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. Contact person;
 4. Physician's name and address;
 5. 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;
 6. 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;
 7. The election of community services by the waiver beneficiary;
 8. The name and title of the DHS RN responsible for the development of the plan of care; and,
 9. 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 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 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 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 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 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 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 thirty (30) and no more than forty-five (45) days before the expiration of each plan of care, the provider shall notify the 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 (3) months, the assisted living provider RN must evaluate each Living Choices beneficiary.
- D. The DHS RN must evaluate 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 DHS RN regarding beneficiaries whose status or condition has changed and who need evaluation.

REVISIONS TO A BENEFICIARY PLAN OF CARE MAY ONLY BE MADE BY THE DHS RN.

NOTE: All revisions to the plan of care must be authorized by the 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 DHS RN and signed by the beneficiary or the beneficiary's representative and the 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 sixty (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 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.

212.200 Periodic Nursing Evaluations

1-1-21

The assisted living provider RN must evaluate each Living Choices Program beneficiary at least every three (3) months, more often if necessary. The assisted living provider RN must alert the DHS RN to any indication that a beneficiary's direct care services needs are changing or have changed, so that the DHS RN can reevaluate the individual.

Each Living Choices beneficiary will be evaluated at least annually by a DHS RN. The 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. Evaluations and subsequent plan of care revisions must be made within fourteen (14) days of any significant change in the beneficiary's status.

TOC not required

214.300 Authorization of ARChoices Person Centered Service Plan and Personal Care Individual Service Plan

1-1-21

The DHS RN is responsible for developing an ARChoices Person-Centered Service Plan (PCSP) that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DHS RN authorizing the services listed.

The signed ARChoices PCSP will suffice as the “Personal Care Authorization” for services required in the Personal Care Program. The personal care individualized service plan, developed by the Personal Care provider, is still required.

The ARChoices PCSP is effective for one (1) year from the date of the beneficiary’s most recent assessment, reassessment, or evaluation. The authorization for personal care services, when included on the ARChoices PCSP, will be for one (1) year from the date of the beneficiary’s most recent assessment, reassessment, or evaluation unless revised by the DHS RN or the personal care individualized service plan needs to be revised, whichever occurs first.

NOTE: For ARChoices beneficiaries who receive personal care through traditional agency services or have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a DHS RN, will serve as the authorization for personal care services for one year from the date of the beneficiary’s most recent assessment, reassessment, or evaluation as described above.

The responsibility of developing a personal care individualized service plan is not placed with the 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 DHS RNs.

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. 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. Program Title:

ARChoices in Homecare

C. Waiver Number: AR.0195

Original Base Waiver Number: AR.0195.

D. Amendment Number: AR.0195.R05.05

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

12/31/20

Approved Effective Date: 12/31/20

Approved Effective Date of Waiver being Amended: 01/01/16

2. Purpose(s) of Amendment

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

The proposed rule change seeks to change the way evaluations are handled for Long Term Care and Home and Community Based (HCBS) waiver programs.

Steps are being added for members of HCBS waiver programs to request reassessments by the DHS RN when necessary or if a change in condition warrants a change to the Person-Centered Service Plan (PCSP).

Definitions to clarify the Level of Care Evaluation/Reevaluation process has been added. This affected language in the person centered service plan development process and the individual services budget, as well as service descriptions.

Clarification was added with regard to the Targeted Case Manager role and responsibility when reporting a change in medical condition to the DHS RN.

Grammatical and technical corrections have been made in the identified sections.

3. 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)
<input checked="" type="checkbox"/> Waiver Application	2. Brief Waiver Description; 6. Additional Requirements, I Public Input; 7
<input checked="" type="checkbox"/> Appendix A Waiver Administration and Operation	A.3.Use of Contracted Entities
<input checked="" type="checkbox"/> Appendix B Participant Access and Eligibility	B.6 d., e., f., i; Quality Improvement: LOC: b.i; B-7 Freedom of Choice a;
<input checked="" type="checkbox"/> Appendix C Participant Services	Service Specification PERS; Quality Improvement c.ii; C-4 Additional Limits,
<input checked="" type="checkbox"/> Appendix D Participant Centered Service Planning and Delivery	D.1.d, e, f; D.2.a, b
<input type="checkbox"/> Appendix E Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F Participant Rights	F-1a; F-3c
<input checked="" type="checkbox"/> Appendix G Participant Safeguards	G-1c;G-3.b.2; Quality Improvement, ii;
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I Financial Accountability	
<input type="checkbox"/> Appendix J Cost-Neutrality Demonstration	

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)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

To correct grammatical and technical errors. To provide definitions that pertain to the level of care determination process.

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

1. Request Information (1 of 3)

A. The State of Arkansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title *(optional - this title will be used to locate this waiver in the finder):*

ARChoices in Homecare

C. Type of Request: amendment

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

- 3 years 5 years

Original Base Waiver Number: AR.0195

Waiver Number: AR.0195.R05.05

Draft ID: AR.005.05.07

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/16

Approved Effective Date of Waiver being Amended: 01/01/16

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

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

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

Individuals requiring a skilled level of care are not eligible for the ARChoices program. The State's definition of "skilled level of care" is set forth below at b-6-d.

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

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

§440.150)

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

1. Request Information (3 of 3)

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

Select one:

- Not applicable
- Applicable**

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
- Waiver(s) authorized under §1915(b) of the Act.**

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

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

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)
- A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.**
- A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The 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 and who do not require a skilled level of care, as defined by State administrative rule which is set forth in B-6-d. 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 provider 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 an initial assessment completed by the Independent Assessment Contractor's team of registered nurses. The annual evaluation is initiated by the DHS RN. Should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment.

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.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state

uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- Not Applicable**
- No**
- Yes**

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

- No**
- Yes**

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

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

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



5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

Arkansas DHS has determined that this amendment is non-substantive. The 30-day public comment period will run simultaneously with the submission from October 11, 2020 through November 9, 2020. The notice of rulemaking will be published in the Arkansas Democrat-Gazette on October 11 through 13, 2020. The change will be posted on both the Arkansas Medicaid website and DHS website beginning October 9, 2020 through one month after the amendment is adopted, approximately February 1, 2021. There will be no public hearing for this amendment.

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

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

7. Contact Person(s)

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

Last Name:

Golden

First Name:

Mac

Title:

Attorney Specialist, Office of Policy Coordination & Promulgation

Agency:

Arkansas Department of Human Services

Address:

P. O. Box 1437, Slot S-295

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6383 Ext: TTY

Fax:

(501) 682-8009

E-mail:

Mac.E.Golden@dhs.arkansas.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:**Last Name:**

Fisher

First Name:

Ashely

Title:

Assistant Director

Agency:

Arkansas Dept. of Human Services, Division of Aging, Adult, and Behavioral Health Services

Address:

P. O. Box 1437, Slot W-241

Address 2:**City:**

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6345

Ext:

TTY

Fax:

(501) 682-8155

E-mail:

Ashley.Fisher@dhs.arkansas.gov

8. 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:

Rachael Veregge

State Medicaid Director or Designee

Submission Date:

Dec 8, 2020

Note: The Signature and Submission Date fields will be automatically completed when the State

Medicaid Director submits the application.

Last Name:

Hill

First Name:

Jay

Title:

DAABHS Director

Agency:

Arkansas Department of Human Services

Address:

P.O. Box 1437 Slot W-241

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6009 Ext: TTY

Fax:

(501) 682-8155

E-mail:

Attachments

Jay.Hill@dhs.arkansas.gov

Attachment #1: Transition Plan

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

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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

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

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

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

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

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the state Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) and Division of Provider Services and Quality Assurance (DPSQA)

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

The 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 provider 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.

Appendix A: Waiver Administration and Operation

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

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

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

A contractor (“Independent Assessment Contractor”) will perform independent assessments that gather functional eligibility 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).

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

Appendix A: Waiver Administration and Operation

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is

available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

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.

Appendix A: Waiver Administration and Operation

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

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 DMS 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

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

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

Numerator: Number of participants with at least one service per month; Denominator:

Number of participants served

Data Source (Select one):

Other

If 'Other' is selected, specify:

No Waiver Service Report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Source (Select one):

Other

If 'Other' is selected, specify:

ACES Report of Active Cases (Point in Time)

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px; margin-top: 5px;" type="text" value="Division of County Operations"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PDQA Request Forms

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver claims paid correctly on the same date of service as institutional services as specified in the waiver application. Numerator: Number of claims paid correctly; Denominator: Number of claims

Data Source (Select one):

Other

If 'Other' is selected, specify:

Overlapping Services Report or similar data preferred by Operating Agency and approved by Medicaid Agency

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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.

DMS completes a validation review of participant records reviewed by DAABHS. For the validation review, DMS reviews 20% of the records reviewed by DAABHS. 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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency), and the Division of Medical Services (DMS) (Medicaid agency) participate in team meetings as needed to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement for measures related to administrative authority of the waiver.

In cases where the numbers of unduplicated participants served in the waiver are not within approved limits, remediation includes waiver amendments and implementing waiting lists. DMS reviews and approves all policies and procedures (including waiver amendments) developed by DAABHS prior to implementation, as part of the Interagency Agreement. In cases where policies or procedures were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

In cases where there are problems with level of care determinations completed within specified time frames and by a qualified evaluator, additional staff training, staff counseling or disciplinary action may be part of remediation. In addition, if these problems arise, the LOC determination is completed upon discovery, the LOC determination may be redone and payments for services may be recouped. Similarly, remediation for service plans not completed in specified time frames includes, completing the service plan upon discovery, additional training for staff, staff counseling or disciplinary action. DAABHS conducts all remediation efforts in these areas.

Remediation to address participants not receiving at least one waiver service a month in accordance with the service plan and the agreement with DMS includes closing a case, conducting monitoring visits, revising a service plan to add a service, checking on provider billing and providing training.

Remediation associated with provider certifications that are not current according to the DAABHS/DPSQA/DMS agreement may include recertifying providers upon discovery if appropriate, requesting termination of the provider’s Arkansas Medicaid enrollment, referral to the Office of Medicaid Inspector General for possible recoupment for services provided after certification expired, or allowing the participant to choose another provider. DAABHS conducts remediation efforts in these areas.

The tool used for record review documents and tracks remediation.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	21	64	
	<input type="checkbox"/>	Disabled (Other)			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Not Applicable. The State does not further specify its target group.

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

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

Specify:

The participant who ages out in the Disabled (Physical) target subgroup at age 65 automatically remains in the waiver under the Aged target subgroup.

Appendix B: Participant Access and Eligibility

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

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

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

The limit specified by the state is (*select one*)

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

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	11350
Year 2	11350
Year 3	11350
Year 4	11350
Year 5	11350

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the state reserves capacity for:

Purposes
Arkansas Money Follows the Person (MFP) Program

Appendix B: Participant Access and Eligibility

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

Purpose (*provide a title or short description to use for lookup*):

Arkansas Money Follows the Person (MFP) Program

Purpose (*describe*):

Reserved for individuals transitioning from the nursing facilities to the community via the Arkansas Money Follows the Person (MFP) program. At CMS's recommendation, Arkansas MFP will be intensifying efforts through the end of the program, which is currently scheduled to end September 30, 2016, but there is a possibility for an extension so we are reserving capacity for all 5 years. The reserved slots will ensure that transitioned individuals will have access to more cost-effective services.

Describe how the amount of reserved capacity was determined:

The number of MFP participants who have historically transitioned into the waivers which ARChoices in Homecare represents has ranged from 25-36 per year. The 100 slots will allow a substantial buffer to account for the intensified activity level.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

The ARChoices waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once individuals meet all functional and financial eligibility requirements.

However, once all waiver slots are filled, a waiting list will be implemented for this program and the following process will apply. Each ARChoices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services; that all waiver slots are filled; and that the applicant is number _ in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the ARChoices program.

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

- a) Waiver application determination date for persons inadvertently omitted from the waiver waiting list (administrative error);
- b) Waiver application determination date for persons residing in a nursing facility and being discharged 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.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- §1634 State
 SSI Criteria State
 209(b) State

- 2. Miller Trust State.**

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

- No
 Yes

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the state plan**

Select one:

- SSI standard**
- Optional state supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(select one):

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

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the state Plan**

Specify:

- The following dollar amount**

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

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

Specify:

- Other**

Specify:

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.

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

- SSI standard**
- Optional state supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

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

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

- a. Health insurance premiums, deductibles and co-insurance charges

- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- The following dollar amount:**

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

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

Specify formula:

Other

Specify:

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.

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

Select one:

- Allowance is the same**
 Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

i. Minimum number of services.

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

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

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

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

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

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By a government agency under contract with the Medicaid agency.

Specify the entity:

- Other**
Specify:

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

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.

- 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 Definitions:

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 (PCSP).

ASSESSMENT means the process completed by the Independent Assessment Contractor to determine collect information used in determining initial functional eligibility for waiver services.

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

EVALUATION means the process completed, at a minimum, of every 365 days, by the DHS RN to determine continued functional eligibility or a change in medical condition that may impact continued functional eligibility.

FUNCTIONAL ELIGIBILITY means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one of the three criteria, as determined by a licensed medical professional.

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.

REASSESSMENT means the process, completed at the request of DHS, by the independent assessment contractor to determine collect information used in determining continuing functional eligibility for waiver services based upon the evaluation completed by the DHS RN.

Level of Care Criteria: The functional eligibility 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:

i. 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,

ii. 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. The State rule defines "Skilled Level of Care" to mean 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:

- a. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure;
- b. Intravenous injections and hypodermoclysis or intravenous feedings;
- c. Levin tubes and nasogastric tubes;
- d. Nasopharyngeal and tracheostomy aspiration;
- e. Application of dressings involving prescription medication and aseptic techniques;
- f. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV;
- g. 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;
- h. Initial phases of a regimen involving administration of medical gases;
- i. 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;
- j. Ventilator care and maintenance; and
- k. The insertion, removal and maintenance of gastrostomy feeding tubes;

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.

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.

The ARIA instrument is used to collect information to evaluate functional eligibility. 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 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.

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

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

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

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 Arkansas Independent Assessment (ARIA) system is used to support the functional eligibility 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 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.

The state ensures that ARIA is valid and reliable through multiple stages of testing. The Independent Assessment Contractor conducts its own system testing via automated test scripts as well as business testing to validate outcomes. In addition, the state provides mock assessments for a blinded validation analysis. The mock assessments are designed to test the validity of ARIA-assigned tiers (0, 1, 2, 3) compared to the nursing home level of care criteria for waiver functional eligibility. The mock assessments are uploaded to ARIA and tracked, and the ARIA results are compared to the expected tier levels identified by the state. This testing is single-side

- 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 reassessment 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 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 assessment and subsequent reassessments when requested by the DHS RN, 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.

Reevaluations will continue to be performed on at least an annual basis, with the functional eligibility reaffirmed or revised and a written determination issued by the Office of Long Term Care. A reevaluation may also be ordered anytime (or scheduled on a more frequent than annual basis) by the DHS RN 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), an evaluation will be performed by the DHS RN, who requests a reassessment to be completed by the Independent Assessment Contractor 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).

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.

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.)

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

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

Specify the other schedule:

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

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

Specify the qualifications:

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

DAABHS has established and maintains procedures for tracking review dates and initiating timely reevaluations 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 person-centered service plan so that no lapse in service occurs.

Specifically, DAABHS uses an online tracking tool with an integrated dashboard functionality that DHS RNs and RN supervisors use to monitor upcoming review data and service plan expirations. The process of evaluation 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 functional eligibility determination evaluation, whichever is earlier.

On at least a monthly basis, the DHS RN will identify participants who are due for evaluation. The DHS RN will add the cases to the evaluation schedule. The DHS RN will use the online tracking tool, referenced above, to monitor for both the need for evaluation, and for timely completion of the reassessment, when requested, by the Independent Assessment Contractor. Once it has been determined that functional eligibility continues, the DHS RN begins development of the new person-centered service plan.

Reassessments are ordinarily submitted to the Independent Assessment Contractor with a contractually-required 30-day time limit for completion of the reassessment. However, the contract also allows DHS, at its discretion, to submit reassessments with a 10-day time limit or a 7-day time limit when DHS deems it necessary.

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 an 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.

The Targeted Case Manager is responsible for monitoring the beneficiary status on a regular basis for changes in service need, referring the beneficiary to the DHS RN for evaluation of any beneficiary complaints or change of condition or DHS RN Supervisor immediately upon learning of the change. The DHS RN will determine if a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RN's evaluation of the beneficiary.

- 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

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent 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 records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input style="width: 100%; height: 20px;" type="text"/>		Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

Performance Measures

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

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

Performance Measure:

Number and percent 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 redetermination in 12 months; Denominator: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monthly Level of Care Report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of participants LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 assessments, reassessments and evaluations are completed by a registered nurse.

A functional eligibility determination of level of care is required annually. applying the functional eligibility criteria, with referral for the use of the approved assessment instrument in the event of a change of condition that may affect functional eligibility. When referred, the Independent Assessment Contractor conducts a reassessment using ARIA instrument and applies the functional eligibility criteria. The DHS Independent Assessment Contractor will submit data reports to DMS at least monthly listing the number of assessments and reassessments 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.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the time of the development of the person centered service plan for 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 changes to the person centered service plan, 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 Department of Human Services (DHS) forms are available in English and Spanish. The forms can be translated into other languages when the need arises. DHS maintains an ongoing contract with a Spanish interpreter and translator agency for translation services.

All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. 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.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Respite		
Other Service	Adult Day Services		
Other Service	Adult Family Home		
Other Service	Attendant Care Services		
Other Service	Environmental Accessibility Adaptations/Adaptive Equipment		
Other Service	Home-Delivered Meals		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Prevocational Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

11 Other Health and Therapeutic Services

Sub-Category 2:

11010 health monitoring

Category 3:

Sub-Category 3:

11 Other Health and Therapeutic Services

11120 cognitive rehabilitative therapy

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult day health are services furnished two or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Adult day health care provides a continuing, organized program of rehabilitative, therapeutic and supportive health and social services and activities to participants who are functionally impaired and who, due to the severity of their functional impairments, are not capable of fully independent living.

Adult day health facilities operate on a service day of no more than twelve (12) hours. The adult day health center shall serve one meal of nutritional content equal to one-third of the Recommended Daily Allowance, to participants who are present in the adult day health center for more than five (5) hours in that day.

The goals of adult day health go beyond the custodial and personal care goals of adult day services. The emphasis is on rehabilitative and health services. The goals of adult day health are:

1. To enable the participant to function physically, mentally and socially at the highest possible level.
2. To enable functionally impaired participants to remain in a supportive home environment instead of entering a nursing home.
3. To improve the health, well-being and quality of life for the participants by providing a rehabilitation program among their peers.
4. To provide support for family and other caregivers to enable them to maintain the impaired participant in the community.

The essential elements of an adult day health program are directed toward meeting the health restorative and maintenance needs of participants. The objectives of fostering and sustaining optimal capacity for self-care are achieved by:

1. Maximizing the participant's capacity to function independently;
2. Developing the participant's opportunities for socialization and peer support;
3. Providing treatment options other than institutionalization.

Adult day health providers are required to develop a written individual service plan to guide the delivery of adult day health services provided to each waiver participant in the adult day health facility. There must be a regular, ongoing schedule of services and activities (individual and group) based upon the participant's service plan. Adult day health programs provide health services that cannot be provided by adult day services programs. Adult day health is appropriate only for participants whose service plans specify one or more of the following health services that are not consistently provided by adult day services programs:

1. Rehabilitative therapies;
2. Pharmaceutical supervision;
3. Diagnostic evaluation;
4. Health monitoring.

Participants may also receive any of the following ancillary services in accordance with their service plan. These services, although they are non-medical in nature, are an important supplement to the basic health care functions:

1. Assistance with the activities of daily living;
2. Social work;
3. Recreation therapy;
4. Exercise;
5. Counseling.

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

Adult day health care can be utilized by waiver participants for two (2) or more hours per day, not to exceed ten (10) hours per day, when the service is provided according to the participants written service plan. Adult day health services of less than two (2) hours per day are not reimbursable. Adult day health services may be utilized up to fifty (50) hours (200 units) per week, not to exceed two hundred and thirty (230) hours (920 units) per month. ARChoices waiver participants can receive both adult day health and adult day services, but the two services are not allowed on the same date of service.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Health Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Licensed Adult Day Health Care

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.

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.

Other Standard (specify):

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 a waiver beneficiary's:

1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the beneficiary's care.

Respite care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. 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.

Respite care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. 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.

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

Respite Care is subject to the following limitations:

1. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with and shall be limited to amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards ("THS"). Any amounts, frequencies, or durations in excess of the unpaid caregiver assistance amounts identified for the beneficiary in the THS 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;
- e. Habilitation services, including but not limited to, assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and
- f. Services provided for any task not included in a beneficiary's service plans.

3. Participants are limited to no more than 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof. Respite care is not subject to a monthly or weekly limit, but is limited to the annual amount of time identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards.

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

5. Respite care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. 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.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Health Care Agency
Agency	Licensed Level II Assisted Living Facility
Agency	Licensed Medicaid Certified Nursing Facility
Agency	Licensed Acute Care Hospital
Agency	Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency
Agency	Licensed Adult Day Care Agency
Agency	Licensed Residential Care Facility

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

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.

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.

Other Standard (specify):

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.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

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.

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.

Other Standard (specify):

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.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Medicaid Certified Nursing Facility

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

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.

Other Standard (*specify*):

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.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Acute Care Hospital

Provider Qualifications

License (*specify*):

Licensed Acute Care Hospital

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 acute care hospital license.

Other Standard (*specify*):

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 Licensed Acute Care Hospital license at all times.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

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.

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.

Other Standard (specify):

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.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Adult Day Care Agency

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.

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.

Other Standard (specify):

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.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

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.

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.

Other Standard (specify):

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult day services are services provided in a group program designed to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than twenty-four (24) hours, but more than two (2) hours per day in a place other than the adult's own home.

Adult day care facilities operate on a service day of no more than twelve (12) hours.

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

Adult day services may be utilized by waiver participants for two (2) or more hours per day, not to exceed ten (10) hours per day, when the service is provided according to the participant's written service plan. Adult day services may be utilized up to fifty (50) hours (200 units) per week, not to exceed two hundred and thirty (230) hours (920 units) per month.

ARChoices waiver participants can receive both adult day service and adult day health, but the two services are not allowed on the same date of service.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Services

Provider Category:

Agency

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.

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.

Other Standard (specify):

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Family Home

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02013 group living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

ADULT FAMILY HOME SERVICES ARE TERMINATED 1/01/2019.

Adult Family Home services are personal care, attendant care, supportive services such as transportation to allow the waiver participant access to the community, 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. The Adult Family Home provider is responsible for meeting the needs, as described by the waiver service, 24 hours a day, seven days a week. Adult Family Home services shall be included in the service plan only when it is necessary to prevent the permanent institutionalization of a participant as determined by the DAAS RN.

Payment for Adult Family Home services does not include 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 participant's immediate family. The methodology by which the costs of room and board are excluded from payments for Adult Family Home services is described in Appendix I. The waiver participant is responsible for the cost of room and board expenses. Adult Family Home services are provided on a daily basis. Waiver service payments are intended to reimburse the cost of the caregiver in the Adult Family Home who assists with or provides daily living care to the waiver participant.

Adult Family Home services provide a family living environment for no more than three waiver participants who are not related to the principal care provider, who have functional impairments and, due to the severity of their functional impairments, are considered to be at imminent risk of death or serious bodily harm, and as a consequence, are not capable of independent living.

No Adult Family Homes (AFH) provider, employee or family member of the provider may be related to the AFH participant. For the purposes of this section, relative shall be defined as all persons related to the participant by virtue of blood, marriage, or adoption. Individuals who are legally responsible for the participant (i.e., spouse, legal guardian, attorney-in-fact granted authority to direct the participant's care) are prohibited from receiving reimbursement for direct provision of covered services for the ARChoices participant.

Adult Family Home services add a dimension of family living to the provision of supportive services and personal care services. Adult Family Home services provide care in a home-like setting, and the caregiver includes the participant in the life of the family as much as possible. The caregiver also assists the waiver participant in becoming or remaining active in the community.

Each Adult Family Home services provider shall execute with and provide to each waiver participant an admission agreement specifying services to be provided; charges for room and board; and conditions and rules governing waiver participant and grounds for termination of residence in the Adult Family Home.

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

One (1) unit of service equals one (1) day. Adult Family Homes are limited to a maximum of thirty-one (31) units per month.

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

Aside from facility-based respite services, a participant receiving Adult Family Home services is not eligible to receive any other ARChoices service.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Adult Family Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Home

Provider Category:

Individual

Provider Type:

Certified Adult Family Home

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Adult Family Home services. To be certified, providers must provide a copy of their current completed adult family home certification requirements checklist.

Other Standard (specify):

To be certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Adult Family Home services, providers must provide a copy of their completed Adult Family Homes Certification Requirements Checklist.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Attendant Care Services

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

08 Home-Based Services

Sub-Category 2:

08040 companion

Category 3:

08 Home-Based Services

Sub-Category 3:

08050 homemaker

Service Definition (Scope):

Category 4:

Sub-Category 4:

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.

Attendant care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. 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.

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

1. The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the beneficiary in accordance with 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 aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the beneficiary in accordance with the THS 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 the waiver beneficiary’s (i) spouse; (ii) legal guardian of the person; or (iii) attorney-in-fact granted authority to direct the beneficiary’s care;

e. On dates of service when the participant:

i. 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;

ii. 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;

iii. 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;

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

v. 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;

f. When a duplicate claim for the same performance of the same task is paid or submitted for personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan; and/or

g. For a task that was not actually performed.

Attendant care may be provided in a beneficiary’s home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. 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.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider
Agency	Licensed Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services

Provider Category:

Agency

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.

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.

Other Standard *(specify):*

In order to be certified by DPSQA as an agency attendant care provider and enrolled as a Medicaid provider, the attendants hired by the agency must meet the following minimum qualifications:

- o Be 18 years of age or older;
- o Be a United States citizen or legal alien authorized to work in the U. S.;
- o Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime;
- o Be free from communicable diseases;
- o Be free from diseases readily transmittable through casual contact;
- o Be able to read and write at a level sufficient to follow written instructions and maintain records;
- o Be in adequate physical health to perform job tasks required; and
- o Have a current signed formal agreement with an eligible ARChoices participant for the provision of agency attendant care services.

Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant.

Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant’s affairs and are covered under liability insurance.

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.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care Services

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License (specify):

Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency, as cited in Arkansas Code Annotated section 20-10-809.

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.

Other Standard (*specify*):

In order to be certified by DPSQA as an agency attendant care provider and enrolled as a Medicaid provider, the attendants hired by the agency must meet the following minimum qualifications:

- o Be 18 years of age or older;
- o Be a United States citizen or legal alien authorized to work in the U. S.;
- o Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime;
- o Be free from communicable diseases;
- o Be free from diseases readily transmittable through casual contact;
- o Be able to read and write at a level sufficient to follow written instructions and maintain records;
- o Be in adequate physical health to perform job tasks required; and
- o Have a current signed formal agreement with an eligible ARChoices participant for the provision of agency attendant care services.

Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant.

Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.

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.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations/Adaptive Equipment

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 a waiver beneficiary’s:

1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the beneficiary’s care.

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

Medicaid reimbursement for Environmental Accessibility Adaptations/Adaptive Equipment is determined by the job. The Medicaid maximum allowable equals \$7,500 per ARChoices participant for the life of the participant. A waiver participant may access through the waiver several occurrences of this service over a span of years or the whole \$7,500 at one time.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Installer (Builder, Tradesman or Contractor)

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations/Adaptive Equipment

Provider Category:

Individual

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.

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.

Other Standard (specify):

Environmental Accessibility Adaptations/Adaptive Equipment providers must:

- Certify that his or her work meets state and local building codes
- Be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines

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/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home-Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Home-delivered meals are services that provide one (1) meal per day of nutritional content equal to one-third of the Recommended Daily Allowance. This service is designed for participants who are unable to prepare meals, and who lack an informal provider to do meal preparation. Provision of home-delivered meals reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner.

The goals of home-delivered meals are:

1. To facilitate participant independence by allowing them the choice to remain in their own homes rather than entering a nursing facility.
2. To provide one (1) daily nutritious meal to participants at risk of being institutionalized;
3. To provide a daily social contact to homebound participants to insure the participant's safety and well-being.

In order to receive home-delivered meals under the waiver, a participant must:

1. Be homebound which is defined as:
 - a) A participant with normal inability to leave home without assistance (physical or mental) from another person;
 - b) The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
 - c) Leaving home requires considerable and taxing effort by the participant, and
 - d) Absences of the participant from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment; and
2. Be unable to prepare some or all of his/her own meals, or require a special diet and is unable to prepare it; and
3. Have no other person available to prepare his/her meals, and the provision of a home-delivered meal is the most cost-effective method of ensuring a nutritionally adequate meal; and
4. Have the provision of meals included in the participant's person-centered service plan.

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

One unit of service equals one meal. The maximum number of home-delivered meals eligible for reimbursement per month is 31 meals.

Four (4) emergency meals may be supplied per SFY.

Home delivered meals are not allowed on the same date of service when a waiver participant has received more than five (5) hours of adult day health, adult day service, or in-home or facility-based respite. Licensure requirements include provision of a meal while at the day care facility under these circumstances.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider of Food Services

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Provider of Food Services

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Food Establishment Permit issued by the Department of Health

 Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA), as an ARChoices waiver provider of Home Delivered Meals. To be certified, providers must provide a copy of their current food establishment permit issued by the Department of Health.

Other Standard (*specify*):

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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. The system includes an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. PERS enables an elderly, infirm or homebound participant to secure immediate help in the event of physical, emotional or environmental emergency.

PERS services are limited to those participants who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive, routine supervision.

The goals of the personal emergency response system are:

1. To provide a high-risk participant with the security and assurance of immediate assistance in an emergency, making it possible for them to remain in their home.
2. To eliminate the need for costly in-home supervision provided by a paid attendant that also affords the participant the emotional satisfaction or independent living.

PERS is not intended to be a universal benefit. It is specifically for those "high-risk" participants whose needs are determined through the person centered service plan development process. The criteria for eligibility are based on the participant's level of medical vulnerability, functional impairment and social isolation. Participants receiving PERS services must be physically and mentally capable of utilizing the service or reside in the home with a caregiver who is capable of utilizing the service for the benefit of the waiver participant.

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

One (1) unit of service equals one (1) day. PERS is limited to a maximum of thirty-one (31) units per month.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Alarm or Security Company

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Alarm or Security Company

Provider Qualifications

License (specify):

Certificate (specify):

Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) as an ARChoices waiver provider of Personal Emergency Response System services. To be certified, providers must provide a copy of their current certificate of compliance for protective signaling services issued by the Underwriters Laboratories Safety Standards.

Other Standard (specify):

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/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Prevocational Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 Respite Care services provided by a waiver beneficiary's:

1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the beneficiary's care.

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.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Prevocational Services Vendor

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Certified Prevocational Services Vendor

Provider Qualifications

License (specify):

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.

Other Standard (specify):

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)

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

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

- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
- As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
- As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
- As an administrative activity. Complete item C-1-c.
- As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

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

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.

Appendix C: Participant Services

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

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

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

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

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):

- No. The state does not conduct abuse registry screening.**
- Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

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.

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

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

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

- Self-directed**
- Agency-operated**

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify

state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

All ARChoices services may be reimbursed if provided by a relative of the participant, subject to the limitations specified below.

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.

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

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

ARChoices provider enrollment is open and continuous. Those interested in becoming an ARChoices provider can contact the Division of Provider Services and Quality Assurance (DPSQA) Provider Enrollment Unit 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 DPSQA website lists information for potential ARChoices providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percentage of 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

If 'Other' is selected, specify:

Provider Certification Unit (DPSQA) Provider Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

If 'Other' is selected, specify:

Provider Certification Unit (DPSQA) Provider Database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

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

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

Performance Measure:

Number and percent of providers certified by the Division of Provider Services and Quality Assurance (DPSQA). Numerator: Number of current providers certified by DPSQA; Denominator: Number of providers participating in the waiver program.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

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

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

Performance Measure:

Number and 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

If 'Other' is selected, specify:

In-Service Attendance Documentation

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

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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. Non-certified providers are not allowed to provide services under this waiver.

Each month the DHS RN receives a provider list for each county included in their geographical area. This provider list may be used during the development of the person centered service plan 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, the Division of Provider Services and Quality Assurance (operating agency) (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 States 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), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for provider certification and quality assurance), 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 related to qualified providers, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver.

All providers must meet required provider qualifications prior to Medicaid enrollment and prior to providing services. Because of this, performance measures related to these processes will always result in 100% compliance, and not allow for the possibility of remediation.

To continue 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.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

- No
- Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

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

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 nurse panel will review and act on the exception request within ten (10) working days from the date that the exception request is received by DAABHS. 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 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 DHS RN will use the results of the ARIA Independent Assessment to determine ISB amounts and assign individuals to grouped levels. 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 eligibility requirements for ARChoices 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 for 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 for 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 for 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 the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:
 - (a) 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
 - (b) 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.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Attachment 2 for the transition plan to ensure all providers are in compliance.

Arkansas is still assessing settings compliance in accordance with the transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the state**
- Licensed practical or vocational nurse, acting within the scope of practice under state law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the

service plan development process and (b) the participant's authority to determine who is included in the process.

When scheduling the person-centered service plan development visit, the 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 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) 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 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 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 the Division of Provider Services and Quality Assurance (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.

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

(g) Each evaluation of functional eligibility and development of a person-centered service plan 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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 each evaluation. 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.

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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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.

During completion of the person centered service plan, 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 , 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 (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 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 DAABHS. For the validation review, DMS reviews 20% of the records reviewed by DAABHS. 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Waiver participants are monitored through a variety of means and all monitoring by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) 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, 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.

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

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

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 the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency); 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 the Division of Provider Services and Quality Assurance (DPSQA) (operating agency) 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 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 evaluation by the DHS RN, 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

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

Number and 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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

Number and percent of service plans that were reviewed and revised as warranted on or before waiver participants annual review date. Numerator: Number of participants' service plans that were reviewed/revised before annual review date; Denominator: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

Number and 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 service plan; Denominator: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participant records reviewed with an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with choice between institutional care waiver services and among waiver services; Denominator: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 100px;"></div>

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

The state currently operates a system of review that assures completeness, appropriateness, accuracy, and freedom of choice. This system focuses on participant-centered service planning and delivery, participant rights and responsibilities, and participant outcomes and satisfaction.

Individual records are reviewed monthly by DAABHS for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Remediation is performed on service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the RN supervisor and is a part of the record review process.

DAABHS supervisory staff uses the Raosoft calculation system to determine appropriate sample size for ARChoices in Homecare Record Review, and selects every nth name on the list to be included in the sample.

Record reviews of the overall program files are thorough and include a review of all required documentation regarding compliance with the service plan development assurance and service plan delivery. 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; compliance with program policy regarding all aspects of the service plan development, changes, and renewal.

Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including service plan development and delivery of services. Initial verification of service delivery is verified via the Start of Care form. This documentation is a part of every record review.

Record reviews check for the presence of justification for requested changes and proper documentation, and data is summarized for the Record Review Summary. Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers. Records are reviewed to assure that a Freedom of Choice form was presented to the participant and that a complete, up-to-date list of providers has been made available to the participant.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Remediation is performed on person-centered service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the DHS RN supervisor and is a part of the record review process.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for provider certification and quality assurance), 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 related to service plans, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver.

If a participant record lacks required documentation regarding this assurance, DAABHS’s remediation includes completing the required documentation according to policy and additional staff training in this area.

The tool used to review waiver participants' records captures and tracks remediation in these areas.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

- No
- Yes

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

Appendix E: Participant Direction of Services

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

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

Appendix.

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The form DCO-707 (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 person centered 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: During the development of the person centered service plan, 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: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

- Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- No. This Appendix does not apply**
- Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) and Division of Provider Services and Quality Assurance (DPSQA)

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 evaluation 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

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

Yes. The state operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)

No. This Appendix does not apply (do not complete Items b through e)

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

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

Arkansas state law requires that suspected abuse, neglect, and exploitation of endangered and impaired adults be reported to the Adult Maltreatment Hotline for investigation. 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 or injury which provoke fear or alarm; or unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Exploitation includes illegal or unauthorized use of the person's funds or property; or use of the person's power of attorney or guardianship for the profit of one's own self; or improper acts or process that deprive the person of rightful access to benefits, resources, belongings and assets. Neglect is an act or omission by the endangered or impaired person (self-neglect), or an act or omission by the person's caregiver (caregiver neglect) constituting failure to provide necessary treatment, care, food, clothing, shelter, supervision or medical services; failure to report health problems and changes in health condition to appropriate medical personnel; 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 (DPSQA), 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 during the development of the person centered service plan. 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 Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) 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 DAABHS 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 DAABHS waiver program 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: Participant Safeguards

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

- 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 RNs reassess participants annually.

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.

- The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. (Select one):

- The state does not permit or prohibits the use of restrictive interventions**

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

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restrictive interventions. 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 RNs reassess participants annually.

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.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to

WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

The state does not permit or prohibits the use of seclusion

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

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. 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 RNs reassess participants annually.

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.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

The allowed provider types for Respite Care include licensed facilities that may provide respite care in a licensed facility on a round-the-clock basis for a period of time. Medication oversight must be conducted in accordance with state law and the licensure and scope of practice requirements applicable to the particular type of facility and staff.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Independent Assessment Contractor reviews the medication regimes at the time of assessment. The DHS RN reviews the medication regimens at the time of each evaluation . All medications are documented. Any potentially harmful practices the Independent Assessment Contractor or DHS RN discovers are documented in the participant record, addressed, and tracked for resolution.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

Do not complete the rest of this section

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

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

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

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

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

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

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

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

Performance Measure:

Number and percent of complaints addressed within required time frame.

Numerator: Number of complaints addressed in required time frame; Denominator: Number of complaints

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaint Database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:
Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of unpreventable and preventable causes. Numerator: Number of deaths with unpreventable causes; Denominator: Number of deaths

Data Source (Select one):

Other

If 'Other' is selected, specify:

Unexpected Death Report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>

Performance Measure:

Number of substantiated complaints. Numerator: Number of substantiated complaints; Denominator: Number of complaints

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaint Database

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:
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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: 100px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: 100px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: 100px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: 100px;"></div>

Performance Measure:

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/critical incidents; Denominator: Number of records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
--	---	---

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of critical incidents requiring reviews/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up; Denominator: Number of critical incidents reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:

Number and percent of the use of restrictive interventions requiring investigations.

Numerator is the number of investigations for the use of restrictive interventions.

Denominator is the reported uses of restrictive interventions.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

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

Performance Measure:

Number and percent of changes in Level of Care Tier Levels and ISB Levels.

Numerator - number of changes in Level of Care Tier Levels and ISB Levels.

Denominator - Number of records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

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 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 DMS.

DAABHS staff are required to review the APS information with participants and other interested parties during the development of each person centered service plan.. 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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 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.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

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.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, the Division of Medical Services (DMS) (Medicaid agency) will meet with the operating agencies (DAABHS and the Division of Provider Services and Quality Assurance (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 DMS 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 DMS, DAABHS, and DPSQA.

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

Medicaid related issues are documented by DAABHS waiver staff and reviewed by DMS, 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 DAABHS waiver staff and DMS. DMS reviews reports for proper resolution. These activities occur on a daily basis, and reviews occur monthly by DMS.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Other

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
Specify: <input type="text"/>	Specify: <input type="text" value="Ongoing, as needed"/>

b. System Design Changes

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

The Division of Aging, 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 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 utilizes the Quality Improvement Strategy during all levels of QA reviews.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one)*:

- No
- Yes *(Complete item H.2b)*

- b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey :
- NCI Survey :
- NCI AD Survey :
- Other *(Please provide a description of the survey tool used)*:

Appendix I: Financial 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. Division of Medical Services (DMS) (Medicaid agency) reviews are validation reviews of 20% of the records reviewed by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) 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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number and percent of reviewed claims with services specified in the participant's service plan. Numerator: Number of claims with services specified in service plan; Denominator: Number of claims

Data Source (Select one):

Other

If 'Other' is selected, specify:

Recipient Profiles

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> Other <i>Specify:</i> <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified <i>Describe Group:</i> <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other <i>Specify:</i> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"><i>DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.</i></div>
	<input type="checkbox"/> Other <i>Specify:</i> <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number of failed MMIS edit checks which are corrected to assure appropriate payment.

Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks

Data Source (Select one):

Other

If 'Other' is selected, specify:

Weekly Worksheets

<i>Responsible Party for data collection/generation (check each that applies):</i>	<i>Frequency of data collection/generation (check each that applies):</i>	<i>Sampling Approach (check each that applies):</i>
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified</i> <i>Describe Group:</i>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Daily LTC Update Error Report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other	

	Specify: <input style="width: 100%;" type="text"/>	
--	---	--

Data Source (Select one):

Other

If 'Other' is selected, specify:

Daily Waiver Update Error Report

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

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis(check each that applies):</i>
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

Number and percent of waiver claims that were paid using the correct rate as specified in the waiver application. Numerator: Number of claims paid at correct rate;

Denominator: Number of claims

Data Source (Select one):

Other

If 'Other' is selected, specify:

Recipient Claims History Profile (Chart Reviews)

<i>Responsible Party for data collection/generation (check each that applies):</i>	<i>Frequency of data collection/generation (check each that applies):</i>	<i>Sampling Approach(check each that applies):</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>

<input type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified</i> <i>Describe Group:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input checked="" type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"><i>DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.</i></div>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <div style="border: 1px solid black; height: 20px; width: 250px; margin-top: 5px;"></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 250px; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

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

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) is responsible for the rate determination with oversight conducted by the Division of Medical Services (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.

DAABHS will review the rate methodologies no later than CY 2020. If a methodology change is determined appropriate, it will be addressed in a subsequent waiver amendment or the waiver renewal application.

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 - Actuaries under contract with DMS developed a rate per 15 minutes for Attendant Care service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; annual number of hours practitioners are at work; and percentage of time an at-work practitioner is able to convert to billable units (productivity). Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Adult Day Health – Actuaries under contract with DMS developed a rate per 15 minutes for Adult Day Health service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; average number of beneficiaries and hours per beneficiary served each day; and annual number of days of operation. Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Respite (In-Home) - Actuaries under contract with DMS developed a rate per 15 minutes for in-home Respite service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; annual number of hours practitioners are at work; and percentage of time an at-work practitioner is able to convert to billable units (productivity). Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Respite (facility-based): Facility-based 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 – Actuaries under contract with DMS developed a rate per 15 minutes for Adult Day Services using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; average number of beneficiaries and hours per beneficiary served each day; and annual number of days of operation. Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. 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 DMS and is equivalent to the rate established for state plan supportive employment services that are services similar to prevocational services. 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.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver providers bill for the services and are reimbursed directly through the MMIS.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures (select one):

- No. state or local government agencies do not certify expenditures for waiver services.**
- Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

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

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial

participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) staff verifies services were provided according to the person-centered service plan through an internal monthly monitoring system. Adjustments are made or referred to the Office of Medicaid Inspector General when claims are paid incorrectly.

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

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- No. The state does not make supplemental or enhanced payments for waiver services.**
- Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.*
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

g. Additional Payment Arrangements

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

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

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

ii. Organized Health Care Delivery System. Select one:

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

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

iii. Contracts with MCOs, PIHPs or PAHPs.

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

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

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver**

and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

- This waiver is a part of a concurrent §1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(c) waiver specifies the types of health plans that are used and how payments to these plans are made.*
- If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

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

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

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

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

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

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

Appendix I: Financial Accountability

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

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or

sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

Other Local Government Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

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

Appendix I: Financial Accountability

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

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

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

individual.

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

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

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.

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

- Ⓒ *No. The state does not impose a co-payment or similar charge upon participants for waiver services.*
- *Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

i. Co-Pay Arrangement.

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

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

- Nominal deductible*
- Coinsurance*
- Co-Payment*

Other charge

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8504.21	9666.00	18170.21	47580.00	2520.00	50100.00	31929.79
2	7726.73	9934.00	17660.73	48898.00	2590.00	51488.00	33827.27
3	8248.90	10209.00	18457.90	50252.00	2662.00	52914.00	34456.10
4	4704.78	10492.00	15196.78	51644.00	2735.00	54379.00	39182.22
5	5503.42	10782.00	16285.42	53075.00	2811.00	55886.00	39600.58

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	11350		11350
Year 2	11350		11350
Year 3	11350		11350
Year 4	11350		11350
Year 5	11350		11350

Appendix J: Cost Neutrality Demonstration

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

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

Data from the annual reports (CMS-372) for the 2013 reporting year for each of the two existing DAAS 1915(c) waivers which are being replaced with the new ARChoices in Homecare waiver were tabulated to estimate the average length of stay on the waiver.

A total of 9,374 unduplicated participants were served by the two waivers, with a total of 2,591,698 days of waiver coverage. The average length of stay on the waiver(s) is estimated at 276 days.

Appendix J: Cost Neutrality Demonstration

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

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

For Waiver Years 1 through 3, historic utilization and cost data from SFYs 2011, 2012 and 2013 were used to derive utilization rates and cost for the elderly in home-based settings (ElderChoices waiver - EC), and adults with physical disabilities in home-based services (Alternatives for Adults with Physical Disabilities waiver - AAPD). The utilization rates for the existing EC and AAPD were used to estimate the future utilization of these services for individuals, assuming that the elderly will have similar utilization rates to those found among adults with physical disabilities and vice versa.

For Waiver Years 4 and 5, the average costs/unit for Adult Day Health, Respite In-Home, Adult Day Services, Personal Emergency Response System (PERS) Unit Monitoring, and Attendant Care Services were modified to reflect the new payment rates to be effective January 1, 2019. The number of users for Adult Day Health was modified to reflect expected use based on experience to date, and the number of users for Attendant Care was modified to reflect changes expected due to the expected transition of service hours to state plan Personal Care services and modifications made to the Attendant Care service definitions. The number of users for the new service of Prevocational Services was projected as 1% of the unduplicated cap, and the average units/user was projected as the maximum number of units permitted for this service under the limits on amount, frequency, and duration identified in Appendix C-1/C-3 for this service. The number of users and average units per user for all components of Adult Family Home were changed to 0 to reflect the elimination of that service effective with Waiver Year 4.

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

Weighted average of factor D from historic waivers, less current D, plus historic D prime.

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

Weighted average of historic waivers forward to forecast the combined waivers.

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

Weighted average of historic waivers forward to forecast the combined waivers.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Health	
Respite	
Adult Day Services	
Adult Family Home	
Attendant Care Services	

Waiver Services	
<i>Environmental Accessibility Adaptations/Adaptive Equipment</i>	
<i>Home-Delivered Meals</i>	
<i>Personal Emergency Response System (PERS)</i>	
<i>Prevocational Services</i>	

Appendix J: Cost Neutrality Demonstration

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							799606.08
Adult Day Health	<input type="checkbox"/>	15 Minutes	63	4068.00	3.12	799606.08	
Respite Total:							6441773.60
Respite In-Home	<input type="checkbox"/>	15 Minutes	1147	1228.00	4.50	6338322.00	
Respite Short-Term Facility-Based	<input type="checkbox"/>	15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based	<input type="checkbox"/>	15 Minutes	10	946.00	0.56	5297.60	
Adult Day Services Total:							2176785.00
Adult Day Services	<input type="checkbox"/>	15 Minutes	234	3721.00	2.50	2176785.00	
Adult Family Home Total:							12000.40
Adult Family Home - Level A	<input type="checkbox"/>	Day	1	76.00	56.25	4275.00	
Adult Family Home - Level C	<input type="checkbox"/>	Day	1	76.00	48.22	3664.72	
Adult Family Home - Level B	<input type="checkbox"/>	Day	1	76.00	53.43	4060.68	
Attendant Care Services Total:							77957590.50
Attendant Care Services	<input type="checkbox"/>	15 Minutes				67805581.50	
GRAND TOTAL:							96522751.30
Total: Services included in capitation:							
Total: Services not included in capitation:							96522751.30
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							8504.21
Services included in capitation:							
Services not included in capitation:							8504.21
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			6577	2291.00	4.50		
Self-directed Attendant Care Transitioning-1st Year	<input type="checkbox"/>	15 Minutes	1050	3806.00	2.43	9711009.00	
CSM Transition Costs-1st Year	<input type="checkbox"/>	1 Month	1050	6.00	70.00	441000.00	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							715864.00
Environmental Accessibility Adaptations/Adaptive Equipment	<input type="checkbox"/>	Package	172	1.00	4162.00	715864.00	
Home-Delivered Meals Total:							6927038.76
Home-Delivered Meals	<input type="checkbox"/>	Meal	5422	214.00	5.97	6927038.76	
Personal Emergency Response System (PERS) Total:							1492092.96
PERS Installation	<input type="checkbox"/>	One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring	<input type="checkbox"/>	Day	5324	257.00	1.07	1464046.76	
Prevocational Services Total:							0.00
Prevocational Services - Skill Development	<input type="checkbox"/>	15 Minutes	0	0.00	6.40	0.00	
Prevocational Services - Career Exploration	<input type="checkbox"/>	15 Minutes	0	0.00	6.40	0.00	
GRAND TOTAL:							96522751.30
Total: Services included in capitation:							
Total: Services not included in capitation:							96522751.30
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							8504.21
Services included in capitation:							
Services not included in capitation:							8504.21
Average Length of Stay on the Waiver:							276

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							799606.08
Adult Day Health	<input type="checkbox"/>	15 Minutes	63	4068.00	3.12	799606.08	
Respite Total:							6574397.60
Respite In-Home	<input type="checkbox"/>	15 Minutes	1171	1228.00	4.50	6470946.00	
Respite Short-Term Facility-Based	<input type="checkbox"/>	15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based	<input type="checkbox"/>	15 Minutes	10	946.00	0.56	5297.60	
Adult Day Services Total:							2176785.00
Adult Day Services	<input type="checkbox"/>	15 Minutes	234	3721.00	2.50	2176785.00	
Adult Family Home Total:							12000.40
Adult Family Home - Level A	<input type="checkbox"/>	Day	1	76.00	56.25	4275.00	
Adult Family Home - Level C	<input type="checkbox"/>	Day	1	76.00	48.22	3664.72	
Adult Family Home - Level B	<input type="checkbox"/>	Day	1	76.00	53.43	4060.68	
Attendant Care Services Total:							68857150.50
Attendant Care Services	<input type="checkbox"/>	15 Minutes	6679	2291.00	4.50	68857150.50	
Self-directed Attendant Care Transitioning-1st Year	<input type="checkbox"/>	15 Minutes	0	0.00	0.01	0.00	
CSM Transition Costs-1st Year	<input type="checkbox"/>	1 Month	0	0.00	0.01	0.00	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							753322.00
Environmental Accessibility Adaptations/Adaptive Equipment	<input type="checkbox"/>	Package	181	1.00	4162.00	753322.00	
Home-Delivered Meals Total:							7033077.90
Home-Delivered Meals	<input type="checkbox"/>	Meal	5505	214.00	5.97	7033077.90	
Personal Emergency Response System (PERS) Total:							1492092.96
GRAND TOTAL:							87698432.44
Total: Services included in capitation:							
Total: Services not included in capitation:							87698432.44
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							7726.73
Services included in capitation:							
Services not included in capitation:							7726.73
Average Length of Stay on the Waiver:							276

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS Installation	<input type="checkbox"/>	One Installation	938	1.00	29.90	28046.20	
PERS Unit Monitoring	<input type="checkbox"/>	Day	5324	257.00	1.07	1464046.76	
Prevocational Services Total:							0.00
Prevocational Services - Skill Development	<input type="checkbox"/>	15 Minutes	0	0.00	0.01	0.00	
Prevocational Services - Career Exploration	<input type="checkbox"/>	15 Minutes	0	0.00	0.01	0.00	
GRAND TOTAL:							87698432.44
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							87698432.44
<i>Total Estimated Unduplicated Participants:</i>							11350
<i>Factor D (Divide total by number of participants):</i>							7726.73
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							7726.73
<i>Average Length of Stay on the Waiver:</i>							276

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							863066.88
Adult Day Health	<input type="checkbox"/>	15 Minutes	68	4068.00	3.12	863066.88	
Respite Total:							6707021.60
Respite In-Home	<input type="checkbox"/>	15 Minutes	1195	1228.00	4.50	6603570.00	
Respite Short-Term Facility-Based	<input type="checkbox"/>	15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based	<input type="checkbox"/>	15 Minutes	10	946.00	0.56	5297.60	
GRAND TOTAL:							93624977.78
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							93624977.78
<i>Total Estimated Unduplicated Participants:</i>							11350
<i>Factor D (Divide total by number of participants):</i>							8248.90
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							8248.90
<i>Average Length of Stay on the Waiver:</i>							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2223297.50
Adult Day Services	<input type="checkbox"/>	15 Minutes	239	3721.00	2.50	2223297.50	
Adult Family Home Total:							24000.80
Adult Family Home - Level A	<input type="checkbox"/>	Day	2	76.00	56.25	8550.00	
Adult Family Home - Level C	<input type="checkbox"/>	Day	2	76.00	48.22	7329.44	
Adult Family Home - Level B	<input type="checkbox"/>	Day	2	76.00	53.43	8121.36	
Attendant Care Services Total:							74331495.00
Attendant Care Services	<input type="checkbox"/>	15 Minutes	7210	2291.00	4.50	74331495.00	
Self-directed Attendant Care Transitioning-1st Year	<input type="checkbox"/>	15 Minutes	0	0.00	0.01	0.00	
CSM Transition Costs-1st Year	<input type="checkbox"/>	1 Month	0	0.00	0.01	0.00	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							844886.00
Environmental Accessibility Adaptations/Adaptive Equipment	<input type="checkbox"/>	Package	203	1.00	4162.00	844886.00	
Home-Delivered Meals Total:							7139117.04
Home-Delivered Meals	<input type="checkbox"/>	Meal	5588	214.00	5.97	7139117.04	
Personal Emergency Response System (PERS) Total:							1492092.96
PERS Installation	<input type="checkbox"/>	One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring	<input type="checkbox"/>	Day	5324	257.00	1.07	1464046.76	
Prevocational Services Total:							0.00
Prevocational Services - Skill Development	<input type="checkbox"/>	15 Minutes	0	0.00	0.01	0.00	
Prevocational Services - Career Exploration	<input type="checkbox"/>	15 Minutes	0	0.00	0.01	0.00	
GRAND TOTAL:							93624977.78
Total: Services included in capitation:							93624977.78
Total: Services not included in capitation:							11350
Total Estimated Unduplicated Participants:							8248.90
Factor D (Divide total by number of participants):							8248.90
Services included in capitation:							8248.90
Services not included in capitation:							
Average Length of Stay on the Waiver:							276

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							983561.04
Adult Day Health	<input type="checkbox"/>	15 Minutes	77	4068.00	3.14	983561.04	
Respite Total:							7223886.80
Respite In-Home	<input type="checkbox"/>	15 Minutes	1280	1228.00	4.53	7120435.20	
Respite Short-Term Facility-Based	<input type="checkbox"/>	15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based	<input type="checkbox"/>	15 Minutes	10	946.00	0.56	5297.60	
Adult Day Services Total:							2343671.85
Adult Day Services	<input type="checkbox"/>	15 Minutes	255	3721.00	2.47	2343671.85	
Adult Family Home Total:							0.00
Adult Family Home - Level A	<input type="checkbox"/>	Day	0	0.00	56.25	0.00	
Adult Family Home - Level C	<input type="checkbox"/>	Day	0	0.00	48.22	0.00	
Adult Family Home - Level B	<input type="checkbox"/>	Day	0	0.00	53.43	0.00	
Attendant Care Services Total:							32724720.00
Attendant Care Services	<input type="checkbox"/>	15 Minutes	4200	1720.00	4.53	32724720.00	
Self-directed Attendant Care Transitioning-1st Year	<input type="checkbox"/>	15 Minutes	0	0.00	0.01	0.00	
CSM Transition Costs-1st Year	<input type="checkbox"/>	1 Month	0	0.00	0.01	0.00	
GRAND TOTAL:							53399240.43
Total: Services included in capitation:							
Total: Services not included in capitation:							53399240.43
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							4704.78
Services included in capitation:							
Services not included in capitation:							4704.78
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations/Adaptive Equipment Total:							915640.00
Environmental Accessibility Adaptations/Adaptive Equipment	<input type="checkbox"/>	Package	220	1.00	4162.00	915640.00	
Home-Delivered Meals Total:							7429127.70
Home-Delivered Meals	<input type="checkbox"/>	Meal	5815	214.00	5.97	7429127.70	
Personal Emergency Response System (PERS) Total:							1495548.24
PERS Installation	<input type="checkbox"/>	One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring	<input type="checkbox"/>	1 Month	5324	8.45	32.62	1467502.04	
Prevocational Services Total:							283084.80
Prevocational Services - Skill Development	<input type="checkbox"/>	15 Minutes	114	268.00	6.40	195532.80	
Prevocational Services - Career Exploration	<input type="checkbox"/>	15 Minutes	114	120.00	6.40	87552.00	
GRAND TOTAL:							53399240.43
Total: Services included in capitation:							
Total: Services not included in capitation:							53399240.43
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							4704.78
Services included in capitation:							
Services not included in capitation:							4704.78
Average Length of Stay on the Waiver:							276

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							996334.56
Adult Day Health	<input type="checkbox"/>	15 Minutes	78	4068.00	3.14	996334.56	
Respite Total:							8030498.60
Respite In-Home	<input type="checkbox"/>	15 Minutes	1425	1228.00	4.53	7927047.00	
Respite Short-Term Facility-Based	<input type="checkbox"/>	15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based	<input type="checkbox"/>	15 Minutes	10	946.00	0.56	5297.60	
Adult Day Services Total:							2499916.64
Adult Day Services	<input type="checkbox"/>	15 Minutes	272	3721.00	2.47	2499916.64	
Adult Family Home Total:							0.00
Adult Family Home - Level A	<input type="checkbox"/>	Day	0	0.00	56.25	0.00	
Adult Family Home - Level C	<input type="checkbox"/>	Day	0	0.00	48.22	0.00	
Adult Family Home - Level B	<input type="checkbox"/>	Day	0	0.00	53.43	0.00	
Attendant Care Services Total:							40516320.00
Attendant Care Services	<input type="checkbox"/>	15 Minutes	5200	1720.00	4.53	40516320.00	
Self-directed Attendant Care Transitioning-1st Year	<input type="checkbox"/>	15 Minutes	0	0.00	2.43	0.00	
CSM Transition Costs-1st Year	<input type="checkbox"/>	15 Minutes	0	0.00	70.00	0.00	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							1040500.00
Environmental Accessibility Adaptations/Adaptive Equipment	<input type="checkbox"/>	Package	250	1.00	4162.00	1040500.00	
Home-Delivered Meals Total:							7601601.00
Home-Delivered Meals	<input type="checkbox"/>	Meal	5950	214.00	5.97	7601601.00	
Personal Emergency Response System (PERS) Total:							1495548.24
GRAND TOTAL:							62463803.84
Total: Services included in capitation:							
Total: Services not included in capitation:							62463803.84
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							5503.42
Services included in capitation:							
Services not included in capitation:							5503.42
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS Installation	<input type="checkbox"/>	One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring	<input type="checkbox"/>	1 Month	5324	8.45	32.62	1467502.04	
Prevocational Services Total:							283084.80
Prevocational Services - Skill Development	<input type="checkbox"/>	15 Minutes	114	268.00	6.40	195532.80	
Prevocational Services - Career Exploration	<input type="checkbox"/>	15 Minutes	114	120.00	6.40	87552.00	
GRAND TOTAL:							62463803.84
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							62463803.84
<i>Total Estimated Unduplicated Participants:</i>							11350
<i>Factor D (Divide total by number of participants):</i>							5503.42
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							5503.42
<i>Average Length of Stay on the Waiver:</i>							276

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. 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. Program Title:

Living Choices Assisted Living Waiver

C. Waiver Number:AR.0400

Original Base Waiver Number: AR.0400.

D. Amendment Number:AR.0400.R03.06

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

12/31/20

Approved Effective Date: 12/31/20

Approved Effective Date of Waiver being Amended: 02/01/16

2. Purpose(s) of Amendment

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

The proposed rule change seeks to change the way evaluations are handled for Long Term Care and Home and Community Based (HCBS) waiver programs.

Steps are being added for members of HCBS waiver programs to request reassessments by the DHS RN when necessary or if a change in condition warrants a change to the Person-Centered Service Plan (PCSP).

Definitions to clarify the Level of Care Evaluation/Reevaluation process has been added. This affected language in the person centered service plan development process and the individual services budget, as well as service descriptions.

Grammatical and technical corrections have been made in the identified sections.

3. 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)
<input checked="" type="checkbox"/> Waiver Application	2. Brief Waiver Description; 6 I Public Input; 7 Contact Persons;
<input type="checkbox"/> Appendix A Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B Participant Access and Eligibility	B.6.d, e, f, i; Quality Improvement b.i; B.7 Freedom of Choice
<input checked="" type="checkbox"/> Appendix C Participant Services	Quality Improvement a,ii
<input checked="" type="checkbox"/> Appendix D Participant Centered Service Planning and Delivery	D.1d;e,f; D.2a
<input type="checkbox"/> Appendix E Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F Participant Rights	F.1; F.3
<input checked="" type="checkbox"/> Appendix G Participant Safeguards	Quality Improvement ii
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I Financial Accountability	
<input type="checkbox"/> Appendix J Cost-Neutrality Demonstration	

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)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other**
Specify:

To make grammatical and technical corrections. To clarify definitions.

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

1. Request Information (1 of 3)

A. The State of Arkansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Living Choices Assisted Living Waiver

C. Type of Request: amendment

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

- 3 years
- 5 years

Original Base Waiver Number: AR.0400

Waiver Number:AR.0400.R03.06

Draft ID: AR.016.03.04

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 02/01/16

Approved Effective Date of Waiver being Amended: 02/01/16

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

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

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

Individuals requiring a skilled level of care are not eligible for the Living Choices program. The State's definition of "skilled level of care" is set forth below at b-6-d.

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Living Choices Assisted Living waiver program allows individuals to live in apartment-style living units in licensed level II assisted living facilities and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity, and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes participants' personal decision-making while protecting their health and safety. The major goal of this program is to delay or prevent institutionalization of these individuals. However, assisted living services are not intended as a substitute for nursing facility or hospital care for individuals needing skilled care, as defined by State administrative rule which is set forth in B-6-d. 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 provider 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 an initial assessment completed by the Independent Assessment Contractor's. The annual evaluation is initiated by the DHS RN. Should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment.

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.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- Not Applicable**
- No**
- Yes**

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

- No**
- Yes**

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

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

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

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals

with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

Updates and revisions to the waiver are posted on both the DHS and Medicaid websites to allow for a general public comment period of at least 30 days. Notices of updates or revisions are also published in a statewide newspaper to allow for public review and comment. Regulations, policies, rules, and procedures are promulgated in accordance with the Arkansas Administrative Procedure Act. Promulgation includes review by three Arkansas legislative committees, which are open to the public and may include testimony by the public. After review by the committees, the regulations, policies, rules, and procedures are adopted and incorporated into the appropriate document. All provider manuals containing program rules are available to all providers and the general public via the Medicaid website.

Arkansas DHS has determined that this amendment is non-substantive. The 30-day public comment period will run simultaneously with the submission from October 11, 2020 through November 9, 2020. The notice of rulemaking will be published in the Arkansas Democrat-Gazette on October 11 through 13, 2020. The change will be posted on both the Arkansas Medicaid website and DHS website beginning October 9, 2020 through one month after the amendment is adopted, approximately February 1, 2021. There will be no public hearing for this amendment.

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

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

7. Contact Person(s)

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

Last Name:

Golden

First Name:

Mac

Title:

Attorney Specialist, Office of Policy Coordination & Promulgation

Agency:

Arkansas Department of Human Services

Address:

PO Box 1437, Slot S-295

Address 2:

City:

Little Rock

State: Arkansas

Zip: 72203-1437

Phone: (501) 320-6383 Ext: TTY

Fax: (501) 682-8009

E-mail: Mac.E.Golden@dhs.arkansas.gov

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

Last Name: Fisher

First Name: Ashely

Title: Assistant Director

Agency: Arkansas Dept. of Human Services, Division of Aging, Adult, and Behavioral Health Services

Address: P. O. Box 1437, Slot W-241

Address 2:

City: Little Rock

State: Arkansas

Zip: 72203-1437

Phone: (501) 320-6345 Ext: TTY

Fax: (501) 686-9182

E-mail: Ashley.Fisher@dhs.arkansas.gov

8. 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: Rachael Veregge

State Medicaid Director or Designee

Submission Date: Dec 8, 2020

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

Last Name: Hill

First Name: Jay

Title: Director,

Agency: Arkansas Department of Human Services; Division of Aging, Adult and Behavioral Health Services

Address: P.O. Box 1437 Slot W241

Address 2:

City: Little Rock

State: Arkansas

Zip: 72203-1437

Phone: (501) 320-6009 Ext: TTY

Fax: (501) 682-8155

E-mail: Jay.Hill@dhs.arkansas.gov

Attachments**Attachment #1: Transition Plan**

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

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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

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

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

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

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

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

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the state Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been

identified as the Single State Medicaid Agency.

(Complete item A-2-a).

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

Specify the division/unit name:

Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) and Division of Provider Services and Quality Assurance (DPSQA)

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

The 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 provider 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.

Appendix A: Waiver Administration and Operation

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

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

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

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).

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

Appendix A: Waiver Administration and Operation

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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.

Appendix A: Waiver Administration and Operation

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

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 DMS 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

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

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

Numerator: Number of participants with at least one service per month; Denominator:

Number of participants served.

Data Source (Select one):

Other

If 'Other' is selected, specify:

No Waiver Service Report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PDQA Request Forms

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

correctly paid only for the date of discharge; Denominator: Number of waiver claims reviewed from the Overlapping Services Report.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Overlapping Services Report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

ACES Report of Active Cases (Point in Time)

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Division of County Operations</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency), and the Division of Medical Services (DMS) (Medicaid agency) participate in team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement for measures related to administrative authority of the waiver.

In cases where the numbers of active participants and unduplicated participants served in the waiver are not within approved limits, remediation includes waiver amendments and possibly implementing a waiting list. DMS reviews and approves all policy and procedures (including waiver amendments) developed by DAABHS or DPSQA prior to implementation, as part of the Interagency Agreement. In cases where policy or procedures were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

In cases where there are problems with level of care determinations completed within specified time frames and by a qualified evaluator, additional staff training, staff counseling or disciplinary action may be part of remediation. In addition, if these problems arise, the LOC determination is completed upon discovery, the LOC determination may be redone and payments for services may be recouped. Similarly, remediation for service plans not completed in specified time frames includes completing the service plan upon discovery, additional training for staff and staff counseling or disciplinary action. DAABHS conducts all remediation efforts in these areas.

Remediation to address participants not receiving at least one waiver service a month in accordance with the service plan and the agreement with DMS includes closing a case, conducting monitoring visits, revising a service plan to add a service, checking on provider billing and providing training. DAABHS conducts remediation efforts in these areas, and the tool used for case record review documents and tracks remediation.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing

identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

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

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

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

N/A

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

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

Specify:

The participant remains in the waiver under the Aged group.

Appendix B: Participant Access and Eligibility

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

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

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

The limit specified by the state is (*select one*)

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

Specify the percentage:

- Other**

Specify:

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.
- The following percentage that is less than 100% of the institutional average:

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

- Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1300
Year 2	1300
Year 3	1300
Year 4	1725
Year 5	1725

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1200
Year 2	1200
Year 3	1200
Year 4	1200
Year 5	1200

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Entrance onto the Living Choices waiver program is on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements.

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

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

- a) Waiver application determination date for persons inadvertently omitted from the waiver waiting list (administrative error);
- b) Waiver application determination date for persons residing in a nursing facility and being discharged 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.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- §1634 State
- SSI Criteria State
- 209(b) State

2. Miller Trust State.

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

- No
- Yes

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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

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

under 42 CFR §435.217.

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by

law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the state plan**

Select one:

- SSI standard**
- Optional state supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(select one):

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

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the state Plan**

Specify:

- The following dollar amount**

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

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

Specify:

- Other**

Specify:

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

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

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

- Not Applicable**

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

Specify:

Specify the amount of the allowance (select one):

- SSI standard**
- Optional state supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

- The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (select one):

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

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

- The amount is determined using the following formula:**

Specify:

- Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (4 of 7)**

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- The following dollar amount:

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

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

Specify formula:

- Other

Specify:

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

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

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

Select one:

- Allowance is the same**
 Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By a government agency under contract with the Medicaid agency.

Specify the entity:

- Other**
Specify:

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

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.

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 DEFINITIONS:

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 (PCSP).

ASSESSMENT means the process completed by the Independent Assessment Contractor to collect information used in determining initial functional eligibility for waiver services.

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

EVALUATION means the process completed, at a minimum of every 365 days, by the DHS RN to determine continued functional eligibility or a change in medical condition that may impact continued functional eligibility.

FUNCTIONAL ELIGIBILITY means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one of three criteria, as determined by a licensed medical professional.

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.

REASSESSMENT means the process, completed at the request of DHS, by the independent assessment contractor to collect information used in determining continuing functional eligibility for waiver services.

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 State rule. The State rule defines "Skilled Level of Care" to mean 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:

- a. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure;
- b. Intravenous injections and hypodermoclysis or intravenous feedings;
- c. Levin tubes and nasogastric tubes;
- d. Nasopharyngeal and tracheostomy aspiration;
- e. Application of dressings involving prescription medication and aseptic techniques;
- f. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV;
- g. 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;
- h. Initial phases of a regimen involving administration of medical gases;
- i. 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;
- j. Ventilator care and maintenance; and
- k. The insertion, removal and maintenance of gastrostomy feeding tubes;

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.

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:

The Arkansas Independent Assessment (ARIA) collects information to used in determining functional eligibility. Registered nurses from the Independent Assessment Contractor will use the ARIA instrument to conduct face-to-face, in-home assessments and reassessments at the request of DHS. Using the information collected during the assessment, the Office of Long Term Care in DPSQA will evaluate whether an individual meets the State's functional eligibility criteria.

All State laws, regulations, and policies concerning functional eligibility criteria and the assessment instrument (including 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.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain

how the outcome of the determination is reliable, valid, and fully comparable.

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 functional eligibility 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 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.

- 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 assessment and subsequent reassessments when requested by the DHS RN, 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.

Evaluations will continue to be performed on at least an annual basis, with the functional eligibility re-affirmed or revised and a written determination issued by the Office of Long Term Care. A reassessment may also be ordered anytime (or scheduled on a more frequent than annual basis) by the DHS RN responsible for the participant's person-centered service plan, the 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), an evaluation will be performed by the DHS RN, who may request a reassessment to be completed by the Independent Assessment Contractor 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 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.

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 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.)

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

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

Specify the other schedule:

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

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- The qualifications are different.**
Specify the qualifications:

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

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 person-centered service plan so that no lapse in service occurs.

Specifically, DAABHS uses an online tracking tool with an interrogated dashboard functionality that DHS RNs and RN supervisors use to monitor upcoming review data and service plan expirations. The process of evaluation begins at a minimum of two months prior to the expiration date of the current person-centered service plan or at a minimum of two months prior to the annual anniversary date of the last functional eligibility determination evaluation, whichever is earlier.

On at least a monthly basis, the DHS RN will identify participants who are due for evaluation. The DHS RN will add the cases to the evaluation schedule. The DHS RN will use the online tracking tool, referenced above, to monitor for both the need for evaluation, and for timely completion of the reassessment by the Independent Assessment Contractor. Once it has been determined that functional eligibility continues, the DHS RN begins development of the new person-centered service plan.

Reassessments are ordinarily submitted to the Independent Assessment Contractor with a contractually-required 30-day time limit for completion of the reassessment. However, the contract also allows DHS, at its discretion, to submit reassessments with a 10-day time limit or a 7-day time limit when DHS deems it necessary.

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 an 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.

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

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative

		<p>Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px;"> <p>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.</p> </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<div style="border: 1px solid black; width: 100%; height: 50px;"></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px;"></div>

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative

		<p>Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px;"> <p>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.</p> </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<div style="border: 1px solid black; width: 100%; height: 40px; margin-bottom: 5px;"></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

Number and percentage of participants LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> 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.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monthly Level of Care Report

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

	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: 	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 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. </div>
<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

The state currently implements a system of monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected from individual participant records, aggregated to produce summation reports, and compared with periodic randomly sampled record reviews and sampled Program Integrity reviews.

Participant records undergo record reviews performed by DHS RN supervisors. Monthly activity reports track assessments and reassessments performed by the Independent Assessment Contractor. DHS RN reports are submitted to program RN supervisors and the Nurse Manager, who then review for timeliness and accuracy. The 45 Day Report tracks all waiver applications and identifies applications pending for more than 45 days. In addition, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) maintains a daily log of assessments and reassessments sent to the Division of Provider Services and Quality Assurance (DPSQA) (operating agency) Office of Long Term Care for medical determination. Data from all assessment and review activity is aggregated to produce an annual Record Review Summary, and Level of Care Monthly Report.

Level of Care is provided to all applicants for whom there is reasonable indication that services may be needed. DHS RN supervisors perform record reviews of individual participants and results are aggregated for the Record Review Summary Report. Enrolled participants are re-evaluated at least annually. The same record review process, described above, is utilized for the re-evaluation process. Cases are identified for re-evaluation through alerts in the ARIA assessment tool.

The assessment process and instruments described in the waiver are applied appropriately and according to the approved description to determine participant level of care. Record reviews include a review of assessment and reassessment functions, and their alignment with waiver guidelines and timeframes. Findings are aggregated and included in the annual Record Review Summary.

The DHS RN supervisory staff conducts random record reviews, in which all aspects of Living Choices policy are reviewed. The Annual Report is a compilation of the results of the review of the random record selection. The record review allows reviewers to evaluate trends and identify where additional training for DHS RNs is needed. Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including level of care determinations. DHS RN supervisory staff use the Raosoft calculation system to determine appropriate sample size for Record Review. This system provides a statistical valid sample based on a 95% confidence level with a margin of error of +/- 5%. A systematic random sampling of the active cases includes every "nth" name in the population.

The Division of Medical Services (DMS) QA review process includes review of the billing process by Living Choices Medicaid providers. The DMS QA review process reviews 20% of the records reviewed by DAABHS.

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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.

A functional eligibility determination of level of care is required annually, applying the functional eligibility criteria, with referral for use of the approved assessment instrument in the event of a change of condition that may affect functional eligibility. 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.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

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

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

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

At the time of assessment and re-assessment of the waiver participant, the 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 Department of Human Services (DHS) forms are available in English and Spanish. The forms can be translated into other languages when the need arises. DHS maintains an ongoing contract with a Spanish interpreter and translator agency for translation services.

All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. 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: Summary of Services Covered (1 of 2)

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

Service Type	Service		
Extended State Plan Service	Extended Medicaid State Plan Prescription Drugs		
Other Service	Living Choices Assisted Living Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Extended Medicaid State Plan Prescription Drugs

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Living Choices waiver participants are eligible for the same prescription drug benefits of regular Medicaid, plus three additional prescriptions beyond the Arkansas Medicaid State Plan Pharmacy Programs benefit limit. An extension of the monthly benefit limit is provided to waiver clients unless a client is eligible for both Medicaid and Medicare (dually eligible). No prior authorization is required for the three additional prescriptions for Living Choices clients.

A waiver client who is dually eligible must obtain prescribed medications through the Medicare Part D Prescription Drug Plan or, for certain prescribed medications excluded from the Medicare Part D plan, through the Arkansas Medicaid State Plan Pharmacy Plan. Medicare has no restrictions on the number of prescription drugs that can be received during a month.

Duplication of services or potential overlap of the scope of services is managed and monitored through the MMIS.

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

N/A

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Pharmacist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Extended Medicaid State Plan Prescription Drugs

Provider Category:

Individual

Provider Type:

Licensed Pharmacist

Provider Qualifications

License (specify):

Licensed as a pharmacist in the state of Arkansas, a pharmacist holding a current Pharmacy Permit issued by the Arkansas State Board of Pharmacy and issued a DEA number by the Drug Enforcement Agency.

The Division of Medical Services, Office of Long-Term Cares rules and regulations include specific experience, education and qualifications for Level II Assisted Living Facilities and their staff. Facilities must fulfill these regulations prior to licensure.

Certificate (specify):

Providers must also be enrolled with the Arkansas Division of Medical Services as a Medicaid State Plan Prescription Drug Program provider.

Other Standard (*specify*):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The Medicaid program's fiscal agent

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Living Choices Assisted Living Services

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02013 group living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Basic Living Choices Assisted Living direct care services are:

1. Attendant care services
2. Therapeutic social and recreational activities
3. Periodic nursing evaluations
4. Limited nursing services
5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing
6. Medication oversight to the extent permitted under Arkansas law
7. Assistance obtaining non-medical transportation specified in the plan of care

Assisted Living services are provided in a home-like environment in a licensed Level II Assisted Living Facility and include activities such as physical exercise, reminiscence therapy and sensorineural activities, such as cooking and gardening. These services are provided on a regular basis according to the clients plan of care and are not diversionary in nature.

Personalized care is furnished to persons who reside in their own living units/apartments at the facility that may include dually occupied units/apartments when both occupants consent to the arrangement that may or may not include kitchenette and/or living rooms and that contain bedrooms and toilet facilities. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence and provides supervision, safety and security. Other persons or agencies may also furnish care directly or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it.

Care must be furnished in a way that fosters the independence of each client to facilitate aging in place. Routines of care provision and service delivery must be consumer driven to the maximum extent possible and treat each person with dignity and respect.

Assisted living services may also include medication administration consistent with the Arkansas Nurse Practice Act and interpretation thereto by the Arkansas Board of Nursing; limited nursing services; periodic nursing evaluations and non-medical transportation specified in the plan of care. Nursing and skilled therapy services (except periodic nursing evaluation) are incidental rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision.

Living Choices waiver clients may receive services through the Medicaid State Plan that are not duplicative of assisted living waiver services. State plan services must be provided by qualified providers enrolled with the Medicaid agency as a provider of the specific service, (i.e. home health services, DME equipment, therapy services, prescription drugs), and who would have to meet the provider standards for the Medicaid State Plan service that is provided. The Medicaid State Plan services are not paid for through the waiver.

Attendant care services through Living Choices is the provision of assistance to a person who is medically stable and/or has a physical disability to accomplish tasks of daily living that the person is unable to complete independently, such as eating, dressing, bathing and personal hygiene, mobility and ambulation, and bowel and bladder requirements. Waiver attendant care services assist persons to remain independent as much as possible and to that extent are most often not provided as direct care to the total degree of doing the task or activity for the person. However, the required assistance may vary from actually doing a task for the person, assisting the person in performing the task himself or herself or providing safety support while the person performs the task. Attendant care services include oversight, supervision and cueing persons while performing a task. Incidental housekeeping and shopping for personal care items or food may be included in attendant care. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Preparation and serving of meals and laundry are in a congregate setting.

Pursuant to Act 1230 of 2001, the Arkansas Legislature defines limited nursing services as acts that may be performed by licensed personnel while carrying out their professional duties, but limited to those acts that the department (DHS) specifies by rule. Acts which may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department (DHS) for facilities offering assisted living services, shall not be complex enough to require twenty-four (24) hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces and splints (Ark. Code Ann. §20-10-1703).

Limited nursing services provided through the Living Choices waiver are not services requiring substantial and specialized nursing skills that are provided by home health agencies or other licensed health care agencies. Living Choices limited nursing services will be provided by registered nurses (RN), licensed practical nurses (LPN) and certified nursing assistants (CNA) who are employed or contracted with the assisted living facility. Limited nursing services include the assessment and monitoring of the waiver clients health care needs, including the preparation, coordination and implementation of services, in conjunction with the physician/primary care physician or community agencies as appropriate. LPN limited nursing services are provided under the supervision of the RN and include monitoring of the waiver clients health condition and notification of the RN if there are significant changes in the waiver clients health condition. Both the RN and LPN may administer medication and deliver medical services as provided by Arkansas law or applicable regulation. CNAs, under the supervision of an RN and LPN, may perform basic medical duties as set forth in Part II, Unit VII of the Rules and Regulations governing Long Term Care Facility Nursing Assistant Curriculum. These basic medical duties include taking vital signs (temperature, pulse, respiration, blood pressure, height/weight), and recognizing and reporting abnormal changes.

Therapeutic, social and recreational activities are activities that can improve a residents eating or sleeping patterns; lessen wandering, restlessness, or anxiety; improve socialization or cooperation; delay deterioration of skills; and improve behavior management. Therapeutic activities include gross motor activities (e.g., exercise, dancing, gardening, cooking, etc.); self-care activities (e.g., dressing, personal hygiene, or grooming); social activities (e.g., games, music, socialization); and, sensory enhancement activities (e.g., reminiscing, scent and tactile stimulation).

A periodic nursing evaluation by the ALF RN is required quarterly, and revisions made as needed. If required by licensing regulations, and an occupancy admission agreement is in place, the health care services plan portion of the occupancy admission agreement shall be revised within fourteen (14) days upon any significant enduring change to the resident and monitoring of the conditions of the residents on a periodic basis.

As described in B-6, 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 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. The Office of Long Term Care (OLTC) will use the assessment results to evaluate level of care for the waiver and medical eligibility for the waiver.

The daily rate pays for all direct care services in the participants plan of care. These rates are exclusive of room and board.

Potential overlap of the scope of services is managed and monitored through MMIS.

Limited nursing services provided through the Living Choices waiver are not services requiring substantial and specialized nursing skills that are provided by home health agencies or other licensed health care agencies. Living Choices limited nursing services will be provided by registered nurses (RN), licensed practical nurses (LPN) and certified nursing assistants (CNA) who are employed or contracted with the assisted living facility. Limited nursing services include the assessment and monitoring of the waiver clients health care needs, including the preparation, coordination and implementation of services, in conjunction with the physician/primary care physician or community agencies as appropriate. LPN limited nursing services are provided under the supervision of the RN and include monitoring of the waiver clients health condition and notification of the RN if there are significant changes in the waiver clients health condition. Both the RN and LPN may administer medication and deliver medical services as provided by Arkansas law or applicable regulation. CNAs, under the supervision of an RN and LPN, may perform basic medical duties as set forth in Part II, Unit VII of the Rules and Regulations governing Long Term Care Facility Nursing Assistant Curriculum. These basic medical duties include taking vital signs (temperature, pulse, respiration, blood pressure, height/weight), and recognizing and reporting abnormal changes.

Therapeutic, social and recreational activities are activities that can improve a residents eating or sleeping patterns; lessen wandering, restlessness, or anxiety; improve socialization or cooperation; delay deterioration of skills; and improve behavior management. Therapeutic activities include gross motor activities (e.g., exercise, dancing, gardening, cooking, etc.); self-care activities (e.g., dressing, personal hygiene, or grooming); social activities (e.g., games, music, socialization); and, sensory enhancement activities (e.g., reminiscing, scent and tactile stimulation).

A periodic nursing evaluation by the ALF RN is required quarterly, and revisions made as needed. If required by licensing regulations, and an occupancy admission agreement is in place, the health care services plan portion of the occupancy admission agreement shall be revised within fourteen (14) days upon any significant enduring change to the resident and monitoring of the conditions of the residents on a periodic basis.

As described in B-6, 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 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. The Office of Long Term Care (OLTC) will use the assessment results to evaluate level of care for the waiver and medical eligibility for the waiver.

The daily rate pays for all direct care services in the participants plan of care. These rates are exclusive of room and board.

Potential overlap of the scope of services is managed and monitored through MMIS.

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

N/A

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Level II Assisted Living Facility
Agency	Licensed Class A Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Living Choices Assisted Living Services

Provider Category:

Agency

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.

Certificate (*specify*):

Other Standard (*specify*):

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Living Choices Assisted Living Services

Provider Category:

Agency

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.

Certificate (specify):

Other Standard (specify):

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)

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

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

Check each that applies:

- As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*
- As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

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):

- No. The state does not conduct abuse registry screening.**
- Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

The Division of 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.

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

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

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

- Self-directed**
- Agency-operated**

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

- The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

All Living Choices waiver services may be provided by a family member of the participant when the family member is employed by the assisted living facility. 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.

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

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

Living Choices provider enrollment is open and continuous. Prospective Living Choices Assisted Living 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: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percentage of providers, by provider type, which maintained its license to participate in the waiver program in accordance with State law and waiver provider qualifications. Numerator: Number of providers with maintained license; Denominator: Total number of providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS Provider Report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of providers, by provider type, which obtained the appropriate license in accordance with State law and waiver provider qualifications prior to delivering services. Numerator: Number of new providers with appropriate license prior to delivery of services; Denominator: Number of new providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS Provider Report

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

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

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

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

Performance Measure:

Number and 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.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

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

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

Performance Measure:

Number and percent of providers meeting waiver provider training requirement as evidenced by the in-service attendance documentation. Numerator: Number of providers indicating training by in-service attendance documentation; Denominator: Total number of providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider In-Service Attendance Documentation

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

		Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input data-bbox="875 254 1235 327" type="text"/>

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 during the development of the person centered service plan 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.

Non-licensed/non-certified providers are not allowed to provide services under this waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

limits on the amount of waiver services (*select one*).

- Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet

requirements at the time of submission. Do not duplicate that information here.

Please see Module 1, Attachment #2 for the states HCB Settings Waiver Transition Plan.

Arkansas is still assessing settings compliance in accordance with the statewide transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the state**
- Licensed practical or vocational nurse, acting within the scope of practice under state law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

--

Appendix D: Participant-Centered Planning and Service Delivery

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

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

When scheduling the 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

a) 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 evaluations, based on reports secured through providers, waiver participants and their support systems.

(g)- Each evaluation of functional eligibility and development of a person-centered service plan 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 and service providers. 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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.

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 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 each evaluation. 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 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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.

During the completion of the person centered service plan, 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 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. DAABHS reviews a statistically valid random sampling of participant records which includes the service plan, and DMS reviews 20% of the records reviewed by DAABHS. 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.

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.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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, 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. DAABHS 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, and DMS reviews 20% of the records reviewed by DAABHS. The DAABHS 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.

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and 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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> 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.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">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.</div>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 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. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: *The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and 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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
--	---	---

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 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. </div>
<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and 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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

Agency		
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 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. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and 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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 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. </div>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 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. </div>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Number and percent of waiver participant records reviewed with an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with a choice between institutional care and waiver services and among waiver services; Denominator: Number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> 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.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state currently operates a system of review that assures completeness, appropriateness, accuracy and freedom of choice. This system focuses on participant-centered service planning and delivery, participant rights and responsibilities, and participant outcomes and satisfaction.

Individual records are reviewed monthly by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report. A Division of Medical Services (DMS) (Medicaid agency) QA audit is also conducted from a review of 20% of the records reviewed by DAABHS, to confirm that service plans are updated and revised as warranted by changes in participants' needs.

Start of Care forms are reviewed to confirm the appropriateness of service delivery.

Finally, records are reviewed to assure that a Freedom of Choice form was presented to the participant and that a complete, up-to-date list of providers has been made available to the participant.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Monthly chart reviews check for the presence of justification for requested changes and proper documentation and data is summarized for the Chart Review Summary.

Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers.

Remediation is performed on service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the RN supervisor and is a part of the chart review process.

The Division of Medical Services (DMS) QA review reflects internal review of the billing process by Medicaid providers of ALF. DMS conducts a record review on a monthly basis of 20% of the records reviewed by DAABHS to monitor accuracy and completeness of the record, service plan implementation, service delivery, and the health and welfare of the participant.

DAABHS supervisory staff uses the Raosoft calculation system to determine appropriate sample size for Chart Review and selects every "nth" name on the list to be included in the sample.

Record reviews of the overall program files are thorough and include a review of all required documentation regarding compliance with the service plan development assurance and service plan delivery. 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 service plan development, changes and renewal.

Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including service plan development and delivery of services. Initial verification of service delivery is verified via the Start of Care form. This documentation is a part of every record review.

The State Medicaid Agency assures compliance with the service plan subassurances through the review of 20% of the records reviewed by DAABHS. DAABHS provides DMS with copies of any data analysis of the findings and plans for remediation of data analysis, including trend identification. DMS and DAABHS participate in team meetings to review findings and discuss resolution.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency), and the Division of Medical Services (DMS) (Medicaid agency) participate in team meetings to discuss and address individual problems related to service plans, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures related to the service plans as part of the waiver.

If a participant record lacks required documentation regarding this assurance, DAABHS’s remediation includes completing the required documentation according to policy and additional staff training in this area.

The tool used to review waiver participants' records captures and tracks remediation in these areas.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The state requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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 person centered 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. During the development of the person centered service plan, if no change in provider is requested, the provider list is not signed by the participant.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights**Appendix F-3: State Grievance/Complaint System**

a. Operation of Grievance/Complaint System. *Select one:*

- No. This Appendix does not apply**
- Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

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 evaluation 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

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or

Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Arkansas state law requires that suspected abuse, neglect, and exploitation of endangered and impaired adults be reported to the Adult Maltreatment Hotline for investigation. 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 or injury which provoke fear or alarm; or unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Exploitation includes illegal or unauthorized use of the person's funds or property; or use of the person's power of attorney or guardianship for the profit of one's own self; or improper acts or process that deprive the person of rightful access to benefits, resources, belongings and assets. Neglect is an act or omission by the endangered or impaired person (self-neglect), or an act or omission by the person's caregiver (caregiver neglect) constituting failure to provide necessary treatment, care, food, clothing, shelter, supervision or medical services; failure to report health problems and changes in health condition to appropriate medical personnel; 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 during the development of the person centered service plan. 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: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 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.)*

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.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted through incident reports received and monitoring of the participant by the DHS RN, if needed.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. This oversight is conducted through incident reports received and monitoring of the participant by the DHS RN, if needed.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are

available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
 Yes. This Appendix applies (complete the remaining items)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

- c. Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

- i. Provider Administration of Medications.** Select one:

- Not applicable.** (do not complete the remaining items)
 Waiver providers are responsible for the administration of medications to waiver participants who

cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

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

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of unpreventable and preventable causes. Numerator: Number of deaths with unpreventable causes; Denominator: Number of deaths.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Unexpected Death Report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 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. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number of substantiated complaints. Numerator: Number of substantiated complaints; Denominator: Number of complaints.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaint Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 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. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of complaints addressed within required time frame.

Numerator: Number of complaints addressed in time frame; Denominator: Number of complaints.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaint Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input style="width: 100%; height: 20px;" type="text"/>		Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of critical incidents reviews/investigations that were initiated and completed according to program policy and state law. Numerator: Number of critical incident investigations initiated/completed according to policy/law; Denominator: Number of critical incidents reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 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. </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: 100px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: 100px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: 100px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: 100px;"></div>

Performance Measure:

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.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (check each that applies):

collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 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. </div>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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 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 during the development of each person centered service plan. 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 States 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 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.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

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.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px;">Ongoing, as needed</div>

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 H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one)*:

- No
- Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey :
- NCI Survey :
- NCI AD Survey :
- Other *(Please provide a description of the survey tool used):*

--

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.

Paid claims are compared to the person-centered service plan (PCSP) during the chart review process. Any claims paid over the authorized amount of services on the PCSP are recouped from the provider. Underutilization of services is researched to determine why the provider did not fully meet the PCSP authorized amounts and documented in the client's chart. If necessary, the PCSP is revised to reflect the actual amount of services needed to care for the beneficiary.

The Division of Medical Services (DMS) reviews a random selection of 20% of the charts reviewed by DAABHS during the chart review process. DMS verifies that the PCSP correlate to what the provider has billed. By the 15th day of each month, DMS requests the client charts. By the end of the month, DAABHS uploads the client charts selected. DMS compares the monthly amount paid to the Assisted Living Facility as shown in the database Cognos with the patient liability amount shown in MMIS for the past 12 months. DMS reports via a transmittal to DAABHS through the reporting system any discrepancies in the client chart such as billing, patient liability, dates, signatures, etc. to be sure the PCSP is in compliance with the waiver. At this point, DAABHS is responsible for any discrepancies, and if there is any remediation needed, DAABHS has up to 14 days to resolve the issue in order to complete the transmittal.

Desk audits are performed to review provider documentation that supports billing for the services. A random sampling approach is used in determining which provider to audit, with at least 10% of all providers selected annually for review of beneficiary files. Desk audits may also be performed when DAABHS becomes aware of potential irregularities, concerns, or complaints regarding a provider's billing practices. Desk audits will not evolve into on-site reviews. If DAABHS identifies an irregularity or concern in the course of a desk audit, the issue will be referred to the Office of Medicaid Inspector General (OMIG) for further review. Providers are notified of the desk audit findings by letter. Claims paid for services that are not documented according to the Medicaid policy are recouped and corrective action plans are required to be

implemented for all providers with billing errors.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number of failed MMIS edit checks which are corrected to assure appropriate for payment. Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Weekly Worksheets

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: 	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Daily Waiver Update Error Report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify: 	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	Ongoing	<i>Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	<input type="checkbox"/> Other <i>Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Daily LTC Update Error Report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample <i>Confidence Interval =</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
<input type="checkbox"/> Other <i>Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified <i>Describe Group:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other <i>Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	<input type="checkbox"/> Other <i>Specify:</i> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of waiver claims reviewed that were paid using the correct rate as specified in the waiver application. Numerator: Number of claims paid at correct rate; Denominator: Number of claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Recipient Claims History Profile (Chart Reviews)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample</i> <i>Confidence Interval =</i>

		<i>DMS 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.</i>
<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified Describe Group:</i> <input type="text"/>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>
	<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis(check each that applies):</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:
Number and percent of reviewed claims with services specified in the participants service plan. Numerator: Number of claims with services specified in service plan;
Denominator: Number of claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Recipient Profiles

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify:	

	<div style="border: 1px solid black; width: 80%; margin: 0 auto; height: 20px;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

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. As described below, a rate change takes effect 01/01/2019, with the implementation of the rate phased-in over two years.

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 after 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.

The current payment rate for WY1-WY3 includes rates for four payment tiers, based on the participant's acuity. The current rates are \$70.89, \$75.48, \$81.89, and \$85.35. The state's actuary calculated a composite average of these four rates, adjusted to reflect the distribution of participants between the four tiers, of \$80.33. The payment rate recommended by the actuary is \$62.89, which is a 20.7% decrease from the \$80.33 composite average rate. Because this is such a significant decrease, the state is proposing to phase-in the new rate over the remaining two years of the waiver, to allow providers and participants time to adjust and adapt to the new rate. The phase-in schedule that the state is currently proposing is to move to a single payment tier effective January 1, 2019, at the composite average rate of \$80.33, and then reduce the rate by \$4.36 every six months: On July 1, 2019, the rate will decrease to \$75.97; on January 1, 2020, the rate will decrease to \$71.61; on July 1, 2020, the rate will decrease to \$67.25; and on January 1, 2021, for the final month of the waiver, the rate will decrease to the actuary's recommended rate of \$62.89.

This rate may be interim, in that DAABHS intends to review the rate methodology in the first half of WY4. The purpose of this review is to gain a greater percentage of provider response to the provider surveys distributed by the Arkansas Medicaid program's contracted actuaries. The contracted actuaries will review the new round of provider survey results and then make recommendations for changes as appropriate. If the review results in revision to the rate, DAABHS will submit a waiver amendment to effectuate the revised rate.

Beyond the review in the first half of WY4, DAABHS will review the rate methodology no later than 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.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Living Choices providers bill for services and are reimbursed directly through MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures (select one):**

- No. state or local government agencies do not certify expenditures for waiver services.**
- Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies

that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. 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.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- No. The state does not make supplemental or enhanced payments for waiver services.**
- Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or

enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for

expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. **Voluntary Reassignment of Payments to a Governmental Agency.** Select one:

- No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** Select one:

- No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.**

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the**

delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer

(IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. *Services Furnished in Residential Settings. Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. *Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Room and board costs are separate and excluded from payments for services provided by assisted living facilities. The waiver recipient is responsible for paying room and board costs directly to the facility from their own income. To ensure that room and board is affordable for persons on the Living Choices waiver and within the participant's income, the room and board amount is deducted from the participant's income, just as the personal needs allowance amount is deducted. To cover room and board, 90.8% of the Individual SSI Federal Benefit Rate (FBR), rounded to the nearest dollar, can be set aside from the waiver recipients income. Nine percent of the Individual SSI FBR rounded to the nearest dollar is deducted for personal needs allowance.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. *Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim*

for federal financial participation. Select one:

- No. The state does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.*
- Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.*

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	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	19722.61	2457.00	22179.61	44598.00	2457.00	47055.00	24875.39
5	17516.60	2530.00	20046.60	45931.00	2530.00	48461.00	28414.40

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	1300		1300
Year 2	1300		1300
Year 3	1300		1300
Year 4	1725		1725
Year 5	1725		1725

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay on the waiver is estimated to be 255 days. This average was calculated as days of eligibility from the MMIS segments, using the Medicaid DSS (BusinessObjects). These numbers were determined by reporting the total days of waiver service (based on service eligibility days within the waiver year) for all participants and dividing by the unduplicated count of participants.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is derived from current reporting of expenditures from the Medicaid DSS (BusinessObjects) and consideration of previous waiver estimates of utilization and growth rates.

The unduplicated cap of 1300 was used as the number of users for WY1-WY3 as it is believed this cap will be reached each year. For WY4-WY5, the intent of the state is to expand the unduplicated cap to an amount sufficient to allow for full-year participation of each available slot. Given the average length of stay of 255 days, the state calculates 1,717 as the maximum number of unduplicated participants who can be served under a point-in-time (PIT) maximum of 1,200. The calculation is:

$$1,200 \text{ (max PIT cap)} \times 365 \text{ days} \div 255 \text{ days (avg. length of stay)} = 1,717$$

This exact amount was used for the estimated number of users in Appendix J-2-d. The state currently has a waiting list for this waiver, and the state does not expect demand for waiver services to decrease. Therefore, the state believes that an estimate of maximum usage is appropriate.

For purposes of calculating the requested increase in the unduplicated cap in Appendix B-3-a, the state rounded this amount up to 1,725 to allow for a small margin of error.

Extended Medicaid State Plan Prescription Drug costs were estimated based on actual costs from the previous 6 years of the waiver. The following factors were considered in the estimates:

- The number of users for SFY 2015 was 96. Since the point-in-time cap is being increased by 20%, the number of users is projected to increase by 4% in each of the 5 waiver years.

- An average of the units used per user over the last 6 years was determined to be 15.

- The average cost per unit over the past 6 years was determined to be \$62. There has been an average growth rate of 5.61% over the last 6 years, which is applied to the average cost per unit in each year of the waiver to allow for inflation of Rx drug costs. Please note that the average cost of drugs is not a rate set by the state, but is based on a negotiation between Arkansas Medicaid and prescription drug companies.

The current payment rate for WY1-WY3 includes rates for four payment tiers, based on the participant's acuity. The current rates are \$70.89, \$75.48, \$81.89, and \$85.35. The state's actuary calculated a composite average of these four rates, adjusted to reflect the distribution of participants between the four tiers, of \$80.33. The payment rate recommended by the actuary is \$62.89, which is a 20.7% decrease from the \$80.33 composite average rate.

Because this is such a significant decrease, the state is proposing to phase-in the new rate over the remaining two years of the waiver, to allow providers and participants time to adjust and adapt to the new rate. The phase-in schedule that the state is currently proposing is to move to a single payment tier effective January 1, 2019, at the composite average rate of \$80.33, and then reduce the rate by \$4.36 every six months: On July 1, 2019, the rate will decrease to \$75.97; on January 1, 2020, the rate will decrease to \$71.61; on July 1, 2020, the rate will decrease to \$67.25; and on January 1, 2021, for the final month of the waiver, the rate will decrease to the actuary's recommended rate of \$62.89. This phase-in schedule is the reason that the average unit cost for the composite tier in WY5 is lower than WY4.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' was computed based on what was done in prior years. Using the market basket forecasts and the related Living Choices report of all waiver eligible recipients annual expenditures were extracted from the decision support system (DSS) component of the MMIS. Note: Costs indicated for State Category of Service AL (Assisted Living Facility), and AX (Extension of 3 prescriptions for Assisted Living) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the ALF waiver recipients.

Medicare Part D has been in effect for approximately 10 years. Arkansas Medicaid has not paid for prescription drugs for Medicare recipients during this time. Thus, prescription drug costs of individuals receiving Medicare Part D are not contained in our source documents. Therefore, they do not need to be removed.

For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G, and G' in section J are the product of applying a geometric mean to three years of this BLS data.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS. Using the average annual expenditures for nursing home recipients and the market basket forecasts for the next 5 years. Factor G was computed for each of the 5 years of the waiver.

For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G, and G' in section J are the product of applying a geometric mean to three years of this BLS data.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' was derived using the same methodology as in prior years. It was computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS. Using the average annual expenditures for nursing home recipients. Note: Costs indicated for State Category of Service 58 (Private SNF), 59 (Private SNG Crossover), 62 (Public ICF Mentally Retarded), and 63 (Public SNF) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the ALF waiver.

For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G, and G' in section J are the product of applying a geometric mean to three years of this BLS data.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.*

<i>Waiver Services</i>	
<i>Extended Medicaid State Plan Prescription Drugs</i>	
<i>Living Choices Assisted Living Services</i>	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						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	
Composite Tier	1 Day	0	0.00	80.33	0.00	
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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						102960.00
GRAND TOTAL:						26155843.35
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20119.88
Average Length of Stay on the Waiver:						255

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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	
Composite Tier	1 Day	0	0.00	80.33	0.00	
GRAND TOTAL:						26155843.35
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20119.88
Average Length of Stay on the Waiver:						255

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						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	
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

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier Level 1	1 Day	182	255.00	70.89	3290004.90	
Composite Tier	1 Day	0	0.00	80.33	0.00	
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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						124320.00
Extended Medicaid State Plan Prescription Drugs	1 Month	112	15.00	74.00	124320.00	
Living Choices Assisted Living Services Total:						33897185.70
Tier Level 2	1 Day	0	0.00	75.48	0.00	
Tier Level 3	1 Day	0	0.00	81.89	0.00	
Tier Level 4	1 Day	0	0.00	85.35	0.00	
Tier Level 1	1 Day	0	0.00	70.89	0.00	
Composite Tier	1 Day	1717	255.00	77.42	33897185.70	
GRAND TOTAL:						34021505.70
Total Estimated Unduplicated Participants:						1725
Factor D (Divide total by number of participants):						19722.61
Average Length of Stay on the Waiver:						255

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg.

Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						136890.00
Extended Medicaid State Plan Prescription Drugs	1 Month	117	15.00	78.00	136890.00	
Living Choices Assisted Living Services Total:						30079264.50
Tier Level 2	1 Day	0	0.00	75.48	0.00	
Tier Level 3	1 Day	0	0.00	81.89	0.00	
Tier Level 4	1 Day	0	0.00	85.35	0.00	
Tier Level 1	1 Day	0	0.00	70.89	0.00	
Composite Tier	1 Day	1717	255.00	68.70	30079264.50	
GRAND TOTAL:						30216154.50
<i>Total Estimated Unduplicated Participants:</i>						1725
<i>Factor D (Divide total by number of participants):</i>						17516.60
<i>Average Length of Stay on the Waiver:</i>						255

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-265 PACE Disenrollment

C-265 PACE Disenrollment

MS Manual 01/01/21

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

1. The participant's failure to pay if he/she has a payment responsibility
2. The participant's disruptive or threatening behavior
3. The participant moving out of the PACE service delivery area
4. The participant no longer meeting the nursing facility Level of Care requirement
5. The participant's death
6. The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers
7. A PACE program agreement is not renewed

The PACE Organization may appeal an adverse decision to the Division of Aging, Adult and Behavioral Health Services (DAABHS). If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-600 Changes

I-630 ARChoices Waiver

I-630 ARChoices Waiver

MS Manual 01/01/21

Recipients will be advised to report any changes in the amount of household income or resources.

If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) determines that cost effectiveness is not met, that the client no longer meets the requirements for Intermediate Level of Care, or that the client is no longer receiving Waiver services, the County Office will be notified, and the Waiver case will be closed. If the Waiver case is closed for any reason, the eligibility worker will determine if the client is eligible for any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ARChoices Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month (e.g., land rent paid annually), procedures at [MS E-410](#) will be followed, advance notice given, and the case adjusted.

If the Waiver client will be ineligible for more than one month, the case will be closed and a new application will be required.

A Waiver client may appeal an adverse decision made on his/her case as outlined in [MS L 100-173](#) of the Medical Services Policy manual. If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-600 Changes

I-641 Temporary Absences from the Assisted Living Facility

I-640 Assisted Living Facility (ALF)

MS Manual 01/01/21

ALF Waiver recipients will be advised to report any changes in income or resources to the DHS County Office. If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or the Office of Long Term Care determines that cost effectiveness is not met or that the client no longer meets the requirements for an Intermediate Level of Care, the County Office will be notified and the ALF case will be closed. If the case is closed for any reason, the eligibility worker will determine if the client is eligible in any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ALF Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month, procedures at [MS E-410](#) will be followed, advance notice given, and the case adjusted at the appropriate time.

If the ALF recipient will be ineligible for more than one month, the case will be closed and a new application will be required to reopen.

An ALF Waiver recipient may appeal an adverse decision made on his/her case as outlined in [MS Section L](#). If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.

L-120 Continuation of Assistance or Services during Appeal Process

MS Manual 01/01/2021

In cases where an adverse action is taken against a beneficiary who qualifies for an institutional level of care (e.g. ARChoices, Living Choices, TEFRA, Autism, PACE, CES/DD, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and LTC/nursing home), if a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits pending the hearing decision, they must opt out.

In all other cases, if a petitioner files an appeal for a hearing within the ten (10) day notice period, or five (5) days in the case of probable fraud, the case will remain open at the petitioner's request until the hearing decision. Otherwise, benefits will NOT continue.

At the conclusion of the hearing, the hearing official will decide whether the case should be closed or services reduced prior to the rendering of the hearing decision. The criteria for determining whether adverse action is taken prior to the rendering of the hearing decision will be based on whether or not a fact or judgment situation exists. If it is determined that the sole issue is one of state or federal law or policy, the proposed action will be taken.

Examples of issues of fact:

- Verified earned or unearned income which caused net income to be in excess of the maximum income limitations.
- Protest of Agency Policy-The recipient agrees that his income or resources exceed the limitation but feels that the policy imposing these limitations is unreasonable.

If the sole issue is one of judgment relating to a state or federal law or policy, no adverse action is taken prior to the hearing decision.

Examples of judgment are:

- Disability in MRT cases.
- Value of real or personal property.

The petitioner will be advised at the beginning of the hearing that a decision will be made at the conclusion of the hearing regarding whether the benefits will be reduced or terminated prior to the rendering of the hearing decision. If the decision by the hearing official is to reduce or terminate benefits, a Notice of Action will be prepared by DCO and mailed for immediate action. This Notice is not an additional appealable adverse action as it is simply an affirmation of the agency's original action.

If a subsequent change in the petitioner's open case occurs that results in adverse action while the hearing decision is pending and the petitioner does not timely appeal that new adverse action, the change will occur on the date specified in the notice.