

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers, according to established program guidelines.

Monitoring visits may be as frequent as necessary, within established Medicaid maximum allowable limitations.

Monitoring is allowed through regular contacts with service providers at least every other month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least monthly, that the beneficiary continues to participate in the service plan and is satisfied with services.

Face to face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case management providers must be certified by the Division of Provider Services and Quality Assurance of Aging and Adult Services on an annual basis, unless approved otherwise by the Division of Medical Services, based on performance evaluations or other approved data.

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TARGETED CASE MANAGEMENT SERVICES
[Target Group]

In order to be certified by the Division of Provider Services and Quality Assurance ~~Aging and Adult Services~~, the provider must meet the following qualifications:

- A. Be located in the state of Arkansas
- B. Be licensed as a Class A or Class B Home Health Agency or Private Care Agency by the Arkansas Department of Health or a unit of state government or be a private or public incorporated agency whose stated purpose is to provide case management to the elderly or adults with physical disabilities.
- C. Is able to demonstrate one year of experience in performing case management services (experience must be within the past 3 years);
- D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group (experience must be within the past 3 years);
- E. Have an administrative capacity to insure quality of services in accordance with state and federal requirements;
- F. Have the financial management capacity and system that provides documentation of services and costs;
- G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements;
- H. Be able to demonstrate that the provider has current liability coverage, and
- I. Employ qualified case managers who reside in or near the area of responsibility and who meet ~~must at least one of the following qualifications:~~
 1. Licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Certified Social Worker), a registered nurse, or a licensed practical nurse; Reside in or near the area of responsibility; and
 2. Have a bachelor's degree from an accredited institution in a health and human services or related field; or Be licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Social Worker or Licensed Certified Social Worker), a registered nurse or a licensed practical nurse; or
 3. Have two years' experience in the delivery of human services, including without limitation having performed satisfactorily as a case manager for a period of two years (experience must be within the past three years). Have a bachelor's degree from an accredited institution in a

health and human services field, plus two years' experience in the delivery of human services to the elderly.

Have performed satisfactorily as a case manager serving the targeted group for a period of two (2) years (experience must be within the past 3 years).

A copy of the current certification must accompany the provider application and Medicaid contract.

MARKKUP

TOC required

262.100 HCPCS Procedure Codes

7-1-204-
4-19

The following procedure codes must be billed for ARChoices Services.

Electronic and paper claims now require the same National Place of Service code.

Procedure Code	Modifiers	Description	Unit of Service	National POS for Claims
S5125		Attendant Care Services	15 minutes	12
S5125	U2	Agency Attendant Care Traditional	15 minutes	12, 99
S5170	U2	Home-Delivered Meals	1 meal	12
S5170		Frozen Home-Delivered Meal	1 meal	12
S5170	U1	Emergency Home Delivered Meals	1 meal	12
S5161	UA	Personal Emergency Response System	1 day	12
S5160		Personal Emergency Response System – Installation	One install	12
S5100	U1	Adult Day Services, 8 to 20 units per date of service	15 minutes	99
S5100		Adult Day Services, 21 to 40 units per date of service	15 minutes	99
S5100	TD, U1	Adult Day Health Services, 8 to 20 units per date of service	15 minutes	99
S5100	TD	Adult Day Health Services, 21 to 40 units per date of service	15 minutes	99
S5150		Respite Care – In-Home	15 minutes	12
S5135		Respite Care – Short-Term Facility-Based	15 minutes	99, 21, 32
T1005		Respite Care – Long-Term Facility-Based	15 minutes	21, 32, 99
T2015		Prevocational Services Skills Development	15 minutes	11, 12, 99
T2015	U3	Prevocational Services Career Exploration	15 minutes	11, 12, 99

262.220 Rounding

7-1-20

When a quotient contains decimals, look at the numbers after the decimal point.

- A. If the number after the decimal point is 500 (e.g., 3.500) or less (e.g., 3.495) round downward to the whole number displayed before the decimal point (three (3), in this example)
- B. If the number after the decimal is 501 (e.g., 3.501) or greater (e.g., 3.576) round upward to the whole number one (1) greater than the whole number displayed before the decimal point (four (4) in this example, because it is a whole number one greater than three (3)).

MARK-UP

TOC required

214.200 Service Plan Review and Renewal

7-1-2014-
19

- A. A personal care service plan ~~terminates~~ is effective for up to one (1) year after its initial or revised beginning date of service, unless described otherwise in this section ~~from the date of the beneficiary's last independent assessment.~~

DHS professional staff or contractor(s) designated by DHS must review the service plan no less often than once per year, unless described otherwise in this section. See **NOTE** below.

- B. Personal care services may not continue past the one-year anniversary of the last independent assessment ~~an initial or revised beginning date of service until DHS professional staff or contractor(s) designated by DHS authorizes a revised service plan, or renews, or extends the authorization of an existing service plan.~~

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

7-1-2014-
19

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.

As the ARChoices PCSP is effective for one (1) year from the date of the beneficiary's last independent assessment, ~~once signed by the DHS RN, 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 last independent assessment.~~ DHS RN's signature, 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 DHS RN's signature beneficiary's last independent assessment, 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.

215.200 Personal Care Provider's ~~Proposed Individualized Service Plan~~ Prior Authorization Request7-1-2014-
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- A. As part of each prior authorization request, each provider shall submit a complete and accurate form designated by DHS. ~~The provider is not required to submit a proposed Individualized Service Plan to DHS. The form must be prepared, certified, and signed by an Arkansas licensed registered nurse.~~
- B. The completed form designed by DHS shall include all information required ~~on the form~~ applicable to the individual beneficiary, including:

1. Beneficiary and provider information;
 2. Certification that the beneficiary's service plan will not duplicate any other in-home services of which the provider is aware; Detailed information concerning physician diagnosed physical and Behavioral Health Services conditions, identified physical dependency needs, and mental/cognitive status; and
 3. The total number of hours per month the provider seeks to offer the beneficiary; For each physical dependency need identified, written descriptions including:
 - a. The extent to which the beneficiary can personally perform individual task components of routines and activities of daily living;
 - b. The type and amount of assistance the beneficiary may need with each task thus identified, including the frequency (per day, week, or month, as applicable) of each task with which the beneficiary needs assistance and for which other sources of assistance are not available; and
 - c. The extent beyond which the beneficiary cannot personally perform individual task components or routines and activities of daily living;
 4. Detailed information on all personal assistance available to the beneficiary through other sources, including informal caregivers (e.g., family, friends), community organizations (e.g., Meals on Wheels), Medicare (e.g., Medicare home health aide services), or the beneficiary's Medicare Advantage health plan;
 5. The frequency of in-person supervisory visits to be made by an agency supervisor based on the specific needs of the beneficiary and the recommendations of an agency-designated registered nurse; and A proposed service plan, with proposed hours/minutes and frequency of needed tasks consistent with the Task and Hour Standards (as described in Section 240.100); and
 6. The signed approval of the beneficiary or the beneficiary's legal representative.
- C. When a beneficiary has two or more personal care providers, the providers should cooperate in the required nursing evaluation and the preparation and submission of the prior authorization request and completed form designated by DHS on behalf of the beneficiary.
- D. When an individual will receive some or all of his or her services in a congregate setting, the assessment must reflect the RN's determination that the individual is an appropriate candidate for services delivered in that setting. See Section 216.201 and Sections 220.110 through 220.112.
- E. Before furnishing any personal care services to an individual, the provider must prepare a complete and accurate Individualized Service Plan with proposed hours/minutes and frequency of needed tasks consistent with the aggregate number of hours authorized under the Task and Hour Standards (as described in Section 240.100). The service plan must be prepared, certified, and signed by a supervisor or registered nurse. The service plan and all subsequent revisions must be kept by the personal care provider as Documentation under Section 221.000.

215.320**Identifying Frequency of In-Person Supervisory Visits****7-1-20**

- A. A registered nurse designated by the personal care provider must identify and recommend the frequency for in-person visits to be made by the supervisor of the personal care aide, based on the specific needs of the beneficiary.
- B. The frequency of in-person visits shall be at least every 365 days and shall be determined jointly by the personal care provider and the beneficiary or the beneficiary's legal representative, based on the recommendations of the registered nurse.

- C. The individualized service plan must identify the agreed frequency, the risk factors that are specific to that beneficiary, and a justification for the agreed frequency. The risk factors identified by the service plan must include without limitation any relevant medical diagnoses; the beneficiary's mental status; the presence of family or other residents in the beneficiary's home, and the frequency of their presence; and the beneficiary's physical dependency needs, including the activities of daily living (ADL) with which the beneficiary needs assistance.
- D. If the frequency identified in the service plan is less than the frequency recommended by the registered nurse, the service plan shall identify the medical justification for the reduced frequency.
- E. If the beneficiary has a significant change of condition affecting a risk factor, the registered nurse shall review the frequency of in-person visits and recommend changes as appropriate.

215.330 Service Plan Revisions

7-1-2014-
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NOTE: Subsections (A) (3) and (B) are not applicable to IndependentChoices program.

- A. DHS professional staff or contractor(s) designated by DHS must authorizeA personal care provider must amend a beneficiary's individualized service plan to document any permanent service plan changes before the provider amends service delivery.
 - 1. For purposes of this requirement, a **permanent** service plan change is one expected to last thirty (30) days or more.
 - 2. Service plan revisions must be made if a beneficiary's condition changes to the extent that the personal care provider must modify, add or delete tasks.
 - 3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.
 - a. Changes in the amount, frequency or duration of a service must be documented in the medical record,
 - b. The reasons for the service variances must be written daily in the service documentation.
 - 4. All A Sservice plan revisions must be authorized by DHS professional staff or contractor(s) designated by DHS only if require the provider requests to increase or decrease the total monthly hours. to submit an amended prior authorization request. DHS professional staff or the DHS contractor will review the request and determine, based on application of the Task and Hour Standards described in Section 240.100, the amount of adjustment to make in prior authorized minutes. DHS professional staff or the DHS contractor will revise the number of minutes in Interchange.
- B. Providers may not reduce a beneficiary's services without prior authorization by DHS professional staff or contractor(s) designated by DHS
- C. The personal care provider must document medical reasons for service plan revisions.
- D. The new beginning date of service is the date authorized by DHS professional staff or contractor(s) designated by DHS.
- E. Service plan revisions and updates since the previous assessment must remain with the service plan. Updates since the previous assessment must include documentation of when and why the change occurred.

215.351 Service Plan Requirements for Multiple Providers

7-1-2014-
48

When a beneficiary receives services from more than one personal care provider, each provider must comply with the following requirements.

- A. Each provider must create an individualized service plan and collaborate with the beneficiary's other personal care provider(s) to create a comprehensive service plan.
 1. Each comprehensive service plan must clearly state which provider provides which services, where and on which day(s) they do so, which time(s) of day they furnish services and the maximum and minimum amount of time per day and per week that the provider will take to perform those services.
 2. Each comprehensive service plan must be authorized, signed and dated by the provider.
- B. Each time a personal care provider intends to revise or renew a comprehensive service plan, that provider must notify the beneficiary's other personal care provider(s) to agree on the revision or renewal and to submit the revised or renewed comprehensive plan to DHS professional staff or contractor(s) designated by DHS for approval.
- C. If the providers cannot agree on a comprehensive service plan, plan revision or plan renewal, the providers shall submit the various alternatives to DHS professional staff or contractor(s) designated by DHS, who shall determine the terms of the final comprehensive service plan.
- D. Any Medicaid provider having knowledge that another Medicaid provider has failed to comply with a service plan, including a comprehensive service plan, shall notify the DMS Director of such failure within ten (10) business days of the occurrence, or sooner if the beneficiary's life or health is threatened.

215.360 Changes of Condition

7-1-20

- A. The individualized service plan must identify individualized, beneficiary-specific standards based on the identified risk factors, for when a caregiver or supervisor must document and report any significant change in the beneficiary's condition. A significant change is one that exhibits a major decline or improvement in the physical or mental health status of the beneficiary.
- B. If a caregiver or supervisor observes a significant change of condition, the caregiver or supervisor must document and report the change of condition as required by the change-reporting standards contained in the beneficiary's individualized service plan. Documentation must include the time and date the change was identified by the caregiver and a full description of the change.
- C. Within twenty-four (24) hours of a significant change of condition being reported, a registered nurse must evaluate and document an assessment of the beneficiary, including without limitation the reported change of condition.
- D. A change of condition under this section may result in a change to the service plan or to the frequency of supervisory visits, but it does not automatically result in a new Independent Assessment by the DHS Independent Assessment Contractor. Independent Assessments or Reassessments are governed by the provisions of the Arkansas Independent Assessment Medicaid Provider Manual.

216.000 Coverage

**7-1-2014-
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- A. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, Level II assisted living facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State
 2. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family"
 3. Prior authorized by DHS professional staff or contractor(s) designated by DHS
 4. Provided by an individual who is
 - a. Qualified to provide the services;
 - b. Supervised by an individual meeting the qualification set forth in Section 220.100: ~~registered nurse (RN) or (when applicable) a Qualified Intellectual Disabilities Professional (QIDP) and~~
 - c. Not a member of the beneficiary's family; OR
 - d. Qualified to provide the service according to approved policy in the Independent Choices Program.
 5. Furnished in the beneficiary's home or, at the State's option, in another location
- B. Medicaid restricts coverage of personal care to services directly helping a beneficiary with certain specified routines and activities, regardless of the beneficiary's ability or inability to execute other non-covered routines and activities. Personal care services 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, subject to the restrictions on travel time in this section.
- C. Travel Time of Personal Care Aide Accompanying Beneficiary:
1. Personal care only covers personal care aide travel time when all of the following apply:
 - a. The personal care aide accompanies the beneficiary in the same vehicle as the beneficiary travels to and returns from a community location for medical appointment or community activity;
 - b. The travel time billed is solely for necessary time in transit from the beneficiary's home to the community location and the return travel from the community location to the beneficiary's home;
 - c. The beneficiary's participation in the local community activity is for the benefit of the beneficiary and to meet the beneficiary's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the personal care aide, a family member, the driver, or other passengers);
 - d. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;
 - e. The beneficiary's Individualized Service Plan includes Personal Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;
 - f. While in transit to and from the community location, the beneficiary requires, or is likely to need given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility/ambulating; and
 - g. The travel time is reasonable given driving distances, traffic conditions, and weather, with time and locations documented.
 2. Travel time is not reimbursable if any other adult person accompanying (or driving) the beneficiary is a family member and is reasonably able to assist the beneficiary in transit if needed.

3. Travel time accompanying a beneficiary will count against the total number of Personal Care hours per month authorized in the participant's Individualized Service Plan and prior authorization.

4. Requesting Hours for Travel Time of Attendant Accompanying Participant:

Beneficiaries vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of a personal care aide accompanying a beneficiary is incident to but itself not the ADL task of toileting or the ADL task of mobility/ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Personal Care hours, if any, associated solely with travel time of a personal care aide accompanying a beneficiary to a medical visit or community activity.

For an ARChoices beneficiary, the number of hours allowed for travel time of a personal care aide will be determined by the DHS nurse in the beneficiary's Person-Centered Service Plan.

For other beneficiaries, the provider may include in the prior authorization request justification for travel time, based on the beneficiary's community activities, need for a personal care aide to accompany them, and the distances and roundtrip travel times typically involved. Based on this information and consistent with the above requirements, the contractor designated by DHS to process prior authorization requests, or if there is no contractor designated by DHS, DHS professional staff, may increase the number of Personal Care hours per month covered in the Individualized Service Plan and prior authorization to reasonably accommodate the travel time of a personal care aide accompanying the beneficiary.

220.100

Service Supervision

7-1-2014-
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~~Effective for dates of service on and after March 1, 2008, RNs supervising RCF and ALF Personal Care providers' personal care aides shall write, in a designated area on form DMS-873, instructions to aides and comments regarding the beneficiary and/or the aide.~~

- A. The provider must assure that the delivery of personal care services by personal care aides is supervised.
 1. ~~A Supervisor must be a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning performed by a registered nurse (RN). An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.~~
 2. Alternatively, a Qualified Intellectual Disabilities Professional (QIDP) may fulfill the RN-supervision requirement for personal care services to beneficiaries residing in alternative living situations or alternative family homes, licensed and certified by DPSQA as personal care providers.
 3. ~~An individual who personally provides personal care services to a beneficiary may not supervise another personal care aide providing personal care services to that same beneficiary.~~
- B. The supervisor has the following responsibilities.
 1. The supervisor must instruct the personal care aide in
 - a. Which routines, activities and tasks to perform in executing a beneficiary's service plan;

- b. The minimum frequency of each routine or activity; and
 - c. The maximum number of hours per month of personal care service delivery, as authorized in the service plan.
 2. At least once a month, the supervisor must
 - a. Review the aide's records;
 - b. Document the record review; and
 - c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
 3. At least ~~annually~~ three times every 183 days (six months) at intervals no greater than 62 days, the supervisor must visit the beneficiary at the service delivery location to conduct on-site evaluation.
 - a. Medicaid requires that at least one of these supervisory visits annually must be when the aide is not present.
 - b. If the frequency of in-home supervisory visits for a beneficiary is greater than one annually, At least one visit must be while the aide is present and furnishing services.
 4. When the aide is present during the visit the supervising RN or QIDP must
 - a. Observe and document;
 - (1). The condition of the beneficiary;
 - (2). The type and quality of the personal care aide's service provision; ~~and~~
 - (3). The interaction and relationship between the beneficiary and the aide; ~~and~~
 - (4). Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.
 - b. Consult with the agency-designated registered nurse regarding modifications to Modify the service plan, if necessary, based on the observations and findings from the visit and document the consultation in the beneficiary's records; and,
 - c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
 5. When the aide is not present during the visit, the ~~supervising RN or QIDP~~ must
 - a. Observe and document the condition of the beneficiary;
 - b. Observe and document, from available evidence, the type and quality of the personal care aide's service provision; ~~and~~
 - c. Observe, document, and report any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits;
 - ~~ed.~~ Query the beneficiary or the beneficiary's representative and document pertinent information regarding the beneficiary's opinion of;
 - (1). The type and quality of the aide's service;
 - (2). The aide's conduct; and
 - (3). The adequacy of the working relationship of the beneficiary and the aide;
 - ~~de.~~ Consult with the agency-designated registered nurse regarding modifications to Modify the service plan, if necessary, based on observations and findings from the visit and document the consultation in the beneficiary's records; and
 - ~~fe.~~ Further instruct the aide, if necessary, and document the nature of and the reasons for further instructions.
- C. The provider must review the service plan and the aide's records as necessary, ~~but no less often than every 62 days.~~ The review will ensure that the daily aggregate time estimate in the service plan accurately reflects the actual average time the aide spends delivering personal care aide services to a beneficiary.

221.000

Documentation

7-1-2014-

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NOTE: This section is not applicable to the IndependentChoices program.

Rule D in this section is effective for dates of service on and after March 1, 2008.

The personal care provider must keep and make available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services and its authorized agents or officials; records including:

- A. If applicable, certification by the Home Health State Survey Agency as a participant in the Title XVIII Program. Agencies that provided Medicaid personal care services before July 1, 1986 are exempt from this requirement.
- B. When applicable, copies of pertinent residential care facility license(s) issued by the Office of Long Term Care.
- C. Medicaid contract.
- D. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers will be required, when requested by DHS, to provide payroll records to validate service plans and service logs.
- E. Documents signed by the ~~supervising RN supervisor or~~ Qualified Intellectual Disabilities Professional (QIDP), or agency-designated registered nurse including without limitation:
 1. The initial and all subsequent assessments.
 2. Instructions to the personal care aide regarding:
 - a. The tasks the aide is to perform;
 - b. The frequency of each task; and
 - c. The maximum number of hours and minutes per month of aide service authorized by DHS professional staff or contractor(s) designated by DHS.
 3. Notes arising from the ~~a~~ supervisor's visits to the service delivery location, regarding:
 - a. The condition of the beneficiary;
 - b. Evaluation of the aide's service performance;
 - c. The beneficiary's evaluation of the aide's service performance; and
 - d. Difficulties the aide encounters performing any tasks.
 4. The service plan and service plan revisions:
 - a. The justifications for service plan revisions;
 - b. Justification for emergency, unscheduled tasks; and
 - c. Documentation of prior or post approval of unscheduled tasks; and
 - d. Recommendation or justification for the frequency needed for in-person supervisory visits.
- F. Any additional or special documentation required to satisfy or to resolve questions arising during, from or out of an investigation or audit. "Additional or special documentation," refers to notes, correspondence, written or transcribed consultations with or by other healthcare professionals (i.e., material in the beneficiary's or provider's records relevant to the beneficiary's personal care services, but not necessarily specifically mentioned in the foregoing requirements). "Additional or special documentation," is not a generic designation for inadvertent omissions from program policy. It does not imply and one should not infer from it that, the State may arbitrarily demand media, material, records or

documentation irrelevant or unrelated to Medicaid Program policy as stated in this manual and in official program correspondence.

- G. The personal care aide's training records, including:
 - 1. Examination results;
 - 2. Skills test results; and
 - 3. Personal care aide certification.
- H. The personal care aide's daily service notes for each beneficiary, reflecting:
 - 1. The date of service;
 - 2. The routines performed on that date of service, noted to affirm completion of each task;
 - 3. The time of day the aide began performing the first service-plan-required task for the beneficiary;
 - 4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function;
 - 5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks; and
 - 6. The time of day the aide completed the last service-plan-required task for the day for that beneficiary.
- I. Notes, orders and records reflecting the activities of the physician, the agency-designated registered nurse, the supervisor supervising RN or QIDP, the aide and the beneficiary or the beneficiary's representative; as those activities affect delivering personal care services.

222.110 Conduct of Training

7-1-2014-
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NOTE: This section is not applicable to the IndependentChoices program.

- A. A personal care aide training program may be offered by any organization meeting the standards in this section for:
 - 1. Instructor qualifications;
 - 2. Content and duration of personal care aide training; and
 - 3. Documentation of personal care aide training and certification.
- B. Personal Care provider agencies conducting personal care aide training must maintain their training program documentation.
- C. Personal Care providers hiring or contracting with individuals or organizations to conduct personal care aide training must maintain the individual's or organization's training program documentation. The provider is responsible for maintaining the training program documentation file.
- D. Required training program documentation includes:
 - 1. The number of hours each of classroom instruction and supervised practical training;
 - 2. Names and qualifications of instructors and copies of licenses of supervising registered nurses;
 - 3. Street addresses and physical locations of training sites, including facility names when applicable;

4. Maintaining samples of the forms used to document the beneficiary's consent to the training in their home, if the training includes supervised practical training in the home;
 5. The course outline;
 6. Lesson plans;
 7. The instructor's methods of supervising trainees during practical training;
 8. The training program's methods and standards for, determining whether a trainee can read and write well enough to perform satisfactorily the duties of a personal care aide;
 9. The training program's method of evaluating written tests, oral exams (if any) and skills tests, including the relative weights of each in the minimum standard for successful completion of the course;
 10. The training program's minimum standard for successful completion of the course; and
 11. Evidence and documentation of successful completions (Certificates supported by internal records).
- E. Personal Care providers are responsible for the upkeep of all required training program documentation.
- F. A qualified personal care aide training and certification program must include instruction in each of the subject areas listed in Section 222.120.
- G. Classroom and supervised practical training must total at least 40 hours.
1. Minimum classroom training time is twenty-four (24) hours.
 2. Minimum time for supervised practical training is sixteen (16) hours.
 - a. "Supervised practical training" means training in a laboratory or other setting in which:
 - (1). The trainee demonstrates knowledge by performing tasks on an individual while
 - (2). The trainee is under supervision as defined in Section 220.100.
 - b. Trainees must complete at least sixteen (16) hours of classroom training before beginning any supervised practical training.
 3. Supervised practical training may occur at locations other than the site of the classroom training.
 - a. However, trainees must complete at least twenty-four (24) hours of classroom training before undertaking any supervised practical training at an actual service delivery site.
 - b. The training program must have the written consent of the beneficiary or the beneficiary's representative if aide trainees furnish any of the beneficiary's services at the beneficiary's service delivery location.
 - (1). A copy of the beneficiary's consent must be maintained in the file of each aide trainee receiving supervised practical training at the beneficiary's service delivery location.
 - (2). The beneficiary's daily service documentation must include the names of the supervising supervisor or QIDPRN and the personal care aide trainees.
 4. The training of personal care aides and the supervision of personal care aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse whose current credentials are on file with the provider.

- a. The qualified registered nurse must possess a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of in-home health care.
 - b. Other individuals may provide instruction under the supervision of the qualified registered nurse.
 - c. Supervised practical training with a consenting personal care beneficiary for a subject must be personally supervised by:
 - (1). The qualified registered nurse; or
 - (2). By a licensed practical nurse under the general supervision of the qualified registered nurse.
- H. Providers must maintain documentation demonstrating that aide training meets the requirements set forth herein.

222.120 Personal Care Aide Training Subject Areas

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NOTE: This section is not applicable to the IndependentChoices program.

- A. Correct conduct toward beneficiaries, including respect for the beneficiary, the beneficiary's privacy and the beneficiary's property.
- B. Understanding and following spoken and written instructions.
- C. Communications skills, especially the skills needed to:
 - 1. Interact with beneficiaries;
 - 2. Report relevant and required information to supervisors; and
 - 3. Report events accurately to public safety personnel and to emergency and medical personnel.
- D. Record-keeping, including:
 - 1. The role and importance of record keeping and documentation;
 - 2. Service documentation requirements and procedures, especially all documentation Medicaid requires of personal care aides, as described in Medicaid Personal Care Program policy statements current at the time of the aide's training;
 - 3. Reporting and documenting non-medical observations of beneficiary status; and
 - 4. Reporting and documenting, when pertinent, the beneficiary's observations regarding their own status.
- E. Recognizing and reporting, to the supervising RN or Qualified Intellectual Disabilities Professional (QIDP), when changes in the beneficiary's condition or status require the aide to perform tasks differently than instructed.
- F. State law regarding delegation of nursing tasks to unlicensed personnel as designated by the Arkansas State Board of Nursing.
- G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.
- H. Safe transfer techniques and ambulation.
- I. Normal range of motion and positioning.
- J. Recognizing emergencies and knowledge of emergency procedures.

- K. Basic household safety and fire prevention.
- L. Maintaining a clean, safe and healthy environment.
- M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the beneficiary with:
 - 1. Bed bath;
 - 2. Sponge, tub or shower bath;
 - 3. Shampoo; sink, tub or bed;
 - 4. Nail and skin care;
 - 5. Oral hygiene;
 - 6. Toileting and elimination;
 - 7. Shaving;
 - 8. Assistance with eating;
 - 9. Assistance with dressing;
 - 10. Efficient, safe and sanitary meal preparation;
 - 11. Dishwashing;
 - 12. Basic housekeeping procedures; and
 - 13. Laundry skills.
- N. Early recognition and reporting of changes in client condition.

244.000 Duration of PA

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Personal Care PAs are generally assigned for twelve (12) months from the date of the last independent assessment or for the life of the service plan, whichever is shorter, unless the beneficiary has a change in condition.

TOC not required

204.000 Participation Requirements for Providers of Targeted Case Management for Beneficiaries Ages Sixty (60) and Older Including ARChoices in Homecare Waiver Participants 4-4-467-1-20

Providers of targeted case management who are restricted to serving persons sixty (60) years of age and older or serving persons ages twenty-one (21) and older with a physical disability and those sixty-five (65) and older who participate in the ARChoices in Homecare (ARChoices) 1915(c) waiver must be certified by the Division of Aging and Adult Provider Services and Quality Assurance (DPSQA) as an organization qualified to provide targeted case management services.

In order to be certified by the Division of Aging and Adult Services DPSQA, the provider must meet the following qualifications:

- A. Be located in the state of Arkansas;
- B. Be licensed as a Class A or Class B Home Health Agency or Private Care Agency by the Arkansas Department of Health or a unit of state government or be a private or public incorporated agency whose stated purpose is to provide case management to the elderly or adults with physical disabilities;
- C. Be able to demonstrate one year of experience in performing case management services. (Experience must be within the past three (3) years);
- D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group. (Experience must be within the past three (3) years);
- E. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements;
- F. Have the financial management capacity and system that provides documentation of services and costs;
- G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements;
- H. Be able to demonstrate that the provider has current liability coverage; and
- I. Employ qualified case managers who reside in or near the area of responsibility and who meet at least one of the following qualifications: must:
 - ~~1. Reside in or near the area of responsibility; and~~
 1. Be licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Certified Social Worker), a registered nurse or a licensed practical nurse; or
 2. Have a bachelor's degree from an accredited institution in a health and human services or related field, plus two years' experience in the delivery of human services to the elderly; or
 3. Have two years' experience in the delivery of human services, including without limitation having performed satisfactorily as a case manager serving the targeted population for a period of two (2) years (experience must be within the past three (3) years).

A copy of the current certification must accompany the provider application and Medicaid contract.

218.300 Service Monitoring/Service Plan Updating

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This component includes activities and contacts that are necessary to ensure the TCM care plan is effectively implemented and adequately addressing the needs of the Medicaid-eligible beneficiary.

The maximum units allowed for this service may not exceed six (6) units per monitoring visit when providers are dealing with beneficiaries ages twenty-one (21) and older.

- A. The activities and contacts may be with the Medicaid-eligible beneficiary, family members, providers or other entities.
- B. They may be as frequent as necessary, within established Medicaid maximum allowable limitations, to help determine such things as:
 - 1. Whether services are being furnished in accordance with a Medicaid eligible beneficiary's plan of care;
 - 2. The adequacy of the services in the plan of care; and
 - 3. Changes in the needs or status of the Medicaid-eligible beneficiary
- C. Monitoring is allowed through regular contacts with service providers at least every month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least ~~monthly~~ every other month, that the beneficiary continues to participate in the service plan and is satisfied with services.
 - 1. A face-to-face monitoring contact with the beneficiary must be completed once every three (3) months. Required contacts with the service providers may be conducted through face-to-face contact or by telephone. Communication with service providers by email or fax are allowed as described in Section 213.000, F.1.
 - 2. A face-to-face contact is not considered a covered monitoring contact unless the required monitoring form is completed according to instructions, dated, signed by the targeted case manager, and filed in the beneficiary's case record.
- D. Updating includes:
 - 1. Reexamining the beneficiary's needs;
 - 2. Identifying changes that have occurred since the previous assessment;
 - 3. Identifying hospitalizations or other extended absences from the home;
 - 4. Altering the TCM service plan; and
 - 5. Measuring the beneficiary's progress toward service plan goals. Service plans should not be updated more than quarterly unless there is a significant change in the beneficiary's needs.

Monitoring and follow-up activities include making necessary adjustments in the TCM care plan and service arrangements with providers, according to established program guidelines.

Face-to-face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

- E. Non-Covered Services include:
 - 1. The updating of a tickler system;

2. A case management agency is not allowed to monitor or update an activity when the service being monitored or updated is provided to the beneficiary by the same agency;:-
 3. However, the same agency is allowed to be both the TCM agency and the agency providing a direct service, such as personal care, home delivered meals, or PERS;:-
 4. However, the agency is not allowed to bill for a TCM monitoring contact when monitoring the **quality of care or the quality of the service** provided by the same agency or when the purpose of the contact is to monitor the progress of a service being in place, delivered, having started, effective date, etc.;
 5. In addition, TCM is not allowed when monitoring is required through the direct service policy, such as with PERS providers; and:-
 6. Monitoring the PERS service is a part of the certification policy for all PERS providers. Additional monitoring of the PERS service by a TCM is not a covered TCM service.
- F. Examples of case monitoring and service plan updating are shown below:
1. Example # 1
Provider "A" has been chosen by the beneficiary to provide home delivered meals. The beneficiary has also chosen provider "A" for case management services. Case management by provider "A" may not be billed for any activity associated with the provision of home delivered meals. It is the responsibility of the direct service provider to ensure quality services are provided. In this example, the home delivered meal provider is responsible for ensuring meals are delivered timely and to the beneficiary's satisfaction. Case management activity does not include monitoring the provision of home delivered meals by the same agency.
This same policy applies to any service where the case management agency is the same agency providing the in-home service.
 2. Example # 2
Provider "B" has been chosen by the beneficiary to provide personal care. The beneficiary has also chosen provider "B" for targeted case management services. Case management by provider "B" may not be billed for any activity associated with the quality of the personal care services being provided by the same agency. It is the responsibility of the direct service provider to ensure quality services are provided.

In this example, the personal care provider is responsible for ensuring personal care services are provided to the satisfaction of the beneficiary and according to the plan of care (POC) that includes the personal care service. This includes whether or not the aide performs the duties assigned, arrives timely, stays the assigned period of time, is courteous, and meets the requirements established for the Personal Care Program by the Arkansas Medicaid Program.
- G. A TCM provider is allowed to bill a monitoring contact when the monitoring is for the purpose of verifying the services included on the POC are sufficient based on the beneficiary's current condition. This is also true when the case manager is contacted by the beneficiary.
1. If the monitoring contact is billed, based on this purpose, documentation must support the reason for the contact, the results of the contact, and any changes requested to the POC.
 - a. **NOTE:** This type activity, when based on the beneficiary's condition and the sufficiency of the services in place, may be billed regardless of whether or not the case manager and the direct service provider are the same agency.
 - b. If the monitoring contact, whether initiated by the case manager or the

beneficiary, is not addressing quality of care, the monitoring contact is billable, if it meets the definition described in this manual.

2. The same policy applies to the personal emergency response system (PERS) service. The TCM provider may test the PERS unit when completing a monitoring visit, if the PERS unit is not provided by the same agency as the TCM service.
 - a. Since the PERS providers are required to test their units monthly, if they choose to meet that requirement by having their targeted case managers test the units while in the home, this is not considered a covered TCM service.
 - b. It does, however, meet the requirement established for the PERS providers, if results of the testing are documented by the PERS provider and available for audit.
- H. All requests from case managers to increase or decrease services or change service providers will be verified by the DHS RN and justified by the DHS RN prior to any changes being made to the waiver plan of care. This applies when the beneficiary is a participant in a home and community-based waiver program.

See Section 262.100 for the appropriate procedure code and modifier.