Request for a Amendment to a §1915(c) Home and Community-Based ServicesWaiver

1. Request Information

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. Waiver Number:AR.0400
Original Base Waiver Number: AR.0400

D. Amendment Number: AR0400.R04.016.04.07

E. Proposed Effective Date: (mm/dd/yy)
~~07/01/21~~11/11/023

Approved Effective Date: 07/01/21

2. Purpose of Amendment

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

Arkansas has an approved American Rescue Plan Act (ARP) Spending Plan under Section 9817 that outlines the Workforce Stabilization Incentive Program (Program). The effective dates of the Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program terms.

Likewise, due to the Appendix K expiration date, the State is seeking to amend the base waiver to include the current per person per day rate of $81.59, with an additional 5% differential for rural facilities which totals $85.67. The State has amended Appendix J to also reflect these rates.

3 Nature of 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
☐ Waiver Application	
☐ Appendix A: Waiver Administration and Operation	
☐ Appendix B: Participant Access and Eligibility	
☐ Appendix C: Participant Services	
☐ Appendix D: Participant Centered Service Planning and Delivery	
☐ Appendix E: Participant Direction of Services	
☐ Appendix F: Participant Rights	
☐ Appendix G: Participant Safeguards	
☐ Appendix H:	
☒ ~~☐~~ Appendix I: Financial Accountability	I-2: Rates, Billing and Claims I-3: Payment (3 of 7)
☒ ~~☐~~ Appendix J: Cost-Neutrality Demonstration	J-1:Composite Overview J-2: Derivation of Estimates

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 provider qualifications**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

The State is seeking to amend the base waiver to add supplemental or enhanced payments for waiver services as specified in Appendix I.

7.Contact Person(s)

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

Last Name: ~~Gann~~Jay

First Name: ~~Patricia~~Hill

Title: ~~Deputy Director~~Division 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) ~~682-1971~~686-9981 **Ext:** ☐ **TTY**

Fax: (501) 686-9182

E-mail: ~~Patricia.Gann~~Jay.Hill@dhs.arkansas.gov

6.Additional Requirements

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.

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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**.

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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.

Notices of amendments and renewals of the waiver are posted on the DMS website [insert web address] for at least 30 days to allow for the general public to submit comments on changes. Notices of amendments and renewals are also published in a statewide newspaper with instruction for submitting comments to DMS.

The public notice for this waiver renewal was published in the Arkansas Democrat-Gazette on [insert dates]~~April 14-16, 2021~~. The comment period ended xx/xx/xxxx.~~May 13, 2021~~ Physical copies of the proposed waiver amendment were mailed to constituents upon request. A public hearing was held on [insert date]~~April 16, 2020~~. No comments were received.

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.

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).*

DMS is responsible for the oversight of rate determinations with consultation by DAABHS. There is an established procedure followed by DMS to conduct rate studies, get provider input, and rebase rates when needed. Rates are published for public comment and are made available to all providers before implementation of the new rate via an official notice from DMS. Upon enrollment with Medicaid, new providers are referred to the Arkansas Medicaid website which has published fee schedules. Various methodologies are used for rate determination depending on the waiver service.

Throughout the Covid 19 pandemic and National Public Health Emergency, there has been an increase in the need for direct care staff with increased provider personnel cost due to workforce shortages. Arkansas updated the per person per day rate due to this reason through an Appendix K.

The State will continue to utilize the approved Appendix K per person per day rate of $81.59 with an additional 5% differential for rural facilities, which totals $85.67 until data can be received and verified in accordance with Arkansas law, and if warranted, the State will seek any needed amendments.

~~*The Division of Medical Services is required to conduct rate reviews for every Medicaid program in a three year cycle. Living Choices rates were reviewed in 2021 (year 3 of the cycle). The rates were updated last in 2019. The most recent*~~

~~review indicated that no rate rebasing was needed.~~

The rates may be found at https://humanservices.arkansas.gov/wp-content/uploads/LCAL-fees.pdf

~~*Assisted Living Facility Rate Determination Methods: This waiver renewal 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 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).*~~

The rate methodology excludes reimbursement of room and board costs. *The rates are not funded through ARP funding.*

The new methodology and resulting 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 waiver renewal to CMS for federal review and approval, DHS engaged in various opportunities for public comment including a webinar. These are in addition to the public comment process for this waiver renewal and the revised provider manual. Further, both the waiver renewal and the revised provider manual undergo prior review by Arkansas legislative committees.

See Main Section 6-I for additional information.

Entities Responsible for Rate Determination and Oversight of Rate Determination Process: 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 is responsible for day-to-day waiver administration, service planning, and access and care delivery in the waiver and DPSQA is 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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

a. 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.

Arkansas has an approved American Rescue Plan Act (ARP) Spending Plan under section 9817 that outlines the Workforce Stabilization Incentive Program. The effective dates of the Workforce Stabilization Incentive Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program. Arkansas has designed a HCBS Workforce Stabilization Incentive Program to allow providers to customize resources that best fit their organization's size, operational needs, and business priorities. The State allotted funding to providers using the following incentive categories:

Hiring bonus: new direct service providers (DSPs) hired during the ARP effective period (i.e., October 1, 2021 through March 31, 2025) may receive a hiring/recruitment payment after completing a minimum of thirty (30) calendar days of employment. The payment may be made in installments based on the provider's business model but cannot exceed $1,000 per employee or contractor. Longevity bonus: longevity payments for DSPs who continuously provide service with the same employer for a minimum of three (3) months. The bonus cannot be paid in a one-time lump sum and must recur on a regular cadence determined by the employer. The recurring bonus can be paid through March 31, 2025, or until the provider allocation is depleted. Individual DSPs can earn bonuses up the Longevity Bonus cap but cannot exceed $15,000 total per employee or contractor. Complex Care Longevity bonus: complex care longevity payments for DSPs who provide care to at least one (1) individual with complex care needs. Bonus payments are provided on regular and recurring basis determined by the employer and is based upon the DSPs experience, commitment and need for the employee to continue to work with the complex care recipient. DSPs can earn bonuses up to the Complex Care Longevity Bonus cap but cannot exceed $3,500 total per employee or contractor. Complex Care means a history of: legal involvement, elopement risk, combative or aggressive behavior, multiple inpatient placements, DCFS or DYS involvement, or wheelchair or bed bound.

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	*17209.55*	*2173.00*	*19382.55*	*40959.00*	*1687.00*	*42646.00*	*23263.45*
2	*17209.55*	*2244.00*	*19453.55*	*42296.00*	*1742.00*	*44038.00*	*24584.45*
3	*~~21368.222~~ 1368.22*	*2317.00*	*~~19526.55~~ 23685.22*	*43677.00*	*1799.00*	*45476.00*	*~~25949.45~~ 21790.78*
4	*17209.55 21368.22*	*2393.00*	*~~19602.55~~ 23761.22*	*45102.00*	*1858.00*	*46960.00*	*~~27357.45~~ 23198.78*
5	*17209.55 21368.22*	*2471.00*	*~~19680.55~~ 23839.22*	*46574.00*	*1919.00*	*48493.00*	*~~28812.45~~ 24653.78*

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

a. 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 and consideration of previous waiver estimates of utilization and growth rates. Factor D was calculated utilizing data from 01/01/2019 through

12/31/2019.

The unduplicated cap of 1725 was used as the number of users for WY1-WY5 to allow for full-year participation of each available slot. Given the average length of stay of 291 days, the state calculates 1,505 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 (max PIT cap) x 365 days ÷ 291 days (avg. length of stay) = 1,505

This exact amount was used for the estimated number of users in Appendix J-2-d. Units per user was calculated based on actual usage from 02/01/2016-01/31/2019

Extended Medicaid State Plan Prescription Drug costs were estimated based on actual costs from the previous 5 years of the waiver. The most recent data from Medicaid DSS shows that this service cost has remained constant, therefore, we do not anticipate an increase in utilization of this service. The number of users for this service has increased over the last 5 years and have been updated to reflect more users of this service.

The Extended Medicaid State Plan Prescription Drug service was calculated utilizing the actual cost of services from 02/01/2016-01/31/2019.

The State will continue to utilize the approved Appendix K per person per day rate of $81.59 with an additional 5% differential for rural facilities, which totals $85.67 until data can be received and verified in accordance with Arkansas law, and if warranted, the State will seek any needed amendments.

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*	*ComponentCost*	*Total Cost*
Extended Medicaid State Plan Prescription Drugs Total:						***234000.00***
Extended Medicaid State Plan Prescription Drugs	*1 Month*	*250*	*12.00*	*78.00*	***234000.00***	
Living Choices Assisted Living Services Total:						~~***29452473.75***~~ ***36626176.65***
Living Choices Assisted Living Service	*1 Day*	*1505*	*291.00*	~~*67.25*~~ *83.63*	~~***29452473.75***~~ ***36626176.65***	
				GRAND TOTAL:	~~***29686473.75***~~ ***36860176.65***	
				Total Estimated Unduplicated Participants:	***1725***	
				Factor D (Divide total by number of participants):	~~***17209.55***~~ ***21368.22***	
				Average Length of Stay on the Waiver:	*291*	

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	ComponentCost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
Extended Medicaid State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						36,626,176.65 ~~29452473.75~~
Living Choices Assisted Living Service	1 Day	1505	291.00	~~67.25~~ 83.63	36,626,176.65 ~~29452473.75~~	
				GRAND TOTAL:	38,966,260.28 ~~29686473.75~~	
				Total Estimated Unduplicated Participants:	1725	
				Factor D (Divide total by number of participants):	22,589.14 ~~17209.55~~	
				Average Length of Stay on the Waiver:	291	

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	ComponentCost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
Extended Medicaid State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						36,626,176.65 ~~29452473.75~~
Living Choices Assisted Living Service	1 Day	1505	291.00	~~67.25~~ 83.63	36,626,176.65 ~~29452473.75~~	
				GRAND TOTAL:	~~29686473.75~~ 36860176.65	
				Total Estimated Unduplicated Participants:	1725	
				Factor D (Divide total by number of participants):	~~17209.55~~ 21368.22	
				Average Length of Stay on the Waiver:	291	

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

C. Waiver Number:AR.0400
Original Base Waiver Number: AR.0400

D. Amendment Number: AR0400.R04.016.04.07

E. Proposed Effective Date: (mm/dd/yy)
11/11/2023
Approved Effective Date: 07/01/21

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- ☐ **Add/delete services**
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Specify:

The State is seeking to amend the base waiver to add supplemental or enhanced payments for waiver services as specified in Appendix I.

7.Contact Person(s)

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

Last Name: Jay

First Name: Hill

Title: Division Director

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

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Phone: (501) 686-9981 **Ext:** ☐ **TTY**

Fax: (501) 686-9182

E-mail: Jay.Hill@dhs.arkansas.gov

6.Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for

each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Policy and form revisions, procedural changes and clarifications have been made through the years based on input from participants, family, and providers. Comments have been reviewed and appropriate action 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.

Notices of amendments and renewals of the waiver are posted on the DMS website [insert web address] for at least 30 days to allow for the general public to submit comments on changes. Notices of amendments and renewals are also published in a statewide newspaper with instruction for submitting comments to DMS.

The public notice for this waiver renewal was published in the Arkansas Democrat-Gazette on [insert dates]. The comment period ended xx/xx/xxxx. Physical copies of the proposed waiver amendment were mailed to constituents upon request. A public hearing was held on [insert date]. No comments were received.

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.

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).*

DMS is responsible for the oversight of rate determinations with consultation by DAABHS. There is an established procedure followed by DMS to conduct rate studies, get provider input, and rebase rates when needed. Rates are published for public comment and are made available to all providers before implementation of the new rate via an official notice from DMS. Upon enrollment with Medicaid, new providers are referred to the Arkansas Medicaid website which has published fee schedules. Various methodologies are used for rate determination depending on the waiver service.

Throughout the Covid 19 pandemic and National Public Health Emergency, there has been an increase in the need for direct care staff with increased provider personnel cost due to workforce shortages. Arkansas updated the per person per day rate due to this reason through an Appendix K.

The State will continue to utilize the approved Appendix K per person per day rate of $81.59 with an additional 5% differential for rural facilities, which totals $85.67 until data can be received and verified in accordance with Arkansas law, and if warranted, the State will seek any needed amendments.

The rates may be found at https://humanservices.arkansas.gov/wp-content/uploads/LCAL-fees.pdf

. For purposes of this waiver, "assisted living facility" means a Medicaid-certified and enrolled assisted living facility with a Level II license..

The rate methodology excludes reimbursement of room and board costs. The rates are not funded through ARP funding.

The new methodology and resulting 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 waiver renewal to CMS for federal review and approval, DHS engaged in various opportunities for public comment including a webinar. These are in addition to the public comment process for this waiver renewal and the revised provider manual. Further, both the waiver renewal and the revised provider manual undergo prior review by Arkansas legislative committees.

See Main Section 6-I for additional information.

Entities Responsible for Rate Determination and Oversight of Rate Determination Process: 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 is responsible for day-to-day waiver administration, service planning, and access and care delivery in the waiver and DPSQA is 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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

a. 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.

Arkansas has an approved American Rescue Plan Act (ARP) Spending Plan under section 9817 that outlines the Workforce Stabilization Incentive Program. The effective dates of the Workforce Stabilization Incentive Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program. Arkansas has designed a HCBS Workforce Stabilization Incentive Program to allow providers to customize resources that best fit their organization's size, operational needs, and business priorities. The State allotted funding to providers using the following incentive categories:

Hiring bonus: new direct service providers (DSPs) hired during the ARP effective period (i.e., October 1,

2021 through March 31, 2025) may receive a hiring/recruitment payment after completing a minimum of thirty (30) calendar days of employment. The payment may be made in installments based on the provider's business model but cannot exceed $1,000 per employee or contractor. Longevity bonus: longevity payments for DSPs who continuously provide service with the same employer for a minimum of three (3) months. The bonus cannot be paid in a one-time lump sum and must recur on a regular cadence determined by the employer. The recurring bonus can be paid through March 31, 2025, or until the provider allocation is depleted. Individual DSPs can earn bonuses up the Longevity Bonus cap but cannot exceed $15,000 total per employee or contractor. Complex Care Longevity bonus: complex care longevity payments for DSPs who provide care to at least one (1) individual with complex care needs. Bonus payments are provided on regular and recurring basis determined by the employer and is based upon the DSPs experience, commitment and need for the employee to continue to work with the complex care recipient. DSPs can earn bonuses up to the Complex Care Longevity Bonus cap but cannot exceed $3,500 total per employee or contractor. Complex Care means a history of: legal involvement, elopement risk, combative or aggressive behavior, multiple inpatient placements, DCFS or DYS involvement, or wheelchair or bed bound.

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	17209.55	2173.00	19382.55	40959.00	1687.00	42646.00	23263.45
2	17209.55	2244.00	19453.55	42296.00	1742.00	44038.00	24584.45
3	2 1368.22	2317.00	23685.22	43677.00	1799.00	45476.00	21790.78
4	17209.55 21368.22	2393.00	23761.22	45102.00	1858.00	46960.00	23198.78
5	17209.55 21368.22	2471.00	23839.22	46574.00	1919.00	48493.00	24653.78

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

a. 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 and consideration of previous waiver estimates of utilization and growth rates. Factor D was calculated utilizing data from 01/01/2019 through 12/31/2019.

The unduplicated cap of 1725 was used as the number of users for WY1-WY5 to allow for full-year participation of each available slot. Given the average length of stay of 291 days, the state calculates 1,505 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 (max PIT cap) x 365 days ÷ 291 days (avg. length of stay) = 1,505

This exact amount was used for the estimated number of users in Appendix J-2-d. Units per user was calculated based on actual usage from 02/01/2016-01/31/2019

Extended Medicaid State Plan Prescription Drug costs were estimated based on actual costs from the previous 5 years of the waiver. The most recent data from Medicaid DSS shows that this service cost has remained constant, therefore, we do not anticipate an increase in utilization of this service. The number of users for this service has increased over the last 5 years and have been updated to reflect more users of this service.

The Extended Medicaid State Plan Prescription Drug service was calculated utilizing the actual cost of services from

02/01/2016-01/31/2019.

The State will continue to utilize the approved Appendix K per person per day rate of $81.59 with an additional 5% differential for rural facilities, which totals $85.67 until data can be received and verified in accordance with Arkansas law, and if warranted, the State will seek any needed amendments.

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*	*ComponentCost*	*Total Cost*
Extended Medicaid State Plan Prescription Drugs Total:						***234000.00***
Extended Medicaid State Plan Prescription Drugs	*1 Month*	*250*	*12.00*	*78.00*	***234000.00***	
Living Choices Assisted Living Services Total:						***36626176.65***
Living Choices Assisted Living Service	*1 Day*	*1505*	*291.00*	*83.63*	***36626176.65***	

GRAND TOTAL:	***36860176.65***
Total Estimated Unduplicated Participants:	***1725***
Factor D (Divide total by number of participants):	***21368.22***
Average Length of Stay on the Waiver:	*291*

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*	*ComponentCost*	*Total Cost*
Extended Medicaid State Plan Prescription Drugs Total:						***234000.00***

Extended Medicaid State Plan Prescription Drugs	*1 Month*	*250*	*12.00*	*78.00*	***234000.00***	
Living Choices Assisted Living Services Total:						***36,626,176.65***
Living Choices Assisted Living Service	*1 Day*	*1505*	*291.00*	*83.63*	***36,626,176.65***	

GRAND TOTAL:	***38,966,260.28***
Total Estimated Unduplicated Participants:	***1725***
Factor D (Divide total by number of participants):	***22,589.14*** ~~***Average Length of Stay on the Waiver:***~~ *291*

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***	***ComponentCost***	***Total Cost***
Extended Medicaid State Plan Prescription Drugs Total:						***234000.00***
Extended Medicaid State Plan Prescription Drugs	*1 Month*	*250*	*12.00*	*78.00*	***234000.00***	
Living Choices Assisted Living Services Total:						***36,626,176.65***
Living Choices Assisted Living Service	*1 Day*	*1505*	*291.00*	*83.63*	***36,626,176.65***	

GRAND TOTAL:	***36860176.65***
Total Estimated Unduplicated Participants:	***1725***
Factor D (Divide total by number of participants):	***21368.22***
Average Length of Stay on the Waiver:	*291*

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.R06.02

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

~~01/01/23~~11/11/2023

Approved Effective Date: 01/01/23
Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

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

~~The amendment to the waiver allows ARChoices services to be provided to inpatients of acute care hospitals in certain circumstances and such services may be covered and reimbursable on days when the participant has been admitted to an inpatient acute care hospital, though the provided attendant care services may not exceed approved prior authorized rate for the service in place prior to hospitalization. The projected annual cost of this change for state fiscal year (SFY) 2023 is $240,276 (federal share of $172,086) and for SFY 2024 is $480,552 (federal share of $344,171).~~

~~Currently, Attendant Care Services cannot be provided to ARChoices clients while they are admitted tp acute care hospitals. The federal CARES Act, however, contains a provision for attendant care services for HCBS waiver clients while admitted to acute care hospitals to speed recovery and allow for hospital services not otherwise provided. The amendment provides that Attendant Care Services can be provided to ARChoices clients while they are an admitted to acute care hospitals and will be reimbursable to providers under this change. ARChoices attendant care services to be provided to inpatients of acute care hospitals if the services are (a) identified in an individual's person-centered plan (or comparable plan of care), (b) provided to meet needs of the individual that are not met through the provision of hospital services; (c) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under applicable requirement; and (d) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities. The provided attendant care services may not exceed approved prior authorized rate for the service in place prior to hospitalization.~~

~~The state chooses the option to provide HCBS (attendant care services) in acute care hospitals under the following conditions:~~
~~a) The HCBS are provided to meet needs of the individual that are not met through the provision of acute care hospital services;~~
~~b) The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;~~
~~c) The HCBS must be identified in the individual's person-centered service plan; and~~
~~The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.~~

Arkansas has an approved American Rescue Plan Act ~~(ARP)~~ Spending Plan under section 9817 that outlines the Workforce Stabilization Incentive Program. The effective dates of the Workforce Stabilization Incentive Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program terms in Appendix I.

~~d)~~

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
☐ Waiver Application	
☐ Appendix A: Waiver Administration and Operation	
☐ Appendix B: Participant Access and Eligibility	
☐ Appendix C: Participant Services	
☐ Appendix D: Participant Centered Service Planning and Delivery	
☐ Appendix E: Participant Direction of Services	
☐ Appendix F: Participant Rights	
☐ Appendix G: Participant Safeguards	
☐ Appendix H:	
☒ Appendix I: Financial Accountability	I-3: Payment (3 of 7)
☐ 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 provider qualifications**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

The State is seeking to amend the base waiver to add supplemental or enhanced payments for waiver services as specified in Appendix I.

6.Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except

when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Policy and form revisions, procedural changes, and clarifications are based on input from participants, caregivers (related and non-related), and providers. Comments are reviewed and appropriate action taken to incorporate changes or modifications to benefit participants, 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.

Notices of amendments and renewals of the waiver are posted on the DHS website [insert web address] for at least 30 days to allow the general public to submit comments on changes. Notices of amendments and renewals are also published in a statewide newspaper with instructions for submitting comments to DMS.

The public notice for this amendment was published in the Arkansas Democrat-Gazette for three consecutive days from xx/xx/xxxx to xx/xx/xxxx. The 30-day public comment period ended xx/xx/xxxx. Physical copies of the entire proposed waiver renewal were mailed to constituents upon request and were posted on the DHS website on the proposed rules page at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. The entire proposed waiver amendment was also emailed to an Interested Parties list.

Commenters could submit comments to either an email address or a physical address. DHS received public comments on this amendment, please see Main, Optional Additional information for the comment and response.

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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

a. 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.***

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

1. Request Information

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B. Program Title:
ARChoices in Homecare

C. Waiver Number:AR.0195
Original Base Waiver Number: AR.0195.

D. Amendment Number:AR.0195.R06.02

E. Proposed Effective Date: (mm/dd/yy)
11/11/2023
Approved Effective Date: 01/01/23
Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

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

Arkansas has an approved American Rescue Plan Act Spending Plan under section 9817 that outlines the Workforce Stabilization Incentive Program. The effective dates of the Workforce Stabilization Incentive Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program terms in Appendix I.

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
☐ Waiver Application	
☐ Appendix A: Waiver Administration and Operation	
☐ Appendix B: Participant Access and Eligibility	
☐ Appendix C: Participant Services	
☐ Appendix D: Participant Centered Service Planning and Delivery	
☐ Appendix E: Participant Direction of Services	
☐ Appendix F: Participant Rights	
☐ Appendix G: Participant Safeguards	
☐ Appendix H:	
☒ Appendix I: Financial Accountability	**I-3: Payment (3 of 7)**
☐ 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 provider qualifications**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

The State is seeking to amend the base waiver to add supplemental or enhanced payments for waiver services as specified in Appendix I.

6.Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances

and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Policy and form revisions, procedural changes, and clarifications are based on input from participants, caregivers (related and non-related), and providers. Comments are reviewed and appropriate action taken to incorporate changes or modifications to benefit participants, 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.

Notices of amendments and renewals of the waiver are posted on the DHS website [insert web address] for at least 30 days to allow the general public to submit comments on changes. Notices of amendments and renewals are also published in a statewide newspaper with instructions for submitting comments to DMS.

The public notice for this amendment was published in the Arkansas Democrat-Gazette for three consecutive days from xx/xx/xxxx to xx/xx/xxxx. The 30-day public comment period ended xx/xx/xxxx. Physical copies of the entire proposed waiver renewal were mailed to constituents upon request and were posted on the DHS website on the proposed rules page at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. The entire proposed waiver amendment was also emailed to an Interested Parties list.

Commenters could submit comments to either an email address or a physical address. DHS received public comments on this amendment, please see Main, Optional Additional information for the comment and response.

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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

a. 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.

Arkansas has an approved American Rescue Plan Act (ARP) Spending Plan under section 9817 that outlines the Workforce Stabilization Incentive Program. The effective dates of the Workforce Stabilization Incentive Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program. Arkansas has designed a HCBS Workforce Stabilization Incentive Program to allow providers to customize resources that best fit their organization's size, operational needs, and business priorities. The State allotted funding to providers using the following incentive categories:

Hiring bonus: new direct service providers (DSPs) hired during the ARP effective period (i.e., October 1, 2021 through March 31, 2025) may receive a hiring/recruitment payment after completing a minimum of thirty (30) calendar days of employment. The payment may be made in installments based on the provider's business model but cannot exceed $1,000 per employee or contractor. Longevity bonus: longevity payments for DSPs who continuously provide service with the same employer for a minimum of three (3) months. The bonus cannot be paid in a one-time lump sum and must recur on a regular cadence determined by the employer. The recurring bonus can be paid through March 31, 2025, or until the provider allocation is depleted. Individual DSPs can earn bonuses up the Longevity Bonus cap but cannot exceed $15,000 total per employee or contractor. Complex Care Longevity bonus: complex care longevity payments for DSPs who provide care to at least one (1) individual with complex care needs. Bonus payments are provided on regular and recurring basis determined by the employer and is based upon the DSPs experience, commitment and need for the employee to continue to work with the complex care recipient. DSPs can earn bonuses up to the Complex Care Longevity Bonus cap but cannot exceed $3,500 total per employee or contractor. Complex Care means a history of: legal involvement, elopement risk, combative or aggressive behavior, multiple inpatient placements, DCFS or DYS involvement, or wheelchair or bed bound.