TOC required

200.100 Qualifying Criteria for Living Choices Assisted Living Providers 7-1-2~~10~~

Living Choices providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of the Arkansas Medicaid provider manual as well as the criteria below to be eligible to participate in the Arkansas Medicaid Program.

A. Assisted living facilities (ALF) are licensed and regulated by ~~the Office of Long Term Care in~~ the Division of Provider Services and Quality Assurance (DPSQA). Licensed Level II ALF are qualified to enroll with Medicaid as Living Choices Assisted Living Facilities—Direct Services Providers, if all other requirements for enrollment are met.

B. Home health agencies in Arkansas are licensed and regulated by the Arkansas Department of Health. Licensed Class A home health agencies may contract with Level II ALF to provide the bundled services covered in the Living Choices Program. In such an arrangement, federal regulations permit Medicaid to cover the services only if the home health agency, instead of the ALF, is the Living Choices provider.

Living Choices Assisted Living Waiver Services providers must meet the Provider Participation and enrollment requirements detailed in the Medicaid provider manual.

A licensed home health agency may qualify for Living Choices waiver services provider enrollment only by first contracting with a licensed Level II ALF to provide Living Choices bundled services to Living Choices ~~beneficiaries~~ clients who reside in the ALF.

~~C. All Living Choice providers must be certified by the Division of Provider Services and Quality Assurance (DPSQA).~~

~~D~~C. Option to Temporarily Limit Certification and Enrollment of New Assisted Living Facilities: Consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the concurrence of the federal Centers for Medicare and Medicaid Services (CMS), DPSQA may temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers in the Living Choices HCBS waiver program. Such temporary caps, limits, or moratoria on the certification and enrollment of new assisted living facility providers shall be initially limited to no more than six months, may be extended in 6-month increments subject to DPSQA and CMS approval, and may be applied on a regional or another geographic basis. If DPSQA determines temporary caps, limits, or moratoria are appropriate and would not adversely impact ~~beneficiaries'~~ clients' access to assisted living facility services, it will initiate the process through filing a Request for State Implemented Moratorium (Form CMS–10628) with CMS.

200.105 Provider Assurances ~~1-1-19~~7-1-21

A. Staffing

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

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS.

2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the ~~beneficiary~~ client he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any Living Choices Assisted Living Waiver service(s). This orientation shall include, but not be limited to, a:
    a. Description of the purpose and philosophy of the Living Choices Assisted Living Waiver Program;
    b. Discussion and distribution of the provider agency's written code of ethics;
    c. Discussion of activities which shall and shall not be performed by the employee;
    d. Discussion, including instructions, regarding Living Choices Assisted Living Waiver record keeping requirements;
    e. Discussion of the importance of the ~~Plan of Care~~ Person centered service plan;
    f. Discussion of the agency's procedure for reporting changes in the ~~beneficiary's~~ client's condition;
    g. Discussion, including potential legal ramifications, of the ~~beneficiary's~~ client's right to confidentiality.

B. Quality Controls

The Provider agrees to continually monitor ~~beneficiary~~ client's satisfaction and quality of service delivery and to document his or her findings in the ~~beneficiary's~~ client's record. The Provider must immediately report changes in a ~~beneficiary's~~ client's condition to the DHS ~~registered nurse (DHS RN)~~ PCSP/CC Nurse via Form AAS-9511 (Change of Status).

C. Code of Ethics

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

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

D. Home and Community Based Services (HCBS) Settings

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

Those facilities already enrolled in the waiver before this policy change must comply with the HCBS settings requirements under the timeframe established by the HCBS settings transition plan.

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

HCBS settings must have the following characteristics:

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

i. Identify a specific and individualized assessed need.

ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

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

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

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

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

vii. Include the informed consent of the individual.

200.110 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Facilities 7-1-2~~10~~

Level II ALFs, located within the state of Arkansas, licensed and certified by the ~~Office of Long Term Care~~Division of Provider Service and Quality Assurance~~,~~ (DPSQA), are eligible to apply for Medicaid enrollment as Living Choices providers. Qualified Level II Assisted Living Facility providers contract with Medicaid as Living Choices Assisted Living Facility providers to provide and claim reimbursement for Living Choices bundled services instead of contracting with another entity (e.g., a licensed home health agency) that is enrolled with Medicaid to provide and receive payment for those services. Living Choices includes provisions for alternative methods of delivering services because assisted living facilities have different business and staffing arrangements and the Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service. Additional details in this regard are provided in this manual.

All owners, principals, employees, and contract staff of a Living Choices Assisted Living provider must have a criminal background check and central registry check. Criminal background and central registry checks must comply with Arkansas Code Annotated §§20-33-213 and 20-38-101 *et seq*. Criminal background checks shall be repeated at least once every five (5) years. Central registry checks shall include:

A. Child Maltreatment Central Registry;

B. Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and,

C. Certified Nursing Assistant/Employment Clearance Registry.

200.120 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Agencies' ~~1-1-19~~7-1-21

Within their licensing regulations, Level II ALFs may contract with home health agencies and other entities and individuals to provide required and optional services for ~~residents~~ clients of the ALF. In the Living Choices Program, an ALF that chooses not to be the Medicaid-enrolled provider of Living Choices services may contract only with a licensed home health agency to furnish Living Choices bundled services. The Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service.

A Licensed Class A Home Health Agency is eligible to enroll in the Arkansas Medicaid Program as an Assisted Living Agency provider only if it has a contract with a Level II Assisted Living Facility to deliver all Living Choices bundled services furnished in that facility. A home health agency must have a separate Medicaid provider number for each ALF in which it is the Living Choices provider.

To enroll as a Living Choices Assisted Living Agency, the agency must comply with certain procedures and criteria. This section describes those criteria and procedures, as well as the actions DMS takes to facilitate enrollment.

A. The provider must be licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.

B. The provider must submit to the Medicaid program's Provider Enrollment Unit and to DPSQA the following items, in addition to the other documentation required in this section.

1. A copy of its contract with the ALF (financial details may be omitted). The contract must describe in detail the agency's contractual obligations to provide Living Choices bundled services to the ALF's Living Choices ~~beneficiaries~~clients.
2. Copies of contracts (financial details may be omitted) with any entities or individuals the agency has sub-contracted with to provide components of Living Choices bundled services.

202.100 Records that Living Choices Assisted Living Facilities and Agencies Must Keep ~~1-1-19~~7-1-21

A. Living Choices Assisted Living facility and agency providers must maintain required personal care aide training program documentation as specified in this manual.

B. A provider must also maintain the following items in each Living Choices ~~beneficiary's~~ client's file.

1. The ~~beneficiary's~~ client's attending or primary care physician's name, office address, telephone number and after-hours contact information.
2. A copy of the ~~beneficiary's~~ client's current person centered service plan~~plan of care~~ (form AAS-9503).
3. Written instructions to the facility's attendant care staff.
4. Documentation of limited nursing services performed by the provider's nursing staff in accordance with the ~~beneficiary's~~ client's person centered service plan~~plan of care~~. Records must include:
   a. Nursing service or services performed,
   b. The date and time of day that nursing services (exclusive of attendant care services) are performed,
   c. Progress or other notes regarding the ~~resident's~~ client's health status and
   d. The signature or initials and the title of the person performing the services.
5. Documentation of periodic nursing evaluations performed by the ALF nursing staff in accordance with the ~~beneficiary's~~ client's person centered service plan~~plan of care~~.
6. Records of attendant care services as described in this manual.
7. Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the ~~beneficiary's~~ client's condition to the DHS ~~RN~~PCSP/CC nurse, who is the only authorized individual who may adjust a ~~beneficiary's~~ client's person centered service plan~~plan of care~~. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify the DHS ~~RN~~ PCSP/CC Nurse immediately of any change in the ~~beneficiary~~client's physical, mental or environmental needs the provider observes or is made aware of that may affect the ~~beneficiary's~~ client's eligibility or necessitate a change in the ~~beneficiary's~~ client's

person centered service planplan of care; to continually monitor beneficiaryclient satisfaction and quality of service; and to notify the DHS RNPCSP/CC Nurse in writing within one week of services being terminated, documenting the termination effective date and the reason for termination.

202.110 Attendant Care Service Documentation

2-1-157-1-21

Living Choices Facilities and Agencies must keep the following records documenting attendant care services.

A. Documentation of attendant care services performed in accordance with a resident's person centered service planplan of care and a Registered Nurse's written instructions is required. The attendant may document these services by means of a checklist if:

1. The checklist is individualized to correspond to the individualization of the direct care services plan;
2. The checklist's nomenclature corresponds to the names and descriptions of services ordered by the direct care services plan and
3. The attendant can note, within the same document, comments or observations required by the assisted living RN or notes regarding changes or perceived changes in the resident's client's needs or requirements.

B. Each person providing attendant care services must date the service log and sign it with an original signature or initial it over his or her typed or printed name. Documentation of time in and time out is not required.

210.000 PROGRAM COVERAGE

1-1-197-1-21

Living Choices Assisted Living is a home and community-based services waiver program that is administered jointly by the Division of Medical Services (DMS, the state Medicaid agency) and the Division of Aging, Adult, and Behavioral Health Services (DAABHS), under the waiver authority of Section 1915(c) of the Social Security Act. Home and community-based services waiver programs cover services designed to allow specific populations of individuals to live in their own homes or in certain types of congregate settings. The Living Choices Assisted Living waiver program serves persons aged 65 and older and persons aged 21 through 64 who are determined to be individuals with physical disabilities by the Social Security Administration or the Arkansas DHS Medical Review Team (MRT), and who are eligible for nursing home admission at the intermediate level of care.

The rules and regulations for licensure of Level II Assisted Living Facilities (ALF) are administered by the Office of Long Term Care within DMSDPSQA. As agencies of the Arkansas Department of Human Services (DHS), DAABHS, DMS and the Division of County Operations (DCO) administer the policies and procedures and the rules and regulations governing provider and beneficiary client participation in the Living Choices Program.

Individuals found eligible for the Living Choices Program may participate in the program when residing in a licensed Level II ALF that is enrolled as a Living Choices waiver provider in the Arkansas Medicaid Program.

211.000 Scope of the Program

1-1-197-1-21

The *Level II Assisted Living Facilities Rules and Regulations* manual defines assisted living as: "Housing, meals, laundry, social activities, transportation (assistance with and arranging for transportation), one or more personal services, direct care services, health care services, 24-hour supervision and care, and limited nursing services." Medicaid, by federal law, may not

cover ~~beneficiaries'~~ client's room and board except in nursing and intermediate care facilities. Medicaid covers some services only under certain conditions. This home and community-based services waiver program permits Medicaid coverage of assisted living services as described in this manual.

Individuals participating in the Living Choices Program reside in apartment-style living units in licensed Level II ALF and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes ~~residents'~~ client's self-direction and personal decision-making while protecting their health and safety.

Assisted living includes 24-hour on-site response staff to assist with ~~residents'~~ client's known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living provider staff perform their duties and conduct themselves in a manner that fosters and promotes ~~residents'~~ client's dignity and independence. Supervision, safety and security are required components of the assisted living environment. Living Choices includes therapeutic social and recreational activities suitable to ~~residents'~~ client's abilities, interests and needs.

Services are provided on a regular basis in accordance with individualized person centered ~~plans~~plans ~~of care~~ that are signed by a DHS PCSP/CC Nurse~~registered nurse~~. Assisted living ~~beneficiaries~~ clients reside in their own living units, which are separate and distinct from all others. Laundry and meal preparation and service are in a congregate setting for ~~beneficiaries~~ clients who choose not to perform those activities themselves.

211.050 Definitions **7-1-21**

A. FUNCTIONAL/MEDICAL ELIGIBILITY means the level of care needed by the waiver applicant/client to receive services through the waiver rather than in an institutional setting. To be determined to meet medical and functional eligibility, an applicant/client must not require a skilled level of care, as defined in state rule, and must meet at least one of the following three criteria, as determined by a DHS Eligibility Nurse:

1. The individual is unable to perform either of the following:
   a. At least one (1) of the three (3) activities of daily living (ADL's) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or
   b. At least two (2) of the three (3) activities of daily living (ADL's) of transferring/locomotion, eating or toileting without limited assistance from another person; or,
2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,
3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

B. APPROVED ASSESSMENT INSTRUMENT means DHS approved the instrument used by registered nurses employed by the Independent Assessment Contractor to assess functional need.

C. INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the approved assessment instrument to assess functional need.

D. INITIAL INDEPENDENT ASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved

assessment instrument to assess functional need. This assessment is used by DHS as part of the initial process to make a final determination of eligibility and, if the person is determined to be eligible, to be used in the development of the PCSP.

E. EVALUATION means the process completed by the DHS PCSP/CC Nurse in conjunction with the client, at a minimum of every twelve (12) months, to determine continued evidence of established medical and functional eligibility or a change in medical condition that may impact continued medical and functional eligibility. The evaluation may result in a reassessment being requested by DHS if the DHS Eligibility Nurse determines that there is evidence of a material change in the functional or medical need of the client.

F. REASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need when requested by a DHS Eligibility Nurse, based on evidence of a material change in medical and functional eligibility documented at the evaluation performed by a DHS PCSP/CC Nurse. This information is used by DHS as part of the process to make a final determination of continued eligibility and, if the person is determined to be eligible, to be used in the development of the PCSP.

G. DHS ELIGIBILITY NURSE means a registered nurse authorized by DHS to perform reviews of all functional and medical information available and, based on available information, to make an eligibility determination and, if determined eligible, a level of care determination. DHS eligibility nurses are also responsible for reviewing evaluation documentation for material changes to medical or function need and requesting a reassessment if warranted.

H. DHS PCSP/CC NURSE means a registered nurse authorized by DHS to perform evaluations, develop person-centered service plans, and serve as the primary care coordinator and DHS contact for assigned clients.

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

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

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

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

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

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

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

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

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

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

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

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

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

211.100 Eligibility for the Living Choices Assisted Living Program

~~1-1-21~~7-1-21

A. To qualify for the Living Choices Program, an individual must meet the targeted population as described in section 210.000 of this manual and must be found to require a nursing facility intermediate level of care. ~~Individuals meeting the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the Living Choices Assisted Living Program.~~

~~The Living Choices Program processes for beneficiary intake, assessment, evaluation, and service plan development include:~~

~~1. Determination of categorical eligibility;~~

~~2. Determination of financial eligibility;~~

~~3. Determination of nursing facility level of care;~~

~~4. Development of a person-centered service plan (PCSP); and,~~

~~5. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services.~~

B. Candidates for participation in the program (or their representatives) must make application for services at the DHS office in the county in which the Level II ALF is located or on any electronic format provided by DHS for application through an interactive process. Medicaid eligibility is determined by the Division of County Operations~~DHS County Office~~ and is based on non-medical and medical criteria. ~~Income and resources comprise the non-medical criteria. Medically, the candidate must be an individual with a functional disability.~~

~~C. To be determined an individual with a functional disability, an individual must meet at least one (1) of the following three (3) criteria, as determined by a licensed medical professional.~~

~~1. The individual is unable to perform either of the following:~~

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

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

~~2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or others; or,~~

~~3. The individual has a diagnosed medical condition that requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.~~

~~D~~C. Individuals who require~~d~~ skilled level of care as defined in the Department of Human Services regulations are not eligible for the Living Choices Waiver.

~~E~~D. ~~The Arkansas~~An Independent Assessment ~~(ARIA)~~Contractor ~~is the assessment instrument used by registered nurses of the~~will perform ~~Independent~~ independent ~~Assessment~~ assessments that gather functional eligibility information about each Living Choices waiver client using the approved instrument. The information gathered is used by the DHS Eligibility Nurse to determine the individual's level of care. If an applicant is determined both financially and medically eligible, the Division of County Operations approves the application.~~Contractor to collect information used in determining level of care and developing the person-centered service plan. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or reassessment. The tiers are intended to help inform waiver program oversight and administration and person-centered service planning. The tiers do not replace the Level of Care criteria described in Bullet C above, waiver eligibility determinations, or the person-centered service plan process.~~

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

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

~~3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and, therefore, is not eligible for the Living Choices Waiver program.~~

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

For more information on ~~ARIA~~the approved assessment tool, please see the ~~ARIA~~ approved Provider Manual.

~~F~~E. An evaluation is initiated by the DHS PCSP/CC Nurse responsible for care coordination, at least every twelve (12) months and provided to the DHS Eligibility Nurse for review. Based on the review, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment. The assessment is sent to DHS Eligibility Nurse to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and medically eligible, the Division of County Operations approves the application.

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

G. Individuals diagnosed with a serious mental illness or intellectual and developmental disability~~mental retardation~~ are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or intellectual and developmental disability~~mental retardation~~ and meet the other qualifying criteria. A diagnosis of severe mental illness or intellectual and developmental disability~~mental retardation~~ must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or intellectual and developmental disability~~mental retardation~~ when they meet the other qualifying criteria.

H. Eligibility for the Living Choices waiver program is determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the ~~plan of care~~person centered service plan is signed by the DHS PCSP/CC Nurse~~RN~~ and ~~beneficiary~~client. If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process. If a ~~beneficiary~~ client is moving from a Provider-Led Arkansas Shared Savings Entity (PASSE) to the Living Choices waiver program, the eligibility date will be no earlier than the first day following disenrollment from the PASSE.

I. The Living Choices waiver provides for the entrance of all eligible persons on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements. However, ~~the~~ once all waiver ~~dictates a maximum number of unduplicated beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:~~slots are filled, a waiting list will be implemented for this program and the following process will apply. Each Living Choices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services; that all waiver slots are filled; and that the applicant is number in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the Living Choices program.

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

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

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

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

   b. Waiver application determination date for persons residing in a nursing facility and being discharged from a nursing facility after a 90-day stay; or waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six (6) months or longer;

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

   d. Waiver application determination date for all other persons.

~~211.125 Definitions~~ ~~1-1-21~~

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

~~B. ASSESSMENT means the process completed by the independent assessment contractor to collect information used in determining initial functional eligibility for waiver services.~~

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

~~D. EVALUATION means the process completed, at a minimum of every three hundred sixty-five (365) days, by the DHS RN to determine continued functional eligibility or a change in medical condition that may impact continued functional eligibility~~

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

~~F. FUNCTIONAL ELIGIBILITY means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one (1) of the following three (3) criteria, as determined by a licensed medical professional:~~

~~1. The individual is unable to perform either of the following:~~

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

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

~~2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,~~

~~3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.~~

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

~~H. REASSESSMENT means the process, completed at the request of DHS, by the independent assessment contractor to collect information used in determining continuing functional eligibility for waiver services.~~

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

211.150 Level of Care Determination ~~1-1-21~~7-1-21

A prospective Living Choices ~~beneficiary~~ client must require a nursing facility intermediate level of care.

The initial intermediate level of care determination is made by medical staff with the Department of Human Services (DHS)~~, Office of Long Term Care~~. The determination is based on the assessment performed by the Independent Assessment Contractor RN, using standard criteria for functional eligibility in evaluating an individual's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance with nursing home admission criteria, must be completed and the individual deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving Living Choices services.

An evaluation is initiated by the DHS PCSP/CC Nurse responsible for care coordination, ~~completed annually~~ at least every twelve (12) months and provided to the DHS Eligibility Nurse for review~~by the DHS RN to determine continued functional eligibility~~. Based on the review, S~~s~~hould a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment. The assessment is sent to DHS Eligibility Nurse to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and medically eligible, the Division of County Operations approves the application.~~The Office of Long Term Care re-determines level of care annually.~~

The results of the level of care determination and the ~~re-~~evaluation are documented on form DHS-704, Decision for Nursing Home Placement.

NOTE: While federal guidelines require level of care ~~evaluation~~ determination at least annually, the Independent Assessment Contractor may reassess a ~~beneficiary's~~ client's level of care and/or need any time it is deemed appropriate by the DHS ~~RN~~ Eligibility Nurse to ensure that a ~~beneficiary~~ client is appropriately placed in the Living Choices Assisted Living Program and is receiving services suitable to his or her needs.

211.200 Person Centered Service Plan~~Plan of Care~~ ~~1~~7-1-21

A. Each ~~beneficiary~~ client in the Living Choices Assisted Living Program must have a person-centered service plan, also referred to as an individualized Living Choices person centered service plan ~~Plan of Care~~ (AAS-9503). The authority to develop a Living Choices person centered service plan~~plan of care~~ is given to the Medicaid State agency's designee, the DHS ~~RN~~ PCSP/CC Nurse. The Living Choices person centered service plan~~plan of care~~ developed by the DHS ~~RN~~ PCSP/CC Nurse includes without limitation:

1. ~~Beneficiary~~ Client identification and contact information to include full name and address, phone number, date of birth, Medicaid number and the effective date of Living Choices Assisted Living waiver eligibility;
2. Primary and secondary diagnosis;
3. Contact person;
4. Physician's name and address;
5. The amount, frequency and duration of required Living Choices services and the name of the service provider chosen by the ~~beneficiary~~ client or representative to provide the services;
6. Other services outside the Living Choices services, regardless of payment source identified and/or ordered to meet the ~~beneficiary's~~ client's needs. Living Choices providers are not required to provide these services, but they may not impede their delivery;
7. The election of community services by the waiver ~~beneficiary~~client;
8. The name and title of the DHS ~~RN~~ PCSP/CC Nurse responsible for the development of the person centered service plan~~plan of care~~; and,
9. Each ~~beneficiary~~client, or his or her representative, has the right to choose the provider of each non-waiver service. Non-waiver services are the services listed on the person centered service plan~~plan of care~~ that are not included in the bundled services of the Living Choices Program (e.g., medical equipment rental). The person centered service plan~~plan of care~~ names the provider that the ~~beneficiary~~ client (or the ~~beneficiary's~~ client's representative) has chosen to provide each service.

B. A copy of the person centered service plan~~plan of care~~ signed by the DHS ~~RN~~ PCSP/CC Nurses and the waiver ~~beneficiary~~ client will be forwarded to the ~~beneficiary~~ client and the Living Choices service provider(s) chosen by the ~~beneficiary~~ client or representative, if waiver eligibility is approved by the Division of County Operations~~DHS County Office~~. Each provider is responsible for developing an implementation plan in accordance with the ~~beneficiary plan of care~~client person centered service plan. The original person-centered service plan~~plan of care~~ will be maintained by the DHS ~~RN~~PCSP/CC Nurse.

The implementation plan must be designed to ensure that services are:

1. Individualized to the ~~beneficiary's~~ client's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the ~~beneficiary's~~ client's welfare;
4. Monitored and adjusted as needed, based on changes to the waiver person centered service plan~~plan of care~~, as reported by the DHS ~~RN~~PCSP/CC Nurse;
5. Provided within a system that safeguards the ~~beneficiary's~~ client's rights; and,
6. Documented carefully, with assurance that appropriate records will be maintained.

NOTE: Each service included on the Living Choices person centered service plan~~plan of care~~ must be justified by the DHS ~~RN~~PCSP/CC Nurse. This justification is based on medical necessity, the ~~beneficiary's~~ client's physical, mental and functional status, other support services available to the ~~beneficiary~~ client and other factors deemed appropriate by the DHS ~~RN.~~ PCSP/CC Nurse

Living Choices services must be provided according to the ~~beneficiary plan of care~~client's person centered service plan. Providers may bill only for services in the amount and frequency that is authorized in the person centered service plan~~plan of care~~. As detailed in

the Medicaid Program provider contract, providers may bill only after services are provided.

NOTE: Person centered service plans ~~Plans of care~~ are updated at least once every twelve (12) months~~annually~~ by the DHS ~~RN~~ PCSP/CC Nurse and sent to the assisted living provider prior to the expiration of the current person centered service plan~~plan of care~~. However, the provider has the responsibility for monitoring the person centered service plan ~~plan of care~~ expiration date and ensuring that services are delivered according to a valid person centered service plan~~plan of care~~. ~~At least thirty (30) and no more than forty-five (45) days before the expiration of each plan of care, the provider shall notify the DHS RN via email and copy the RN supervisor of the plan of care expiration date.~~

Services are not compensable unless there is a valid and current care plan in effect on the date of service.

C. The assisted living provider employs or contracts with a Registered Nurse (the "assisted living provider RN") who implements and coordinates person centered service plans~~plans of care~~, supervises nursing and direct care staff and monitors ~~beneficiaries'~~ client's status. At least once every three (3) months, the assisted living provider RN must evaluate each Living Choices ~~beneficiary~~client.

D. The DHS ~~RN~~ PCSP/CC Nurse must evaluate a ~~beneficiary's~~ client's medical condition within fourteen days of being notified of any significant change in the ~~beneficiary's~~ client's condition. The assisted living RN is responsible for immediately notifying the DHS nurse~~RN~~ regarding ~~beneficiaries~~ clients whose status or condition has changed and who may need an evaluation.

REVISIONS TO A ~~BENEFICIARY PLAN OF CARE~~ PERSON CENTERED SERVICE PLAN MAY ONLY BE MADE BY THE DHS ~~RN~~PCSP/CC NURSE.

NOTE: All revisions to the person centered service plan~~plan of care~~ must be authorized by the DHS ~~RN~~PCSP/CC Nurse. A revised person centered service plan ~~plan of care~~ will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on a Living Choices person centered service plan~~plan of care~~, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the Living Choices person centered service plan~~plan of care~~ are subject to recoupment.

~~E. An individual may be served in a Level II Assisted Living Facility under a provisional plan of care developed by the beneficiary and the DHS RN and signed by the beneficiary or the beneficiary's representative and the DHS RN, if the beneficiary and the provider accept the risk of possible ineligibility.~~

~~1. A provisional plan of care may be effective for no more than sixty (60) days.~~

~~2. If approved by the Division of County Operations, eligibility for the program will be determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the provisional plan of care is signed by the DHS RN and the beneficiary, and a plan of care will be sent to the provider.~~

~~**NOTE: No provisional plans of care will be developed if the waiting list process is in effect.**~~

Once a Living Choices eligibility application has been approved, waiver services must be provided in order for eligibility to continue. Medicaid covers Living Choices services on a daily, all-inclusive basis, rather than on an itemized per-service basis. With the exception explained in the NOTE below, a day is a covered date of service when a ~~beneficiary~~ client receives any of the services described as a covered ALF service in this manual, when the service is received between midnight on a given day and midnight of the following day. A day is not a covered date of service when a ~~beneficiary~~ client does not receive any Living Choices services between midnight of that day and midnight of the following day.

NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.

Living Choices waiver services are not allowed on the same day as an individual is admitted to an inpatient facility, regardless of the time of day. If the inpatient facility (hospital, rehab hospital, nursing facility or ICF/IID) is reimbursed by Medicaid on any given day, the ALF waiver provider is not allowed reimbursement for Living Choices service on the same day.

For example: If a waiver ~~beneficiary~~ client is taken and admitted to the hospital on 6/10/12 at 10 a.m. and discharged on 6/13/12 at 10:00 p.m., the hospital will be reimbursed by Medicaid for that date of admission, 6/10/12, but will not be reimbursed for the date of discharge, 6/13/12. In this scenario, the individual left the ALF II facility, was admitted to the hospital, and was returned to the ALF II facility after 3 days of hospitalization.

Date of Admission – 6/10/12 at 10:00 a.m. – Reimbursement to the hospital

6/11/12 – Reimbursement to the hospital

6/12/12 – Reimbursement to the hospital

Date of Discharge – 6/13/12 at 10:00 p.m. – Reimbursement to the ALF facility

The time of admission and the time of discharge are not relevant. Payment is made to the two facilities based on the dates of service.

A. Basic Living Choices Assisted Living direct care services are:

1. Attendant care services,
2. Therapeutic social and recreational activities,
3. Periodic nursing evaluations,
4. Limited nursing services,
5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing,
6. Medication oversight to the extent permitted under Arkansas law and
7. Assistance obtaining non-medical transportation specified in the person centered service plan~~plan of care~~.

B. Living Choices ~~participants~~ clients are eligible for pharmacist consultant services. Level II ALFs are required by their licensing regulations to engage a Consultant Pharmacist in Charge.

NOTE: The removal of Pharmacy Consultant Services as a waiver service does not change the provision of the service, as required under the Level II ALF licensing regulations.

Living Choices waiver ~~beneficiaries~~ clients are eligible for the same prescription drug benefits of regular Medicaid, plus three (3) additional prescriptions for a total of nine (9) per month. No prior authorization is required for the three additional prescriptions. Living Choices waiver ~~beneficiaries~~ clients who are dual eligible (receiving both Medicare and Medicaid) must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

212.100 Attendant Care Services ~~1-1-13~~7-1-21

A. Attendant care is a direct care service to help a medically stable individual who has physical dependency needs in accomplishing activities and tasks of daily living that the individual is usually or always unable to perform independently.

1. Living Choices ~~beneficiaries~~ clients are furnished attendant care on an individualized basis for assistance with eating and nutrition, dressing, bathing and personal hygiene, mobility and ambulation, and bowel and bladder requirements.
2. Attendant care may include assistance with incidental housekeeping and shopping for personal care items or food.
3. ~~With regard to~~Regarding assistance with medication (for ~~residents~~ clients who elect to self-administer their medications) attendant care services include only the very limited functions detailed in Section 702.1.1.5F of the Level II Assisted Living Facilities Rules and Regulations.

B. Activities that constitute assisting a person with physical dependency needs vary.

1. One might perform the entire task (e.g., buttoning his shirt for him), or assist the person in performing the task (e.g., helping him line up button and buttonhole).
2. Assistance might consist of simply providing safety support while the person performs the task (e.g., providing support so he can let go of his cane while he buttons his shirt).
3. Attendant care services may include supervision, visual or auditory cueing, or only observation of a person performing a task or activity to ensure completion of the activity or the safety of the individual.

C. The assisted living provider RN's attendant care instructions must be based, at a minimum, on the waiver person centered service plan~~plan of care~~.

D. The minimum qualifications of an individual providing attendant care in the Living Choices Program are those of a certified personal care aide. See personal care aide training and certification requirements in this manual.

E. Individuals participating in the Living Choices Program are not eligible to access personal care services or extended personal care services through the Arkansas Medicaid Personal Care Program.

212.200 Periodic Nursing Evaluations ~~1~~7-1-21

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

Each Living Choices clientbeneficiary will be evaluated at least every twelve (12) monthsannually by a DHS PCSP/CC NurseRN. The DHS PCSP/CC NurseRN evaluates the resident to determine whether a nursing home intermediate level of care is still appropriate and whether the person centered service plan plan of care should continue unchanged or be revised. Evaluations and subsequent plan of care person centered service plan revisions must be made within fourteen (14) days of any significant change in the client'sbeneficiary's status.

212.300 Limited Nursing Services

10-13-037-1-21

Limited nursing services are acts that may be performed by licensed personnel while carrying out their professional duties, but do not include twenty-four (24) hour nursing supervision of residentsclients. Limited nursing services provided through the Living Choices Program are not services requiring substantial and specialized nursing skills that are provided by home health agencies or other licensed health care agencies.

Living Choices limited nursing services will be provided by registered nurses (RNs), licensed practical nurses (LPNs) and Certified Nursing Assistants (CNAs).

212.310 Registered Nurse (RN) Limited Nursing Services

1-1-137-1-21

RN limited nursing services include:

A. Assessing each Living Choices beneficiary'sclient's health care needs,

B. Implementing and coordinating the delivery of services ordered on the assisted living person centered service planplan of care,

C. Monitoring and assessing the client'sbeneficiary's health status on a periodic basis,

D. Administering medication and delivering limited medical services as provided by Arkansas law and applicable regulations and

E. Making referrals to physicians or community agencies as appropriate.

212.320 Licensed Practical Nurse (LPN) Limited Nursing Services

1-1-137-1-21

LPN limited nursing services are provided under the supervision of an RN and include:

A. Monitoring each waiver client'sbeneficiary's health status,

B. Administering medication and delivering limited medical services as provided by Arkansas law or applicable regulation and

C. Notifying the RN if there are significant changes in a client'sbeneficiary's health status.

212.400 Therapeutic Social and Recreational Activities

10-13-037-1-21

Living Choices providers must provide therapeutic social and recreational activities as ordered on the person centered service planplan of care.

212.500 Non-Medical Transportation

1-1-137-1-21

Living Choices providers must assist clientsbeneficiaries with obtaining and accessing non-medical transportation as required on the person centered service planplan of care.

213.000 Additional Services

~~1-1-13~~7-1-21

Other individuals or agencies may also furnish care directly or under arrangement with the Living Choices provider, but the care provided by other entities may only supplement that provided by the Living Choices provider and may not supplant it.

Clients~~Beneficiaries~~ in the Living Choices Assisted Living Program may receive Title XIX (Medicaid) State Plan services that are provided by enrolled Medicaid providers (e.g., medical equipment rental, prescription drugs) if all eligibility requirements for the specific Medicaid covered service have been met. Clients~~Beneficiaries~~ may not receive services under the Arkansas Medicaid Personal Care Program.

214.000 Benefit Limits

7-1-20~~1~~1

A. Living Choices Assisted Living bundled services are limited to one (1) unit per day.

B. Living Choices Assisted Living Program clients~~beneficiaries~~ may have as many as nine (9) prescription drugs per month covered by Medicaid. Dual eligibles, receiving both Medicare and Medicaid, receive prescription drug coverage through Part D Medicare. Medicare has no restrictions on the number of prescription drugs that can be received during a month. Section III of this manual contains information about available options for electronic claim submission.

215.000 Living Choices Forms

~~1-1-19~~7-1-21

Living Choices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging and Adult Services. These forms include without limitation:

A. Person-centered service plan~~Plan of Care~~ – AAS-9503

B. Start Services – AAS-9510

C. Client~~Beneficiary~~ Change of Status – AAS-9511

Providers may request form AAS-9511 by writing to the Division of Aging, Adult and Behavioral Health Services. **View or print the Division of Aging, Adult and Behavioral Health Services contact information.**

Field Code Changed

Forms AAS-9503 and AAS-9510 will be mailed to the provider by the DHS PCSP/CC Nurse~~RN~~.

Instructions for completion and retention are included with each form. If there are questions regarding any waiver form, providers may contact the DHS PCSP/CC Nurse~~RN~~ in your area.

216.200 Personal Care Aide Training Subject Areas

~~1-1-13~~7-1-21

A qualified personal care aide training and certification program must include instruction in each of the following subject areas.

A. Correct conduct toward clients~~beneficiaries~~, including respect for the client~~beneficiary~~, the client's~~beneficiary's~~ privacy and the client's~~beneficiary's~~ property.

B. Understanding and following spoken and written instructions.

C. Communications skills, especially the skills needed to:

1. Interact with clients~~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,
3. Reporting and documenting non-medical observations of client~~beneficiary~~ status and
4. Reporting and documenting, when pertinent, the client's~~beneficiary's~~ observations regarding his or her own status.

E. Recognizing and reporting to the supervising RN changes in the client's~~beneficiary's~~ condition or status that require the aide to perform tasks differently than instructed.

F. State law regarding delegation of nursing tasks to unlicensed personnel.

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 client~~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.

216.210 Personal Care Aide Training Requirements ~~1-1-13~~7-1-21

Classroom and supervised practical training must total at least 40 hours.

A. Minimum classroom training time is 24 hours.

B. Minimum time for supervised practical training is 16 hours.

1. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge by performing tasks on an individual while the trainee is under supervision.
2. Trainees must complete at least 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. Trainees must complete at least 24 hours of classroom training before undertaking any supervised practical training that involves Living Choices clients~~beneficiaries~~ or Medicaid-eligible individuals who receive Arkansas Medicaid Personal Care services.
   b. The training program must have the written consent of Living Choices clients~~beneficiaries~~ or other Medicaid-eligible individuals (or their representatives) if aide trainees furnish any Attendant Care or personal care to those individuals as part of the supervised practical training.
      i. A copy of each such consent must be maintained in the trainee's file.
      ii. The client's~~beneficiary's~~ (or the personal care client's~~beneficiary's~~) daily service documentation must include the names of the supervising RN 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 with current Arkansas licensure.
   a. The qualified registered nurse must possess a minimum of 2 years of nursing experience, at least 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 Living Choices client~~beneficiary~~ or personal care client~~beneficiary~~ as the subject must be personally supervised by:
      i. A qualified registered nurse or
      ii. A licensed practical nurse under the general supervision of the qualified registered nurse.

216.220 Personal Care Aide Training Documentation ~~1-1-13~~7-1-21

A. Medicaid requires the following documentation of training:

1. The number of hours each of classroom instruction and supervised practical training.
2. Names and qualifications of instructors and current copies of licenses of supervising registered nurses.
3. Street addresses and physical locations of training sites, including facility names when applicable.
4. If the training includes any supervised practical training in the homes of personal care clients~~beneficiaries~~ or in the residences of Living Choices clients~~beneficiaries~~, the forms documenting the client's~~beneficiary's or resident's~~ consent to the training in their home.
5. The course outline.
6. Lesson plans.

7. A brief description of 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.
11. Evidence and documentation of successful completions (certificates supported by internal records).

B. The Living Choices provider is responsible for the upkeep of all required training program documentation, regardless of whether the training is in-house or by contract.

216.240 Personal Care Aide Selection

~~1-1-13~~7-1-21

A. A personal care aide must be at least 18 years of age at the time of personal care aide certification.

B. A Living Choices client~~beneficiary~~ may receive attendant care services only from a certified personal care aide who is not a legally responsible family member or legally responsible caregiver. The Medicaid agency defines, "a legally responsible family member or legally responsible caregiver" as:

1. A spouse.
2. A legal guardian of the person
3. An attorney-in-fact authorized to direct care for the client~~beneficiary~~.

C. Living Choices attendants must be selected on the basis of such factors as:

1. A sympathetic attitude toward the care of the sick,
2. An ability to read, write and carry out directions and
3. Maturity and ability to deal effectively with the demands of the job.

D. The Living Choices provider is responsible for ensuring that attendants in its employ:

1. Are certified as personal care aides,
2. Participate in all required in-service training and
3. Maintain at least "satisfactory" competency evaluations from their supervisors in all attendant care tasks they perform.

216.260 In-Service Training

~~1-1-19~~7-1-21

Medicaid requires personal care aides to participate in least twelve (12) hours of in-service training every twelve (12) months after achieving Personal Care Aide certification.

A. Each in-service training session must be at least 1 hour in length.

1. When appropriate, in-service training may occur at an assisted living facility when the aide is furnishing services.

2. In-service training while serving a Living Choices clientbeneficiary may occur only if the clientbeneficiary or the client'sbeneficiary's representative has given prior written consent for training activities to occur concurrently with the client'sbeneficiary's care.

B. The Living Choices provider and the personal care aide must maintain documentation that they are meeting the in-service training requirement.

C. Providers are required to attend at least one in-service per calendar year. Required in-services are co-sponsored by DMS and DAABHS.

250.100 Reimbursement of Living Choices Assisted Living Facilities and Agencies

1-1-197-1-21

Medicaid reimbursement to Living Choices assisted living facility and agency providers is based on a statewide daily (per diem) rate, as determined by DMS and specified in the Fee Schedule under Section 250.210. The daily rate pays for all direct care services in the client's person centered service planbeneficiary's plan of care. Reimbursement is direct care for services only; room and board are to be paid by the clientbeneficiary or his or her legal representative.

A day is a covered date of service when a Living Choices clientbeneficiary receives any of the services described in Sections 212.100 through 212.500 between midnight of that day and midnight of the following day.

261.000 Introduction to Billing

7-1-210

Living Choices Assisted Living providers use form CMS-1500 to bill the Arkansas Medicaid Program on paper for services provided to Medicaid clientsbeneficiaries. Form CMS-1500 is the official paper counterpart of the Professional (837P) electronic transaction format. Each claim may contain charges for only one (1) clientbeneficiary.

Section III of this manual contains information about available options for electronic claim submission.

262.300 Billing Instructions – Paper Only

11-1-177-1-21

The numbered items in the following instructions correspond to the numbered fields on form CMS-1500. **View a sample form CMS-1500.**

Field Code Changed

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

Field Code Changed

NOTE: A provider delivering services without verifying clientbeneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.310 Completion of CMS-1500 Claim Form

9-1-147-1-21

Field Number and Name	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Client'sBeneficiary's 10-digit Medicaid identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Client'sBeneficiary's last name and first name.

Field Number and Name	Instructions for Completion
3. PATIENT'S BIRTH DATE	Client'sBeneficiary's date of birth as given on the individual's Medicaid identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Client'sBeneficiary's complete mailing address (street address or post office box).
CITY	Name of the city in which the clientbeneficiary resides.
STATE	Two-letter postal code for the state in which the clientbeneficiary resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The client'sbeneficiary's telephone number or the number of a reliable message/contact/ emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the client'sbeneficiary's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the client'sbeneficiary's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If clientbeneficiary has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Not required.
b. AUTO ACCIDENT?	Not required.
PLACE (State)	Not required.

Field Number and Name	Instructions for Completion
c. OTHER ACCIDENT?	Not required.
d. CLAIM CODES	The “Claim Codes” identify additional information about the client's~~beneficiary's~~ condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED’S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED’S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE	Enter “Signature on File,” “SOF” or legal signature.
13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE	Enter “Signature on File,” “SOF” or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Number and Name	Instructions for Completion
15. OTHER DATE	Enter another date related to the client'sbeneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the client'sbeneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not required.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the client'sbeneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.

Field Number and Name	Instructions for Completion
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the provider's usual charge to any client~~beneficiary~~.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Not required.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.

Field Number and Name	Instructions for Completion
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum of all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. ***Do not** include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	Enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

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. **Type of Request:** *(the system will automatically populate new, amendment, or renewal)*

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

○	**3 years**
●	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

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

○	**Model Waiver**
●	**Regular Waiver**

E. **Proposed Effective Date:** ~~12/31/2020~~07/01/2021

Approved Effective Date *(CMS Use):*

2. Brief Waiver Description

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

The Living Choices Assisted Living waiver program allows individuals to live in apartment-style living units in licensed level II assisted living facilities and receive individualized personal, health and social

services that enable optimal maintenance of their individuality, privacy, dignity, and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes participants' personal decision-making while protecting their health and safety. The major goal of this program is to delay or prevent institutionalization of these individuals. However, assisted living services are not intended as a substitute for nursing facility or hospital care for individuals needing skilled care, as defined by State administrative rule which is set forth in B-6-d. Room and board services are not covered per federal law.

Living Choices includes 24-hour on-site response staff to assist with participants' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living facility staff will perform their duties and conduct themselves in a manner that fosters and promotes participants' dignity and independence. Supervision, safety and security are required components of the assisted living environment. Living Choices includes therapeutic, social and recreational activities suitable to the participants' abilities, interests, and needs. Assisted living participants' living units are separate and distinct from all others. Laundry and meal preparation and service are in a congregate setting for participants who choose not to perform those activities themselves. The principles of negotiated service plans and managed risk are applied.

Extended Prescription Drug Coverage is available for Living Choices participants who are eligible for regular Medicaid drug benefits, plus three additional prescriptions. Participants dually eligible for Medicare and Medicaid must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

The Living Choices waiver is administered by ~~two~~ three (3) state operating agencies, the Division of Aging, Adult, and Behavioral Health Services (DAABHS)~~, and~~ the Division of Provider Services and Quality Assurance (DPSQA), and the Division of County Operations (DCO). DAABHS, DCO, and DPSQA operate under the authority of the Division of Medical Services (DMS), the Medicaid Agency. DAABHS DCO, DPSQA, and DMS are all under the umbrella of the Arkansas Department of Human Services (DHS). DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS, DCO, and DPSQA. DAABHS is responsible for the day-to-day administration of the waiver, establishing waiver program policies and procedures, and overseeing the development and management of person-centered service plans, among other functions. ~~DPSQA, through its Office of Long Term Care (OLTC)~~DCO, is responsible for determination of level of care. DPSQA is ~~also~~ responsible for provider certification, compliance, and provider quality assurance. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the ~~Arkansas Independent Assessment (ARIA) system.~~ utilization of the approved assessment instrument.

An Independent Assessment Contractor will perform independent assessments that gather functional eligibility information about each Living Choices waiver applicant using the approved instrument. The information gathered is used by the DHS Eligibility Nurse to determine the individual's level of care. An evaluation is initiated by the DHS PCSP/CC Nurse responsible for care coordination, at least every twelve (12) months and provided to the DHS Eligibility Nurse for review. Based on the review, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment. The assessment is sent to DHS Eligibility Nurse to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and medically eligible, DCO approves the application.

~~Functional eligibility for the waiver is determined using an initial assessment completed by the Independent Assessment Contractor's. The annual evaluation is initiated by the DHS RN. Should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment.~~

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

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

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

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

~~Updates and revisions to the waiver are~~ Notices of amendments and renewals of the waiver are posted on both the DHS and Medicaid websites for at least thirty (30) days to allow for ~~a~~the general public to submit comments on changes ~~comment period of at least 30 days~~. Notices of ~~updates or revisions~~amendments and renewals are also published in a statewide newspaper ~~to allow for public review and comment~~with instruction for submitting comments to DMS. Regulations, policies, rules, and procedures are promulgated in accordance with the Arkansas Administrative Procedure Act. Promulgation includes review by three Arkansas legislative committees, which are open to the public and may include testimony by the public. After review by the committees, the regulations, policies, rules, and procedures are adopted and incorporated into the appropriate document. All provider manuals containing program rules are available to all providers and the general public via the Medicaid website.

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

The public notice for this waiver renewal was published in the Arkansas Democrat-Gazette on _April 14-16,2021. There was a public hearing on April 16, 2021. The comment period ended _May 13, 2021. No public comments were received. Physical copies of the proposed waiver amendment were mailed to constituents upon request. Copies were also published on the state's DHS websites at the following link
https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

7. Contact Person(s)

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

Last Name:	~~Golden~~ Pitman				
First Name:	~~Mac~~ Elizabeth				
Title:	~~Attorney Specialist, Office of Policy Coordination & Promulgation~~Deputy Director				
Agency:	Arkansas Department of Human Services				
Address :	P.O. Box 1437, Slot S-295				
Address 2:					
City:	Little Rock				
State:	Arkansas				
Zip:	72203-1437				
Phone:	~~501-320-6383~~ 501-244-3944	**Ext:**		☐	**TTY**
Fax:	501-682-8009				
E-mail:	~~Mac.E.Golden~~Elizabeth.Pitman@dhs.arkansas.gov				

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

Last Name:	~~Fisher~~ Gann				
First Name:	~~Ashely~~ Patricia				
Title:	~~Assistant~~ Deputy Director				
Agency:	Arkansas Department. of Human Services, Division of Aging, Adult, and Behavioral Health Services				
Address:	P.O. Box 1437, Slot W-241				
Address 2:					
City:	Little Rock				
State:	Arkansas				
Zip :	72203-1437				
Phone:	501-~~320-6345~~ 686-9431	**Ext:**		☐	**TTY**
Fax:	501-682-8155				
E-mail:	~~Ashley.Fisher@dhs.arkansas.gov~~Patricia.Gann@dhs.arkansas.gov				

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

_____

State Medicaid Director or Designee

Submission Date:	

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

Last Name:	Hill				
First Name:	Jay				
Title:	DAABHS Director				
Agency:	Arkansas Department 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:	AR				
Zip:	72203-1437				
Phone:	501-~~320-6009~~686-9981	**Ext:**		☐	**TTY**
Fax:	~~501-682-8155~~				
E-mail:	Jay.Hill@dhs.arkanas.gov				

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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

All types of services covered in the approved waiver continue to be covered in the renewed waiver.

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

No service covered by the approved waiver and received by any participant is discontinued under the renewed waiver.

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

Individuals served in the existing waiver may continue to participate in this HCBS program under the renewed waiver, provided they (1) continue to meet financial eligibility and (2) meet the functional eligibility criteria for the program as defined in the state rule and determined following their evaluation completed by a DHS PCSP/CC nurse.

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

The approved waiver provides for assessments using the approved assessment instrument. The- approved ~~A~~assessment instrument~~s~~ involve a complex array of questions asked by registered nurses during the face-to-face meetings with applicants and participants.

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

There are no new limitations on the amount of waiver services in the renewed waiver.

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

Evaluations will be performed at least every twelve (12) months by the DHS PCSP/CC –Nurse. Re-assessments of existing participants will be performed ~~through~~ using the approved assessment instrument when referred by the DHS Eligibility nurse.

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

The renewed waiver makes no changes to waiver eligibility policy.

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

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

Participants who receive negative determinations regarding eligibility determinations or Individual Service Budgets, including the person-centered service plans, will be able to appeal denials and reductions -during which time their benefits will be automatically continued; however, the beneficiary will have the ability to opt out of this automatic continuation of benefits.

Appendix A: Waiver Administration and Operation

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

○	The waiver is operated by the state Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:	
	○ The Medical Assistance Unit *(specify the unit name) (Do not complete Item A-2*)	
	○ Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a)*	
●	The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency. Specify the division/unit name:	
	Department of Human Services, Division of Aging, Adult and Behavioral Health Services (DAABHS), Division of County Operations (DCO) and Division of Provider Services and Quality Assurance (DPSQA).	
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b)*.	

2. Oversight of Performance.

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the

operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Arkansas Department of Human Services (DHS) uses an Interagency Agreement to define the responsibilities of the ~~three~~ four DHS divisions – Division of Medical Services (DMS, the Medicaid agency) Division of Aging, Adult and Behavioral Health Services (DAABHS), the Division of County Operations (DCO), and the Division of Provider Services and Quality Assurance (DPSQA) – charged with responsibility for administering both the ~~Living~~ AR Choices in Homecare (~~Living~~ AR Choices) and Living Choices Assisted Living (Living Choices) HCBS waiver programs. This agreement is reviewed annually and updated as needed. DMS, as the Medicaid agency, monitors this agreement on a continuous basis to assure that the provisions specified are executed.

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

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

DPSQA is responsible for provider certification, compliance, and provider quality assurance. Through its ~~Office of Long Term Care (OLTC), DPSQA~~ medical staff (DHS RNs), DCO is responsible for level of care determinations.

DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the ~~Arkansas Independent Assessment (ARIA) system~~utilization of the approved assessment instrument.

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

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

●	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	An Independent Assessment Contractor will perform independent assessments that gather functional eligibility information about each Living Choices waiver applicant using the approved instrument. The information gathered is used by the DHS Eligibility Nurse to determine the individual's level of care. An evaluation is initiated by the DHS PCSP/CC Nurse responsible for care coordination, at least every twelve (12) months. Based on the evaluation, should a change of medical condition be

	present, a referral is made to the Independent Assessment Contractor to complete a reassessment. The assessment is sent to DHS Eligibility Nurse to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and medically eligible, DCO approves the application.~~A contractor ("Independent Assessment Contractor") will perform independent assessments that gather functional need information about each Living Choices waiver applicant and participant using the Arkansas Independent Assessment (ARIA) instrument. The information gathered is used to determine the individual's level of care and the tier level (which is intended to help inform waiver program oversight and administration and person-centered service planning).~~
○	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

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

As described in the Interagency Agreement, ~~between~~ the Division of Medical Services (DMS~~,~~) the State Medicaid ~~agency~~Agency~~),~~, along with the Division of Aging, Adult, and Behavioral Health Services (DAABHS), ~~and the Division of Provider Services and Quality Assurance (DPSQA), DAABHS and DMS~~ will jointly share responsibility for oversight of the performance of the Independent Assessment Contractor, with DMS being ultimately accountable. The contract provides for performance measures the Independent Assessment Contractor is required to meet.

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

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

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

The monthly reports include the following:

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

The annual report includes the following:

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

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

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	■	■	☐	☐
Waiver enrollment managed against approved limits	■	■	☐	☐
Waiver expenditures managed against approved levels	■	■	☐	☐
Level of care evaluation	■	■	■	☐
Review of Participant service plans	■	■	☐	☐
Prior authorization of waiver services	☐	☐	☐	☐

Utilization management	■	■	☐	☐
Qualified provider enrollment	■	■	☐	☐
Execution of Medicaid provider agreements	■	■	☐	☐
Establishment of a statewide rate methodology	■	☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	■	■	☐	☐
Quality assurance and quality improvement activities	■	■	☐	☐

	Number and percent of participants with delivery of at least one waiver service per month as specified in the service plan in accordance with the agreement with the Medicaid Agency. Numerator: Number of participants with at least one service per month; Denominator: Number of participants served
Data Source *(Select one) (Several options are listed in the on-line application):* **Other**	
If 'Other' is selected, specify: **No Waiver Service Report**	

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

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

Data Aggregation and Analysis

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

Performance Measure:	**Number and percent of policies and/or procedures developed by DAABHS ~~, in consultation with DPSQA,~~ that are reviewed and approved by the Medicaid Agency prior to implementation. Numerator: Number of policies and procedures by DAABHS reviewed by the Medicaid Agency before implementation; Denominator: Number of policies and procedures developed.**
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify: ***~~PDQA~~ Rule or Policy Revision Request Form***	

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

		Specify:		
				☐ *Other Specify:*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***				
If 'Other' is selected, specify:				
~~*Aces*~~***D Report of Active Cases (Point in Time)***				

Sampling Approach *(check each that applies)*
■ *100% Review*
☐ *Less than 100% Review*
☐ *Representative Sample; Confidence Interval =*
☐ *Stratified: Describe Group:*
☐ *Other Specify:*

b. Methods for Remediation/Fixing Individual Problems

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

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

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

were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

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

Remediation to address participants not receiving at least one waiver service a month in accordance with the service plan and the agreement with DMS includes closing a case, conducting monitoring visits, revising a service plan to add a service, checking on provider billing and providing training. DAABHS conducts remediation efforts in these areas. The tool used for record review documents the remediation that is needed and tracks ~~remediation~~the corrective action taken.

Appendix B: Participant Access and Eligibility

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

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

N/A

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

○	Not applicable. There is no maximum age limit
●	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. *Specify*:
	~~The participant remains in the waiver under the Aged group~~ The participant who ages out in the Disabled (Physical) target subgroup at age sixty-five (65) automatically remains in the waiver under the Aged target subgroup.~~.~~

Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	**Unduplicated Number of Participants**
Year 1	1725~~1300~~
Year 2	1725~~1300~~
Year 3	1725~~1300~~
Year 4 (only appears if applicable based on Item 1-C)	**1725**
Year 5 (only appears if applicable based on Item 1-C)	**1725**

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

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

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

Entry to the waiver will then be prioritized based on the following criteria:
a) Waiver application determination date for persons inadvertently omitted from the waiver waiting list (administrative error);
b) Waiver application determination date for persons residing in a nursing facility and being discharged after a 90 day stay; or waiver application determination date for persons residing in an approved Level II Assisted Living facility for the past six months or longer;
c) Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
d) Waiver application determination date for all other persons.

Appendix B-6: Evaluation / Reevaluation of Level of Care

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

LEVEL OF CARE DEFINITIONS:

FUNCTIONAL/MEDICAL ELIGIBILITY means the level of care needed by the waiver applicant/client to receive services through the waiver rather than in an institutional setting. To be determined to meet medical and functional eligibility, an applicant/client must not require a skilled level of care, as defined in state rule, and must meet at least one of the following three criteria, as determined by a DHS Eligibility Nurse:

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

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

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

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

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

APPROVED ASSESSMENT INSTRUMENT means DHS approved the instrument used by registered nurses employed by the Independent Assessment Contractor to assess functional need.

INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the approved assessment instrument to assess functional need.

INITIAL INDEPENDENT ASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need. This assessment is used by DHS as part of the initial process to make a final determination of eligibility and, if the person is determined to be eligible, to be used in the development of the PCSP.

EVALUATION means the process completed by the DHS PCSP/CC Nurse in conjunction with the client, at a minimum of every twelve (12) months, to determine continued evidence of established medical and functional eligibility or a change in medical condition that may impact continued medical and functional eligibility. The evaluation may result in a reassessment being requested by DHS if the DHS Eligibility Nurse determines that there is evidence of a material change in the functional or medical need of the client.

REASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need when requested by a DHS Eligibility Nurse, based on evidence of a material change in medical and functional eligibility documented at the evaluation performed by a DHS PCSP/CC Nurse. This information is used by DHS as part of the process to make a final determination of continued eligibility and, if the person is determined to be eligible, to be used in the development of the PCSP.

DHS ELIGIBILITY NURSE means a registered nurse authorized by DHS to perform reviews of all functional and medical information available and, based on available information, to make an eligibility determination and, if determined eligible, a level of care determination. DHS eligibility nurses are also responsible for reviewing evaluation documentation for material changes to medical or function need and requesting a reassessment if warranted.

DHS PCSP/CC NURSE means a registered nurse authorized by DHS to perform evaluations, develop person-centered service plans, and serve as the primary care coordinator and DHS contact for assigned clients.

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

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

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

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

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

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

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

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

~~2. Not require a skilled level of care, as defined in the State rule.~~ Beneficiaries who are determined to require a skilled level of care are not eligible for this waiver program. The State rule defines "Skilled Level of Care" to mean the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount:

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

b. Intravenous injections and hypodermoclysis or intravenous feedings;

c. Levin tubes and nasogastric tubes;

d. Nasopharyngeal and tracheostomy aspiration;

e. Application of dressings involving prescription medication and aseptic techniques;

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

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

h. Initial phases of a regimen involving administration of medical gases;

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

j. Ventilator care and maintenance; and

k. The insertion, removal and maintenance of gastrostomy feeding tubes;

No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than 21 days.

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

Instrument/Tool Used:

The ~~Arkansas Independent Assessment (ARIA)~~ approved assessment instrument is used by the registered nurses employed by the Independent Assessment Contractor to asses functional need. ~~collects information to used in determining functional eligibility.~~This assessment is used by DHS as part of the initial process to make a final determination of eligibility. ~~Registered nurses from the Independent Assessment Contractor will use the ARIA instrument to conduct face-to-face, in-home assessments and reassessments~~ at the request of DHS. ~~Using the information collected during the assessment, the Office of Long-Term Care in DPSQA will evaluate whether an individual meets the State's functional eligibility criteria.~~ When requested by the DHS Eligibility Nurse, based on evidence of a material change in medical and functional eligibility documented at the evaluation performed by the DHS PCSP/CC Nurse, the approved instrument will be completed by registered employed by the Independent Assessment Contractor to assess continued need.

All State laws, regulations, and policies concerning functional/medical eligibility criteria and the assessment instrument (including the ~~new ARIA~~approved assessment instrument, the Living Choices waiver program manual, and the ~~ARIA~~ assessment instrument manual) are available to CMS upon request through DAABHS.

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

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

○	**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
●	**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

Level of Care Instrument for Institutional Care:

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

Level of Care Instrument for Waiver Program:

~~The level of care instrument f~~For the Living Choices waiver program ~~will be~~ the ~~Arkansas Independent Assessment (ARIA) system~~approved assessment instrument will be used to support the ~~level of care~~functional/medical eligibility determination process. The evaluation initiated by the DHS PCSP/CC Nurse at a minimum of every twelve (12) months, uses the DHS-703 form to make a determination of continued evidence of established medical and functional eligibility or a change in medical condition that may impact continued medical and functional eligibility. The evaluation may result in a reassessment being requested by DHS if the DHS Eligibility Nurse determines that there is evidence of a material change in the functional or medical need of the client.

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

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

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

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

~~The new process for evaluating waiver applicants and re-evaluation of waiver program participants for their respective needs for the level of care under the waiver is described below.~~

~~Under the new process, e~~Each waiver applicant to the Living Choices program will be assessed ~~needing a re-evaluation will receive an individual assessment performed~~ by the Independent Assessment Contractor.. Each assessment ~~or re-assessment~~ is performed by a licensed registered nurse ~~(RN)~~ using the ~~Arkansas Independent Assessment (ARIA)~~approved assessment instrument. The ~~Office of Long Term Care (OLTC) in DPSQA~~ DHS Eligibility Nurse will ~~use~~ review the approved assessment instrument results ~~to evaluate level of care~~ and the recommended tier level, and make the final level of care determination. Functional/medical ~~need~~ eligibility is valid for ~~one year~~twelve (12) ~~,months, unless~~months unless a shorter period is specified by ~~OLTC~~DCO.

Evaluations will continue to be performed every twelve (12) months, with the functional eligibility re-affirmed or revised and a written determination issued by DCO. In cases where a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), an evaluation will be performed by the DHS PCSP/CC Nurse, and based on the review of the evaluation, the DHS Eligibility Nurse may request a reassessment be completed by the Independent Assessment Contractor, as appropriate. In the manner specified in the DHS Independent Assessment Manual, a participant (or their legal representative) or the participant's physician may request that the DAABHS deputy director (or his/her designee) request a reassessment.

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

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

The approved assessment instrument is a comprehensive tool to collect detailed information to determine an individual's functional eligibility; identify needs, current supports, some of the individual's preferences, and some of the risks associated with home and community-based care for the individual; and inform the development of the person-centered service plan. The approved assessment instrument is used to gather information on the applicant's (or participant's in the case of a re-evaluation) demographics; health care providers; current services and supports received

(including skilled nursing, therapies, medications, durable medical equipment, and human assistance services), housing and living environment; decision-making and designated representatives; emergency contacts; Activities of Daily Living (ADLs) needs; Instrumental Activities of Daily Living (IADLs) needs; health status (including symptoms, conditions, and diagnoses); psychosocial status (including assessment of behavioral health impairments and risk factors); memory and cognition; mental status; sensory and functional communication skills; self-preservation capabilities and supports; family and other caregiver supports; participation in work, volunteering, or educational activities; and quality of life (including routines, preferences, strengths and accomplishments, and goals for future).

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

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

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

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

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

(Note that ~~ARIA~~approved ~~-based~~ assessment instruments are also used to help determine whether Medicaid enrollees meet the minimum ADL needs-based criteria for State Plan coverage of Medicaid personal care services and self-directed personal assistance services. Tier 1 (one) and Tier 2 (two) each indicate that the Medicaid enrollee meets the minimum criteria for personal care or self-directed personal assistance service coverage. Coverage of these State Plan services for Medicaid enrollees is further subject to a medical necessity determination and prior authorization.)

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

~~DAABHS~~ DHS has established and maintains procedures for tracking review dates and initiating timely ~~re~~-evaluations to determine continued functional/medical eligibility and financial eligibility pprior to each participant's ~~respective level of care review date and prior to the~~ expiration of the level of care. ~~and the participant's current person-centered service plan~~. ~~This process ensures timely reevaluations prior to the level of care review date and the expiration of the person-centered service plan so that no lapse in service occurs.~~

Specifically, ~~DAABHS~~ DHS uses ~~an~~ online tracking tools with an interrogated ~~dashboard~~ functionality ~~that DHS RNs and RN supervisors use~~ to monitor upcoming ~~review data and service~~

~~plan~~level of care expirations. The process of evaluation begins at a minimum of two months prior to the ~~expiration~~ annual anniversary date of the ~~current person-centered service plan or at a minimum of two months prior to the annual anniversary date of the~~ last functional/medical eligibility determination ~~evaluation~~or financial eligibility determination, whichever is earlier.

On at least a monthly basis, the DHS ~~RN~~ PCSP/CC Nurse will identify participants who are due for evaluation. The DHS ~~RN~~ PCSP/CC Nurse will ~~add the cases to~~complete the evaluation ~~schedule~~ for continued functional/medical eligibility. ~~The DHS RN will use the online tracking tool, referenced above, to monitor for both the need for evaluation, and for timely completion of the~~Should the participant show evidence of a change in medical condition, a referral is made for a reassessment by the Independent Assessment Contractor. ~~Once it has been determined that functional eligibility continues, the DHS RN begins development of the new person-centered service plan.~~

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

The DHS RN ~~supervisory~~ Reviewer~~staff~~, through the record review process and through routine monitoring and auditing procedures, notifies the appropriate DHS PCSP/CC N~~RN~~nurse, DHS RN Supervisor and DMS ~~supervisor and the Independent Assessment Contractor~~ if an assessment has not been completed within the specified DAABHS policy timeframes.

The ~~ACES~~ report~~s~~ produced by DCO ~~the Division of County Operations is~~are used ~~as a tool~~ by the DHS PCSP/CC N~~RN~~ nurse and DHS RN ~~Reviewer~~Supervisor ~~supervisor~~ to determine if the assessment is current or has expired. Patterns of noncompliance are documented and disciplinary action is taken if necessary.

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

Records of ~~evaluations~~ assessments and ~~re~~evaluations of ~~level of care~~functional/medical eligibility are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS)~~, the primary authority for the daily operation of the waiver program,~~ and the ~~Office of Long Term Care (OLTC) in the Division of Provider Services and Quality Assurance (DPSQA)~~Division of County Operations (DCO)~~, which is responsible for the final level of care evaluations and reevaluations~~. ~~DAABHS maintains r~~Records are ~~for~~ maintained a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations, or court cases are resolved for a participant, whichever is longer.

Quality Improvement: Level of Care

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

The state currently implements a system of monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected from individual participant records, aggregated to produce summation reports, and compared with periodic randomly sampled record reviews and sampled Program Integrity reviews.

~~Participant records undergo record reviews performed by DHS RN supervisors. Monthly activity reports track assessments and reassessments performed by the Independent Assessment Contractor. DHS RN reports are submitted to program RN supervisors and the Nurse Manager, who then review for timeliness and accuracy. The 45 Day Report tracks all waiver applications and identifies applications pending for more than 45 days. In addition, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) maintains a daily log of assessments and reassessments sent to the Division of Provider Services and Quality Assurance (DPSQA) (operating agency) Office of Long Term for medical determination. Data from all assessment and review activity is aggregated to produce an annual Record Review Summary, and Level of Care Monthly Report.~~

~~Level of Care is provided to all applicants for whom there is reasonable indication that services may be needed. DHS RN supervisors perform record reviews of individual participants and results are aggregated for the Record Review Summary Report. Enrolled participants are re-evaluated at least. The same record review process, described above, is utilized for the re-evaluation process. Cases are identified for re-evaluation through alerts in the ARIA assessment tool.~~

~~The assessment process and instruments described in the waiver are applied appropriately and according to the approved description to determine participant level of care. Record reviews include a review of assessment and reassessment functions, and their alignment with waiver guidelines and timeframes. Findings are aggregated and included in the annual Record Review Summary.~~

~~The DHS RN supervisory staff conducts random record reviews, in which all aspects of Living Choices policy are reviewed. The Annual Report is a compilation of the results of the review of the random record selection. The record review allows reviewers to evaluate trends and identify where additional training for DHS RNs is needed. Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including level of care determinations. DHS RN supervisory staff use the Raosoft calculation system to determine appropriate sample size for Record Review. This system provides a statistical valid sample based on a 95% confidence level with a margin of error of +/- 5%. A systematic random sampling of the active cases includes every "nth" name in the population.~~

~~The Division of Medical Services (DMS) QA review process includes review of the billing process by Living Choices Medicaid providers. The DMS QA review process reviews 20% of the records reviewed by DAABHS.~~

~~In addition to the record review process, an office review is completed by the DHS RN supervisor~~Supervisor~~, at a minimum, annually for each DHS RN. Office reviews include, but are not limited to: Documentation maintained appropriately; Processing system clearly defined and office organized; Forms completed properly; and Required follow-up for any problems or concerns documented.~~

b. Methods for Remediation/Fixing Individual Problems

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

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

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

~~A functional eligibility determination of level of care is required annually, applying the functional eligibility criteria, with referral for use of the approved assessment instrument in the event of a change of condition that may affect functional eligibility The DHS RN supervisors complete a regional monthly activity report, which lists the number of level of care evaluations and re-evaluations conducted. Remediation efforts are included on the DHS RN supervisors' monthly report.~~

Appendix B-7: Freedom of Choice

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

i. informed of any feasible alternatives under the waiver; and

ii. given the choice of either institutional or home and community-based services.

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

At the time of ~~assessment and re-assessment~~development of the person-centered service plan for ~~of~~ the waiver participant, the DHS PCSP/CC Nurse ~~RN~~ explains the services available through the Living Choices waiver, discusses the qualified assisted living providers in the state and develops an appropriate person-centered service plan. As part of the service plan development process, the participant (or representative) documents their choice to have services provided in the community setting through the HCBS waiver as opposed to receiving services in an institutional setting. In addition, freedom of choice is explained through a Freedom of Choice form and the applicable qualified provider listing; both are signed by the waiver participant or their representative. This is documented on the service plan, which includes the signature of the waiver participant (or representative) and the DHS PCSP/CC N~~RN~~urse, and included in the participant's electronic record.

NOTE: For ~~reassessments~~changes to the person centered service plan, the Freedom of Choice form is utilized showing if changes are requested by the participant. If no changes are requested, no signatures are required on the provider listing; however, the Freedom of Choice form is signed and dated by the participant or representative. The participant's signature on the service plan, as entered by the participant or representative, documents that the participant (or representative) has made an informed decision to receive HCBS rather than services in an institutional setting and that HCBS are based on the participant's assessment of needs. Freedom of Choice documentation is tracked through the record review process, all staff performance evaluations and monthly reporting.

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

Appendix B-8: Access to Services by Limited English Proficient Persons

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

All Department of Human Services (DHS) forms are available in English and Spanish. The forms can be translated into other languages when the need arises. DHS maintains an ongoing contract with a Spanish interpreter and translator agency for translation services.

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

Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1/C-3: Service Specification

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

Extended Medicaid State Plan Prescription Drugs Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Services	17990 Other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	

Living Choices waiver participants are eligible for the same prescription drug benefits of regular Medicaid, plus three additional prescriptions beyond the Arkansas Medicaid State Plan Pharmacy Programs benefit limit. An extension of the monthly benefit limit is provided to waiver clients unless a client is eligible for both Medicaid and Medicare (dually eligible). No prior authorization is required for the three additional prescriptions for Living Choices clients.

A waiver client who is dually eligible must obtain prescribed medications through the Medicare Part D Prescription Drug Plan or, for certain prescribed medications excluded from the Medicare Part D plan, through the Arkansas Medicaid State Plan Pharmacy Plan. Medicare has no restrictions on the number of prescription drugs that can be received during a month.

Duplication of services or potential overlap of the scope of services is managed and monitored through the MMIS.

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

N/A

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	■	Individual. List types:	☐	Agency. List the types of agencies:
				Licensed Pharmacist

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Pharmacist	Licensed as a pharmacist in the state of Arkansas, a pharmacist holding a current Pharmacy Permit issued by the Arkansas State Board of Pharmacy and issued a DEA number by the Drug Enforcement Agency. The Division of ~~Medical Services, Office of Long-Term Cares~~Provider	Providers must also be enrolled with the Arkansas Division of Medical Services as a Medicaid State Plan Prescription Drug Program provider.	

	Services and Quality Assurance rules and regulations include specific experience, education and qualifications for Level II Assisted Living Facilities and their staff. Facilities must fulfill these regulations prior to licensure.		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Licensed Pharmacist	The Medicaid program's fiscal agent	Annual	

Living Choices Assisted Living Services Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Basic Living Choices Assisted Living direct care services are: 1. Attendant care services 2. Therapeutic social and recreational activities 3. Periodic nursing evaluations 4. Limited nursing services	

5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing

6. Medication oversight to the extent permitted under Arkansas law

7. Assistance obtaining non-medical transportation specified in the plan of care

Assisted Living services are provided in a home-like environment in a licensed Level II Assisted Living Facility and include activities such as physical exercise, reminiscence therapy and sensorineural activities, such as cooking and gardening. These services are provided on a regular basis according to the clients plan of care and are not diversionary in nature.

Personalized care is furnished to persons who reside in their own living units/apartments at the facility that may include dually occupied units/apartments when both occupants consent to the arrangement that may or may not include kitchenette and/or living rooms and that contain bedrooms and toilet facilities. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence and provides supervision, safety and security. Other persons or agencies may also furnish care directly or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it.

Care must be furnished in a way that fosters the independence of each client to facilitate aging in place. Routines of care provision and service delivery must be consumer driven to the maximum extent possible and treat each person with dignity and respect.

Assisted living services may also include medication administration consistent with the Arkansas Nurse Practice Act and interpretation thereto by the Arkansas Board of Nursing; limited nursing services; periodic nursing evaluations and non-medical transportation specified in the plan of care. Nursing and skilled therapy services (except periodic nursing evaluation) are incidental rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision.

Living Choices waiver clients may receive services through the Medicaid State Plan that are not duplicative of assisted living waiver services. State plan services must be provided by qualified providers enrolled with the Medicaid agency as a provider of the specific service, (i.e. home health services, DME equipment, therapy services, prescription drugs), and who would have to meet the provider standards for the Medicaid State Plan service that is provided. The Medicaid State Plan services are not paid for through the waiver.

Attendant care services through Living Choices is the provision of assistance to a person who is medically stable and/or has a physical disability to accomplish tasks of daily living that the person is unable to complete independently, such as eating, dressing, bathing and personal hygiene, mobility and ambulation, and bowel and bladder requirements. Waiver attendant care services assist persons to remain independent as much as possible and to that extent are most often not provided as direct care to the total degree of doing the task or activity for the person. However, the required assistance may vary from actually doing a task for the person, assisting the person in performing the task himself or herself or providing safety support while the person performs the task. Attendant care services include oversight, supervision and cueing persons while performing a task. Incidental housekeeping and shopping for personal care items or food may be included in attendant care. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Preparation and serving of meals and laundry are in a congregate setting.

Pursuant to Act 1230 of 2001, the Arkansas Legislature defines limited nursing services as acts that may be performed by licensed personnel while carrying out their professional duties, but limited to those acts that the

department (DHS) specifies by rule. Acts which may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department (DHS) for facilities offering assisted living services, shall not be complex enough to require twenty-four (24) hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces and splints (Ark. Code Ann. §20-10-1703).

Limited nursing services provided through the Living Choices waiver are not services requiring substantial and specialized nursing skills that are provided by home health agencies or other licensed health care agencies. Living Choices limited nursing services will be provided by registered nurses (RN), licensed practical nurses (LPN) and certified nursing assistants (CNA) who are employed or contracted with the assisted living facility. Limited nursing services include the assessment and monitoring of the waiver client's health care needs, including the preparation, coordination and implementation of services, in conjunction with the physician/primary care physician or community agencies as appropriate. LPN limited nursing services are provided under the supervision of the RN and include monitoring of the waiver client's health condition and notification of the RN if there are significant changes in the waiver client's health condition. Both the RN and LPN may administer medication and deliver medical services as provided by Arkansas law or applicable regulation. CNAs, under the supervision of an RN and LPN, may perform basic medical duties as set forth in Part II, Unit VII of the Rules and Regulations governing Long Term Care Facility Nursing Assistant Curriculum. These basic medical duties include taking vital signs (temperature, pulse, respiration, blood pressure, height/weight), and recognizing and reporting abnormal changes.

Therapeutic, social and recreational activities are activities that can improve a resident's eating or sleeping patterns; lessen wandering, restlessness, or anxiety; improve socialization or cooperation; delay deterioration of skills; and improve behavior management. Therapeutic activities include gross motor activities (e.g., exercise, dancing, gardening, cooking, etc.); self-care activities (e.g., dressing, personal hygiene, or grooming); social activities (e.g., games, music, socialization); and, sensory enhancement activities (e.g., reminiscing, scent and tactile stimulation). A periodic nursing evaluation by the ALF RN is required quarterly, and revisions made as needed. If required by licensing regulations, and an occupancy admission agreement is in place, the health care services plan portion of the occupancy admission agreement shall be revised within fourteen (14) days upon any significant enduring change to the resident and monitoring of the conditions of the residents on a periodic basis.

~~As described in B-6, each waiver applicant needing an evaluation and each waiver participant needing a re-evaluation will receive an individual assessment performed by the Independent Assessment Contractor. Each assessment or re-assessment is performed by a licensed registered nurse (RN) using the Arkansas Independent Assessment (ARIA)approved assessment instrument. The Independent Assessment Contractor's RNs will complete the ARIA approved assessment instrument for each initial evaluation and subsequent re-evaluation, drawing upon information from a face-to-face meeting with the applicant/participant and, if necessary, information from other parties familiar with the individual's conditions, functional limitations, and circumstances. The Office of Long Term Care (OLTC)Division of County Operations will use the assessment results to evaluate level of care for the waiver and medical eligibility for the waiver.~~

The daily rate pays for all direct care services in the participants plan of care. These rates are exclusive of room and board.

Potential overlap of the scope of services is managed and monitored through MMIS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:							
N/A							
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian	
Provider Specifications							
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:			
				Licensed Level II Assisted Living Facility; Licensed Class A Home Health Agency			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Level II Assisted Living Facility;	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Level II Assisted Living Facility.		~~Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) as an Assisted Living Level II facility to be eligible to participate in the Arkansas Medicaid Program. A copy of the ALF's current license must accompany the provider application and Medicaid contract. Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency's written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client's' condition; and, a client's right to confidentiality. This training must be provided prior to the delivery of waiver services.~~ ~~The facility must be located within the state of Arkansas.~~

			~~Consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the concurrence of the federal Centers for Medicare and Medicaid Services (CMS), DPSQA may temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers in the Living Choices HCBS waiver program. If DPSQA determines temporary caps, limits, or moratoria are appropriate and would not adversely impact beneficiaries' access to assisted living facility services, it will initiate the process through filing a Request for State Implemented Moratorium (CMS-10628 Form) with CMS.~~

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Level II Assisted Living Facility;	Division of ~~Provider Services and Quality Assurance~~Medical Services	Annual

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Class A Home Health Agency	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Class A Home Health Agency.~~.~~		~~Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance as a Class A Home Health Agency to be eligible to participate in the Arkansas Medicaid Program. A copy of the Class A Home Health Agency's current license must accompany the provider application and Medicaid contract. Providers must also be~~

			~~enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency's written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client's condition; and, a client's right to confidentiality. This training must be provided prior to the delivery of waiver services.~~ ~~The facility must be located within the state of Arkansas.~~ ~~Provider qualifications, licenses, training, education and experience for the staff of Home Health Agencies are the same as Medicaid enrolled Home Health Agencies.~~

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Class A Home Health Agency	Division of ~~Provider Services and Quality Assurance~~Medical Services	Annual

Appendix C-2: General Service Specifications

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

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

	A criminal history record check is required for employees of long-term care (LTC) facilities, according to Ark. Code Ann. §20-33-213. The Division of Provider Services and Quality Assurance (DPSQA)~~, Office of Long Term Care (OLTC),~~ requires state and national criminal history record checks on employees of long-term care facilities, including assisted living facilities. Employees include any person who has unsupervised access to participants; provides care to participants on behalf of a service provider, under supervision of, or by arrangement with the assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility to provide care to participants. Before making an offer of employment, the assisted living facility shall inform an applicant that employment is contingent on the satisfactory results of criminal history record checks. When a facility operator applies for ~~licensure~~certification to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from ~~the Office of Long Term Care~~DPSQA. The forms and appropriate fees shall be submitted to the ~~Office of Long Term Care~~DPSQA attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the ~~Office of Long Term Care~~DQSQA shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to ~~the Office of Long Term Care~~DQSQA for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure. Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks so that no applicable employee exceeds five years without a new criminal record check. Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule. In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor. Home Health Agencies that contract with the assisted living facilities (ALF's) must meet the same requirements for initial criminal history record checks. Criminal history/background investigations in ~~LTC/NF~~ long term care/nursing facilities are monitored through the ~~Office of Long Term Care~~DPSQA Licensing and Surveying Unit.
○	**No**. Criminal history and/or background investigations are not required.

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

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

The Division of Provider Services and Quality Assurance (DPSQA), ~~Office of Long Term Care~~, requires that assisted living facilities conduct adult abuse registry checks on employees prior to licensure. The facility must provide documentation that employees have not been convicted or do not have a substantiated report of abusing or neglecting residents or misappropriating resident property. The facility shall, at a minimum, prior to employing any individual or for any individuals working in the facility through contract with a third party, make inquiry to the Employment Clearance Registry of the ~~Office of Long Term Care~~DPSQA, the Child Maltreatment Central Registry maintained by the Division of Children & Family Services, another division within DHS, ~~-~~and the Adult Abuse Register maintained by the Adult Protective Services Unit within the Division of Aging, Adult, and Behavioral Health Services. Employees must be re-checked every five (5) years. ~~The Office of Long Term Care~~DHS requires that each facility have written employment and personnel policies and procedures, which include verification that an adult abuse registry check has been completed.

Employees include any person who has unsupervised access to participants; provides care to participants on behalf of a service provider, under supervision of, or by arrangement with the assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility to provide care to participants.

The ~~OLTC~~ DPSQA Licensing and Surveying Unit ensures that mandatory screenings have been conducted.

~~When a facility operator applies for licensure to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from the Office of Long Term Care. The forms and appropriate fees shall be submitted to the Office of Long Term Care attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the Office of Long Term Care shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to the Office of Long Term Care for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure. Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks on applicable employees so that no applicable employee exceeds five years without a new criminal record check.~~

Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule.

	~~In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor. Home Health Agencies that contract with the ALF's must meet the same requirements for initial criminal history record checks. Criminal history/background investigations in LTC/NF facilities are monitored through the Office of Long Term Care Licensing and Surveying Unit.~~ ~~Home Health Agencies that contract with the ALF's must meet the same requirements for initial criminal history record checks.~~ ~~Criminal history/background investigations in LTC/NF facilities are monitored through the Office of Long Term Care Licensing and Surveying Unit.~~
○	**No**. The state does not conduct abuse registry screening.

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

Living Choices provider enrollment is open and continuous. Prospective Living Choices Assisted Living Providers may contact the Medicaid program's Provider Enrollment Unit for information about becoming a provider. There are no restrictions applicable to requesting this information. This process is open and available to any interested party.

~~The website of the Division of Provider Services and Quality Assurance (DPSQA) lists information for potential Living Choices providers. In addition, the Office of Long Term Care within DPSQA provides information about becoming a waiver provider during the process of licensing facilities, upon request.~~

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

i. Performance Measures

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

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

Performance Measure:	***Number and percentage of providers, by provider type, which maintained its license to participate in the waiver program in accordance with State law and waiver provider qualifications. Numerator: Number of providers with maintained license; Denominator: Total number of providers.***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
MMIS Provider Report	

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

Performance Measure:	***Number and percentage of providers, by provider type, which obtained the appropriate license in accordance with State law and waiver provider qualifications prior to delivering services. Numerator: Number of new providers with appropriate license prior to delivery of services; Denominator: Number of new providers.***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
MMIS Provider Report	

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

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

i. Performance Measures

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

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

Performance Measure:	***Number and percent of qualified providers will be ~~licensed~~ enrolled by the Division of ~~Provider~~ Medical Services ~~and Quality Assurance (DPSQA).~~(DMS). ~~Qualified providers will be offered using the freedom of choice list~~. Numerator: Number of providers with maintained***

	~~license~~enrollment credentials; **Denominator: Total number of providers participating in the waiver program.** ~~-~~
Data Source *(Select one) (Several options are listed in the on-line application):* ~~**Record reviews, on-site**~~**Program Logs**	
If 'Other' is selected, specify:	

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

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

i. Performance Measures

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

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

Performance Measure:	***Number and percent of providers meeting waiver provider training requirement as evidenced by the in-service attendance documentation. Numerator: Number of providers indicating training by in-service attendance documentation; Denominator: Total number of providers.***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	

If 'Other' is selected, specify:			
Provider In-Service Attendance Documentation			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ ~~☐~~ *State Medicaid Agency*	☐ *Weekly*	■ *100% Review*
	☐ ~~■~~ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		■ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

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

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

The state verifies that providers meet required licensing or certification standards and adhere to other state standards. License expiration dates are maintained in the MMIS and tracked for all participating and active providers. Non-certified providers are not allowed to provide services under this waiver.

Each month the DHS PCSP/CC ~~RN~~ ~~n~~Nurse receives a provider list for each county included in their geographical area. This provider list may be used during the development of the person centered service plan to give the participant a choice of providers for each service included on the service plan. In addition, this list is used to identify the providers who are new or who have been reinstated in the program.

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

~~DPSQA and DAABHS work collaboratively to train providers on program policy, including documentation requirements, reporting, claims processing and billing, the Medicaid Provider Manual and other areas. This training is scheduled, at a minimum, two times per year based on training needs.~~

Training requirements are explained in the provider manual. ~~In addition, the Division of Provider Services and Quality Assurance (operating agency) (DPSQA) is responsible for contacting new providers according to program policy~~. These contacts provide information regarding proper referrals, eligibility criteria, ~~documentation requirements~~, forms, reporting, general information about the program, etc. ~~Within three months of appearing on the provider list, each new provider must meet with the DHS RN face-to-face to discuss all of the above, plus any problems noted in the first three months of participation.~~

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

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

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

In accordance with the Medicaid provider manual, the provider must require staff to attend orientation training prior to allowing the employee to deliver any waiver services. This orientation shall include, but not be limited to, descriptions of the purpose and philosophy of the Living Choices program; discussion and distribution of the provider agency's written code of ethics; activities which shall and shall not be performed by the employee; instructions regarding Living Choices record keeping requirements; the importance of the service plan; procedures for reporting changes in the participant's condition; discussion, including potential legal ramifications, of the participant's right to confidentiality.

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

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

b. Methods for Remediation/Fixing Individual Problems

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

To continue Medicaid enrollment, a waiver provider must maintain certification requirements ~~by DPSQA~~. In cases where providers do not maintain certification requirements, ~~DPSQA's~~ remediation may include requesting termination of the provider's Arkansas Medicaid enrollment, recouping payment

for services provided after certification/licensure has expired, and allowing the participant to choose another provider.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☐ ■ *State Medicaid Agency*	☐ *Weekly*
	■ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		■ *Continuously and Ongoing*
		☐ *Other: Specify:*

Appendix C-5: Home and Community-Based Settings

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

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

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

~~Please see Module 1, Attachment #2 for the states HCB Settings Waiver Transition Plan.~~

~~Arkansas is still assessing settings compliance in accordance with the statewide transition plan.~~
1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future

ARChoices was implemented starting January 1, 2016. It combined the previous Elder Choices (EC) and Alternatives for Adults with Physical Disabilities (AAPD) waivers.

Most waiver beneficiaries in EC and AAPD, and subsequently ARChoices, reside in private homes in the community and receive HCBS services in their homes. The home may be the person's home or the home of a family member. It is expected that waiver beneficiaries who live in their own home or the

home of a family member meets the setting requirements found at 42 CFR 441.301(c)(4). For any home in which HCBS waiver beneficiaries are living with paid staff, who own the home and are not related to the individual, the state considers these to have elements of provider-owned or controlled settings, and as such will plan to assess, validate, and remediate these as needed to assure full compliance with the HCBS Settings rule.

Current DAABHS Registered Nurses, who develop the Person-Centered Service Plan (PCSP), and Case Managers, who monitor services in the home, have been trained on the HCBS Settings rule. New DAABHS Registered Nurses and Case Managers will be trained on the HCBS Settings rule. DAABHS Registered Nurses and Case Managers have always monitored--and will continue to monitor--the participant's home environment and services provided in the home to ensure the participant's human rights are not violated. DAABHS Registered Nurses and Case Managers will continue to monitor services through annual home visits with 100% of waiver clients. In addition, as part of the certification process, the Division of Provider Services and Quality Assurance Provider Certification Unit staff monitor services in the person's home. DAABHS Registered Nurses, Case Managers, and Provider Certification staff has been trained on the HCBS Settings rule. Information on the HCBS Settings rule will be included in annual training opportunities for DAABHS Registered Nurses, Case Managers, and Provider Certification staff.

If it is discovered that a participant's rights are compromised, the DAABHS Registered Nurses and/or Case Managers will work with the client and, when appropriate, include the family or friend to resolve the issue, involving Adult Protective Services personnel, when necessary.

Review of State Policies and Procedures:

In the first half of 2015, DAABHS identified policies, provider manuals and certification requirement changes needed to comply with settings regulations. HCBS settings policy was integrated into the ARChoices provider manual to be effective January 1, 2016. This manual went through public comment from August 3, 2015 through September 1, 2015, as part of promulgation. The ARChoices provider manual governs Adult Day Care and Adult Day Health Care facilities. Also, the Living Choices Assisted Living (LCAL) provider manual received Arkansas Legislative Council approval Sept. 26, 2016. HCBS settings policy has been incorporated into this manual. The public comment period for this change was October 23, 2015 through November 21, 2015. CMS approved the renewal on July 25, 2016. Once these rules are established in the provider manuals, certification procedures will be adjusted to comply with the new rules by July 1, 2017.

During the first half of 2016, DAABHS performed a more formal and extensive crosswalk of statutes, licensing regulations, policies and procedures governing Level II Assisted Living Facilities and Adult Day Care and Adult Day Health Care facilities. A different crosswalk was completed for each facility type and reflects the level of compliance for each regulatory standard, and what must be changed to meet compliance. Statutes and licensing regulations for these facilities govern all Level II Assisted Living Facilities and Adult Day Care and Adult Day Health Care facilities, regardless of whether the facility is a Medicaid waiver provider, or not. Licenses are granted by the Office of Long-Term Care in the Division of Provider Services and Quality Assurance. Since non-Medicaid providers are not required to meet the HCBS settings rules, the HCBS settings requirements will not be implemented in the statutes or licensing regulations governing these facilities. If a provider of one of these licensed non-Medicaid facilities wants to become a Medicaid waiver provider, they must then enroll as a Medicaid provider and be certified as a Medicaid waiver provider by the Division of Provider Services and Quality Assurance. All new providers must meet the HCBS settings requirements before they can be certified as a waiver provider.

As a result of the DAABHS policy crosswalks, the state will issue a series of Provider Information Memos (PIM) to HCBS residential and non-residential providers. The state will issue a PIM to both HCBS residential and non-residential providers specifying that they must bring themselves into compliance with the HCBS Settings rule even though the state has not codified the HCBS Settings rule into state statue or licensing regulations. In addition, the state will issue a PIM to our HCBS non-residential providers explaining the requirement that the experiences of individuals receiving HCBS in non-residential settings must be consistent with those individuals not receiving HCBS, for example the same access to food and visitors. All PIMs were issued by December 31, 2016.

2, Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing:

An inter-divisional HCBS Settings working group has met regularly since 2014 and will continue to meet during the implementation of the STP. The working group consists of representatives from DAABHS, DDS, and DMS within the Arkansas Department of Human Services. The working group initially met to review the new regulations and develop the initial STP and corresponding timeline. The group has met with external stakeholders to discuss the new regulations. These stakeholders include: assisted living providers, aging providers, intellectual and developmental disability providers, advocates, consumers, and associations representing the aforementioned groups.

The group continues to meet to discuss assessment activities, including provider self-assessment surveys, site visits, and ongoing compliance with the HCBS Settings rule. A small team from this inter-divisional HCBS Settings working group reviewed the provider self-assessment surveys, modified existing HCBS Settings on-site assessment tools to validate provider self-assessments, and analyzed. DAABHS has required Adult Day Cares (ADC), Adult Day Health Cares (ADHC) and Level II Assisted Living Facilities (ALF) to conduct a provider self-assessment and provide the results to DAABHS. DAABHS has used and will continue to use the information from the provider self-assessments to determine what qualities of home and community-based settings exist in the current setting and to inform the development of standards which will facilitate the transition of settings which may not fully meet HCBS characteristics to those which include all the necessary characteristics and traits of a fully compliant HCBS setting.

DAABHS has identified three types of settings that are at risk for not meeting the full extent of the regulations either because the service is provided outside a private residence or because the participant resides in and receives services in a home owned by the provider. These settings are:
• Adult Day Care
• Adult Day Health Care
• Level II Assisted Living Facility

Residential provider self-assessment

To assess compliance with the new HCBS settings requirements, the inter-divisional HCBS Settings working group developed a residential provider self-assessment survey. The survey was developed using the exploratory questions provided in the CMS HCBS Toolkit. Residential providers include Level II Assisted Living Facilities (ALF). The survey questions fall under five general categories: 1) neighborhood characteristics; 2) home environment; 3) community access and supports; 4) services and supports planning process; and 5) setting characteristics and personal experience.

Neighborhood characteristics encompass traits of the surrounding physical environment including location of the facility within the broader community and access to public transportation. The purpose of the CMS HCBS guidelines is to ensure that individuals are receiving services in a facility that

resembles a home-like environment. There are several questions on this survey that address qualities of the home, including questions related to free range inside and outside the facility, lack of restrictive schedules, access to home amenities (television, radio, telephone, etc.), access to home appliances (laundry, kitchen, etc.), meal/snack times, meal/snack choices, physical accessibility of facility and individual's room, and individual preferences for decorating room. Community access and supports describe the integration of residents into the broader community for work-related and leisure activities, as well as visitor access to the facility. The services and supports planning process include habilitation planning, housing protections and due process, and resident rights. Finally, the setting characteristics and personal experience category covers a variety of issues including choice of living arrangement/roommate, privacy and restrictions, interventions, and rights modification.

Residential provider self-assessment surveys (n=45) were distributed via mail in July 2014. Non-responders were contacted via phone and email to encourage completion of the survey which resulted in a response rate of 82% (n=37). Follow-up telephone calls and emails ensued to clarify residential provider responses (as needed). These follow-up calls did not take the place of on-site visits. Residential providers that were licensed and certified after data collection efforts ceased for the provider self-assessment survey or residential providers that began receiving HCBS beneficiaries after data collection ceased were not included in this analysis. However, these providers were subsequently mailed a provider self-assessment so the state could have a baseline "snapshot" of the residential provider's existing self-assessed compliance with the HCBS settings rule. Their responses were then analyzed in order to establish priority for the on-site validation visits. Furthermore, other providers (who responded to the provider self-assessment) have become inactive since the initial self-assessment data collection efforts ceased.

The residential provider-self assessment survey is a necessary part of the HCBS compliance process. This survey allows residential providers to reflect on their current level of compliance as well as take note of areas of potential non-compliance. This survey is intended to raise awareness among ALFs serving HCBS Medicaid beneficiaries about the HCBS settings rules. The survey was distributed prior to ALFs receiving any information on the HCBS Settings rule from DHS. Due to a lack of information or knowledge about the HCBS Settings rule, ALFs may have lacked the level of understanding necessary to accurately complete the provider self-assessment. For this reason, the state decided to use the provider self-assessment as a means to raise awareness among ALFs about the intricacies of the HCBS Settings rule and use it as a way to initiate dialogue between the state and the provider community. The information from the surveys allowed the State to provide targeted technical assistance for ALFs as a whole as well as individually as they move into compliance with the HCBS settings rule. As a follow-up to this survey, the State conducted on-site assessments as a way to validate the self-assessment findings.

While it appears that most ALFs serving HCBS Medicaid beneficiaries are progressing toward HCBS compliance, there are a few areas of concern that need to be addressed. Based on residential provider responses, there may be some ALFs that are in effect isolating residents due to the location of the ALF in relation to the broader community. ALFs self-reporting this characteristic received priority for on-site visits.

There are a small number of ALFs that report having a curfew, restricting access to home-like appliances, restricting meal time and/or choice, and requiring an assigned seat during meals. Some ALFs also report that they do not have a way to ensure privacy for residents using the common-use telephone or computer.

Cameras are also present in approximately half of all ALFs surveyed. Less than half of ALFs report using barriers to prevent resident access to particular areas within the setting.

A small number of ALFs have restricted visiting hours, and half of the ALFs reported not posting visiting hours. Some ALFs indicate that residents do not know how to schedule a person-centered planning meeting; residents may not be able to explain the process of developing and updating their person-centered plan, residents do not attend the planning meeting, and the meeting may not be at a convenient time/place to ensure resident attendance.

Not all ALFs reported that residents have a lease or written agreement to ensure housing rights. Some ALFs also suggest that residents may not understand the relocation process or how to request new housing.

Non-residential provider self-assessment

To assess compliance with the new HCBS settings requirements, DAABHS developed a non-residential provider self-assessment survey. The survey was developed using the exploratory questions provided in the CMS HCBS Toolkit. Non-Residential providers include Adult Day Centers (ADC) and Adult Day Health Centers (ADHC).The survey questions fall under five general categories: 1) neighborhood characteristics; 2) home environment; 3) community access and supports; 4) services and supports planning process; and 5) setting characteristics and personal experience.

Neighborhood characteristics encompass traits of the surrounding physical environment including location of the facility within the broader community and access to public transportation. The purpose of the CMS HCBS guidelines is to ensure that individuals are receiving services in a location that resembles a home-like environment. There are several questions on this survey that address qualities of the home, including questions related to free range inside and outside the facility, lack of restrictive schedules, meal/snack times, meal/snack choices, physical accessibility of facility, ability to secure personal belongings, and privacy. Community access and supports describe the integration of residents into the broader community for non-work and leisure activities, as well as visitor access to the facility. The services and supports planning process include individual needs and preferences, informed consent, and individuals' rights. Finally, the setting characteristics and personal experience category covers a variety of issues including staff behavior and individual restrictions or interventions.

Non-residential provider self-assessment surveys (n=31) were distributed via mail in July. Non-responders were contacted via phone and email to encourage completion of the survey which resulted in a response rate of 77% (n=24). Follow-up phone calls and emails ensued to clarify residential provider responses (as needed). These follow-up calls did not take the place of on-site visits. Non-residential providers that were licensed and certified after data collection efforts ceased for the provider self-assessment survey or non-residential providers that began receiving HCBS beneficiaries after data collection ceased were not included in this analysis. However, these providers were subsequently mailed a provider self-assessment so the state could have a baseline "snapshot" of the non-residential provider's existing self-assessed compliance with the HCBS settings rule. None of these providers returned a survey. Furthermore, other providers (who responded to the provider self-assessment) have become inactive since the initial self-assessment data collection efforts ceased. For this reason, the response rate documented in the non-residential provider self-assessment report of findings will not be the same as the response rate referred to later in this plan (p. 17, paragraph 2).

The non-residential provider-self assessment survey is a necessary part of the HCBS compliance process. This survey allows non-residential providers to reflect on their current level of compliance as well as take note of areas of potential non-compliance. This survey is intended to raise awareness among ADCs/ADHCs serving HCBS Medicaid beneficiaries about the HCBS settings rules. The survey was distributed prior to ADCs/ADHCs receiving any information on the HCBS Settings rule from DHS. Due to a lack of information or knowledge about the HCBS Settings rule, ADCs/ADHCs

may have lacked the level of understanding necessary to accurately complete the provider self-assessment. For this reason, the state decided to use the provider self-assessment as a means to raise awareness among ADCs/ADHCs about the intricacies of the HCBS Settings rule and use it as a way to initiate dialogue between the state and the provider community. The information from the surveys will allow the State to provide targeted technical assistance for the ADCs/ADHCs as a whole as well as individually as they move into compliance with the HCBS settings rule. As a follow-up to this survey, the State conducted on-site assessments as a way to validate the self-assessment findings. In doing so, the State was able to use the findings of this survey to prioritize which ADCs/ADHCs to visit first.

While it appears that most ADCs/ADHCs serving HCBS Medicaid beneficiaries are progressing toward HCBS compliance, there are a few areas of concern that need to be addressed. Based on provider responses, there may be some ADCs/ADHCs that are in effect isolating residents due to the location of the ADC/ADHC in relation to the broader community. ADCs/ADHCs self-reporting this characteristic received priority for on-site visits.

There are a small number of ADCs/ADHCs that report restricting meal/snack time and/or choice, lacking a space to secure personal belongings, and prohibiting engagement in age-appropriate legal activities. One-third of ADCs/ADHCs describe barriers to prevent resident access to particular areas within the setting.

Some ADCs/ADHCs indicate that clients do not engage in regular non-work activities in the community. Additionally, some ADCs/ADHCs do not require informed consent prior to using restraints or restrictive interventions. A small number of ADCs/ADHCs reportedly do not provide clients the opportunity to update or change their preferences, provide information on individual rights, nor do they provide information to clients on the process for requesting additional (or making changes to their current) home and community-based services.

Validation of self-assessment (site visits)

An inter-divisional site review subcommittee of the HCBS Settings working group reviewed several HCBS site assessment surveys developed by other states and chose to modify an existing site visit survey for use in Arkansas. The Arkansas HCBS site review survey examines HCBS settings characteristics as outlined in the CMS exploratory questions. The content of the site review survey is consistent with the areas that were included in the provider self-assessment survey. Separate assessment tools were designed for residential and non-residential settings.

The Residential Site Review Survey includes the following content areas: integrated setting and community access (heightened scrutiny), community integration, housing protections and due process, living arrangements, beneficiary rights, and accessible environment. The Non-Residential Site Review Survey includes the following content areas: integrated setting and community access (heightened scrutiny), community integration, non-residential services, and beneficiary rights. For each question included in the site review survey, the reviewer is asked to mark a yes or no response (the "compliant" or normative response is highlighted for reviewer convenience), mark the information sources accessed to gather information, include notes/evidence of compliance or notes/evidence of non-compliance, and to mark whether remediation will be required. Responses will be qualitatively analyzed for emerging themes that highlight areas of non-compliance.

The on-site visit included: 1) documented observation of the setting, 2) interviews with beneficiaries of the setting, 3) input from staff, family members (of beneficiaries), and others and 4) a review of supporting documents provided by the provider including, but not limited to, occupancy/admission agreements, resident bill of rights, grievance policies, and individual person-centered service plans.

This survey has been reviewed by external stakeholders, and revisions have occurred based on stakeholder feedback.

The same inter-divisional site review subcommittee of the HCBS Settings working group reviewed several HCBS beneficiary/member surveys developed by other states and chose to modify an existing survey tool for use in Arkansas. The Arkansas HCBS beneficiary survey is intended to assess the HCBS characteristics of the setting based on the beneficiary's experience within the setting. The content of the beneficiary survey is consistent with HCBS settings characteristics outlined in the CMS "exploratory questions" as well as the Arkansas provider self-assessment surveys and the Arkansas site review survey tools. Separate beneficiary surveys were designed for both residential settings.

The residential beneficiary survey includes the following content areas: community integration, housing protection and due process, living arrangements, and accessible environment. The non-residential beneficiary survey includes the following content areas: community integration and non-residential services. Each section may include several questions to elicit information from the beneficiaries regarding their experience in the setting. For each question included on the beneficiary survey, the reviewer is asked to mark a yes or no response (the "compliant" or normative response is highlighted for reviewer convenience), mark the information sources accessed to gather information, include notes/evidence of compliance or notes/evidence of non-compliance, and to mark whether remediation will be required. Some questions may have an additional no response option which is "no but supported by the person-centered plan". In addition, probing questions are provided for each survey question to allow the reviewer the opportunity to elicit a more robust response from beneficiaries to provide evidence of compliance or non-compliance. Documentation may be requested to validate the congruence between the person-centered plan and the beneficiary's responses, especially for those questions that appear to reflect a non-compliant setting. Responses will be qualitatively analyzed for emerging themes that highlight areas of non-compliance.

The DAABHS beneficiary sample for the residential beneficiary survey was randomly drawn from an unduplicated count of current Medicaid beneficiaries (n=952) residing in a Level II Assisted Living Facility. To determine the number of beneficiaries to randomly sample, we divided the number of unduplicated Medicaid residential beneficiaries at a given ALF by the total unduplicated residential beneficiary count. This process was repeated for all Level II ALFs serving Medicaid beneficiaries. This gave us the percentage of Medicaid beneficiaries at a given ALF in relation to the total number of unduplicated Medicaid beneficiaries. The percentage of Medicaid beneficiaries at a given ALF was multiplied by the target sample size to determine how many beneficiaries to interview at each ALF. The target sample size for the beneficiary survey was derived from a commonly used statistics website (www.stattrek.org) using a sample size calculator. For an unduplicated beneficiary count of 952 with a 95% confidence interval and a 4% margin of error, our residential beneficiary sample size was 369. We were able to interview approximately 79% (n=291) of our target sample of 369. We interviewed beneficiaries at nearly 100% of the Level II ALFs licensed as Medicaid providers. The only reason we were unable to interview beneficiaries at a particular setting was due to the setting being so new that there were no Medicaid beneficiaries residing there yet. There were multiple reasons that contributed to a lower survey completion rate than we originally expected, including beneficiaries being hospitalized, deceased, non-interviewable (based on diagnosis), as well as beneficiaries refusing to participate and being away from the facility during the site visit.. The state has been brainstorming ways to improve outreach efforts to meet the target sample. These efforts may include making announced/planned visits to ensure that the persons we need to interview are willing and able to meet with us at a scheduled day/time. We will also conduct proxy interviews with guardians/family members/advocates on behalf of beneficiaries, as appropriate and necessary.

In addition, we will conduct data clean-up activities to generate a more reliable list from which we generate our target sample.

Staff employed by DAABHS, DDS, and DMS were assigned to regional site visit teams. Employees with a background in survey/data collection, auditing, and fieldwork were chosen to serve as reviewers and assigned to a regional site visit team. These employees, along with members of the site review subcommittee, completed a day-long training in appropriate qualitative methods including direct observation, qualitative interviewing, note-taking, and record review prior to conducting site visits as well as during the site visit process (as needed). The site visit team training also included a module on the HCBS Final Rule, criteria for heightened scrutiny, and a module on sensitivity training. The training session also included a thorough review of both the residential and non-residential survey instruments. The survey was reviewed question-by-question to clarify the intent of the question and appropriate probing questions. Current members of the site review subcommittee were trained in qualitative research methods and a "train the trainer" model was utilized. Quality control checks were implemented throughout the site visit process. Quality control checks consisted of a member of the site review subcommittee pairing up with a member of the site review team to review the site visit documentation. Quality control checks occurred throughout the site assessment process to ensure that surveys were completed in a consistent manner across all regional site visit teams and within each site visit team.

The residential site review survey and the residential beneficiary survey were pilot-tested in a small number of DAABHS settings prior to statewide implementation and were revised further based on feedback during the pilot tests. An additional training session was scheduled with all members of the site visit team to re-emphasize the importance of thorough documentation, the use of probing questions during the beneficiary survey, and to finalize the site visit process. The site visit team along with select members of the inter-divisional HCBS Settings working group met bi-monthly to discuss issues in the field, undergo re-training (if necessary), and/or provide status updates on site visits.

DAABHS conducted site visits on 100% of residential ALF providers (n=51) and non-residential providers (n=26). Very few residential and non-residential providers were identified as HCBS compliant based on the provider self-assessment survey responses. Residential providers include Level II Assisted Living Facilities (ALF) while non-residential providers include Adult Day Care (ADC) facilities and Adult Day Health Care (ADHC) facilities. All settings were represented in the provider self-assessment and were represented in the on-site visits. DAABHS completed the residential ALF site visits in July 2016 (timeline row A-22) and the non-residential site visits in August 2016 (timeline row A-23) (see Appendix A).

Prior to the site visit, residential and non-residential providers received a letter from DHS announcing the process and a 2-3 month timeframe when they could expect a site visit. DHS intentionally chose to make unannounced visits without pinpointing specific dates/times to providers in order to get a better sense of the typical day in the lives of waiver beneficiaries. The state will consider announcing to providers the dates/times of site visits in the future.

In addition, the state's regional site visit teams contacted the guardians or power of attorney on record for beneficiaries listed in the target sample for a given facility. The state conducted this outreach to ensure that these guardians/family members/advocates had sufficient notice to make themselves available on the day of the site visit, should they choose to participate and contribute to the beneficiary survey on behalf of the beneficiary. During these outreach efforts, the regional site teams disclosed the day/time of the site visit so that guardians/family members/advocates could arrange their schedules accordingly.

The site visits followed a standard process including a brief introduction with setting administrators/staff, initial rounds with administrators/staff using the Residential Site Review Survey, request for supporting documentation, interviews with beneficiaries using the Beneficiary Survey, and an exit summary with administrators/staff.

Upon completion of the initial site visits and review of supporting documents provided by the provider, notes from the site review team member were summarized in a standardized report. A cover letter and the corresponding report were mailed to each provider following the on-site visit. The letter summarized the visit, noted areas needing clarification that were observed and documented, requested clarification of provider policies and procedures and/or a corrective action plan, and provided a deadline with which to comply with the requested action(s). This letter also highlighted discrepancies between the information provided by facility staff on the site visit survey and the information provided by beneficiaries and/or their family members/advocates on the beneficiary survey. Providers were asked to address these discrepancies in their corrective action plans. DHS has provided technical assistance to providers throughout this time period. This technical assistance is frequently initiated by provider phone calls. However, the state has also engaged in several face-to-face training opportunities through provider workshops hosted by the Provider Certification Unit, annual meetings of advocacy organizations, provider membership organizations, and monthly meetings with the small stakeholder group.

As corrective action plans and/or updated provider policies and procedures are submitted, DHS will review these materials and respond via letter to the provider. Follow-up site visits may occur as a result of this back-and-forth process with providers to ensure that corrective actions are implemented in the setting. If additional site visits are required, the provider will receive additional standardized reports and letters summarizing the visits. These will include directions for any further action(s) on behalf of the provider. The successful completion of any corrective action plans will be closely monitored by the Director of DAABHS along with designated staff who will monitor the remediation activities outlined in the corrective action plans to ensure that the state is progressing in a timely manner to meet compliance. The state's inter-divisional HCBS Settings working group currently meets monthly to discuss the state's progress and upcoming activities. The state will include monthly updates on provider implementation of corrective action plans and determine if additional provider technical assistance is warranted. During the first half of 2017, the HCBS site review subcommittee along with the HCBS Settings working group will monitor provider compliance efforts through corrective action plans and follow-up site visits. Some corrective action plans may only require a desk audit, meaning the site visit and beneficiary surveys did not highlight any non-compliance issues. However, the provider policies may not reflect the true intent of the HCBS Settings rule and as such will need to undergo revisions to become compliant with the HCBS Settings rule. Follow-up site visits will be conducted with all providers submitting substantive corrective action plans that require a change in procedure or reflect a culture change within that setting to ensure that providers are implementing the corrective actions outlined in the plan. These follow-up site visits will be conducted by a different set of reviewers than those that conducted the initial site visits, allowing for an additional layer of scrutiny. The State expects corrective action plans to be fully implemented by December 2017.

Remediation

The inter-divisional HCBS Settings working group will develop and conduct provider trainings as well as provide tailored technical assistance to partially compliant and non-compliant providers. In order to achieve initial compliance, the HCBS Settings working group is planning multiple regional training opportunities for providers, beneficiaries, and advocates to discuss reoccurring themes from provider-initiated technical assistance phone calls, appropriate remediation strategies, heightened scrutiny, and ongoing compliance. These regional training sessions will be advertised in a manner to effectively

reach all stakeholders, including providers, beneficiaries and their families, advocates, etc. The HCBS small stakeholder group will be asked to assist the inter-divisional HCBS Settings working group with disseminating information about the regional trainings to the aforementioned stakeholder groups. DHS expects these regional training sessions to occur during the Fall and Winter of 2016-17. In addition, the HCBS Settings working group will host focus groups during Spring 2017to include all providers in an effort to provide a forum for providers to talk openly about provider specific issues and brainstorm potential strategies to achieve compliance. These focus groups will provide the HCBS Settings working group with specific examples of the promising strategies employed by various settings to comply with the HCBS Settings rule. Technical assistance will also be provided on an as needed basis and will be tailored to the specific needs of the provider based on the analysis of the provider self-assessment and the on-site visits. This technical assistance is already occurring via provider-initiated phone calls to an HCBS Settings working group team member. Efforts to engage providers, advocates, beneficiaries, and others will continue to occur through our monthly small stakeholder meetings (with provider representatives and advocates), quarterly large stakeholder meetings, HCBS website, provider workshops, as well as through individual training calls with the aforementioned groups.

Upon receipt of the provider site visit report (see Appendix J and Appendix K), providers are being asked to submit a corrective action plan to respond to the site visit report (timeline row A-28, A-29, A-30, D-19). This corrective action plan should address how the setting meets HCBS compliance in response to a specific discrepancy noted in the site visit report or outline the remediation that will occur to become settings compliant. Provider-initiated remediation may include reviewing their policies and procedures and updating them as necessary to comport with the HCBS Settings requirements. This remediation may also include reviewing their practices and providing in-service training for staff, if applicable. Any changes to policies/procedures/practices should also be communicated to beneficiaries and their families and the provider is also expected to outline how and when this information will be disseminated.

During the first half of 2017, the HCBS site review subcommittee along with the HCBS Settings working group will monitor provider compliance efforts through corrective action plans and follow-up site visits. Some corrective action plans may only require a desk audit, meaning the site visit and beneficiary surveys did not highlight any non-compliance issues. However, the provider policies may not reflect the true intent of the HCBS Settings rule and as such will need to undergo revisions to become compliant with the HCBS Settings rule. However, follow-up site visits will be conducted with all providers submitting substantive corrective action plans that require a change in procedure or reflect a culture change within that setting to ensure that providers are implementing the corrective actions outlined in the plan. The State expects corrective action plans to be fully implemented by December 2017.

DAABHS providers who wish to appeal our findings can follow the appeal rights process described in Section 160.00 Administrative Reconsideration and Appeals of the Arkansas Medicaid Provider Manual (https://www.medicaid.state.ar.us/provider/docs/all.aspx).

If the HCBS Settings working group does not feel that a provider is progressing towards compliance, the State will need to implement the transition plan to move beneficiaries to a compliant setting.

Ongoing Assessment of Settings

The Office of Long-Term Care (OLTC) Licensure unit within the Division of Provider Services and Quality Assurance (DPSQA) is responsible for onsite visits for environmental regulatory requirements. The OLTC Licensure unit licenses the facilities to operate as an Assisted Living Facility or an Adult Day Care or Adult Day Health Care facility and approve the number of slots

that individuals may utilize in these settings. The Provider Certification Unit, also within DPSQA, certifies the providers to provide care under the waiver(s) once they are enrolled to be Medicaid providers. On-going compliance with the assessment of settings will be monitored collectively with DMS, DDS and DAABHS staff.

Licensed and certified settings are subject to periodic compliance site-visits by the Provider Certification Unit. HCBS Settings requirements will be enforced during those visits. DAABHS expects every residential and non-residential setting to receive a visit at least once every three years. These visits will include a site survey and beneficiary experience surveys with a select number of Medicaid beneficiaries. DAABHS Registered Nurses, Case Managers, and Provider Certification staff has been trained on the HCBS Settings rule. Information on the HCBS Settings rule will be included in annual training opportunities for DAABHS Registered Nurses, Case Managers, and Provider Certification staff. Ongoing training for providers on the HCBS Settings rule will be provided during biannual provider workshops hosted by the Provider Certification Unit, as well as through annual meetings of provider membership organizations and via updates to the Arkansas HCBS website.

Settings found to have deficiencies will be required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. Providers who wish to appeal our findings can follow the appeal rights process described in Section 160.00 Administrative Reconsideration and Appeals of the Arkansas Medicaid Provider Manual https://www.medicaid.state.ar.us/provider/docs/all.aspx). New waiver providers will also be subject to an assessment of compliance with the HCBS Settings requirements before being approved to provide services for the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	~~Plan of Care~~Person Centered Service Plan

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

During the service plan development, the DHS PCSP/CC ~~RN~~ Nurse explains to the participant the services available through the Living Choices waiver.

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

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

(a) DHS PCSP/CC ~~RNs~~ Nurses will develop initial person-centered service plans for Living Choices in Homecare participants based on the Independent Assessment Contractor's

assessment of the participant's needs and information gathered during the service plan development meeting with the participant. The DHS PCSP/CC ~~RN~~ Nurse will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting. The DHS PCSP/CC ~~RN~~ Nurse will assist in notifying interested parties if requested by the participant or the representative.

The development of the person-centered service plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor within ten (10) ~~working~~ days from contact with the beneficiary. ~~of the Independent Assessment Contractor receiving a referral from DHS~~ Evaluations, which will be conducted by the DHS PCSP/CC Nurse, will be completed at least every twelve (12) months, or more often, if deemed appropriate by the DHS PCSP/CC Nurse.~~.~~ ~~Following the assessment and assignment of a tier level by the Independent Assessment Contractor, a DHS RN will schedule a meeting with the participant to develop the service plan. Reassessments, which will be conducted by the Independent Assessment Contractor, will be completed annually or more often, if deemed appropriate by the DHS RN.~~ Following the ~~reassessment~~ evaluation, ~~by the Independent Assessment Contractor~~, the DHS PCSP/CC ~~RN~~ Nurse will develop a person-centered service plan. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans are developed and sent to all providers before services may begin.

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

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

The results of the Independent Assessment Contractor's ~~functional~~ assessment using the ~~ARIA~~ approved assessment ~~tool~~ instrument will be used by the ~~Office of Long Term Care~~ DHS Eligibility Nurse to evaluate the level of care and by the DHS PCSP/CC Nurse ~~RN~~ to develop the person-centered service plan. Information collected for the Independent Assessment Contractor's ~~functional~~ assessment using the ~~ARIA tool~~approved instrument will include demographic information and information on the waiver participant's ability to perform the

activities of daily living; transferring and ambulation; continence status; nutritional status; hearing, vision, speech and language; skin condition; behavior and attitude; orientation level; other medical conditions; psychosocial and cognitive status; and, medications/treatments.

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

~~When the service plan development process results in an individual being denied the services or the providers of their choice, the state must afford the individual the opportunity to request a Fair Hearingautomatically undertakes an appeal process that includes a Fair Hearing, unless the participant elects to not undergo the appeal process.~~

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

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

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

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

(c) During the person-centered service plan development process, the DHS PCSP/CC ~~RN~~ Nurse explains the services available through the Living Choices waiver to the participant, including any applicable benefit limits. All services the participant is currently receiving are discussed and documented on the person-centered service plan. This includes all medical and non-medical

services, such as diapers, under pads, nonemergency medical transportation, family support or other services that are routinely provided.

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

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

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

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

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

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DHS PCSP/CC Nurse~~RN~~, who is the only authorized individual who may adjust a participant's service plan. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living ~~Home & Community Based Services~~ Facility Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to

notify the DHS PCSP/CC Nurse ~~RN immediately~~ of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or necessitate a change in the participant's person-centered service plan; to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS PCSP/CC Nurse ~~RN~~ in writing within one week of services being terminated, documenting the termination effective date and the reason for the termination.

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

~~Person Centered~~Person-centered Service plans are revised by DHS PCSP/CC Nurses, ~~RNs~~ as needed between evaluations, based on reports secured through providers, waiver participants, and their support systems.

(g) Each evaluation of functional/medical eligibility and development of a person-centered service plan is completed ~~annually~~at a minimum of twelve (12) months or more often, if deemed appropriate ~~by the DHS nurse~~RN. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Changes are reported to the DHS PCSP/CC Nurse ~~RN~~ by the participant, the participant's family or representatives, and service providers. The DHS nurse ~~RN~~ has sole authority for all development and revisions to the waiver service plan. Service plan updates must be based on a change in the participant's status or needs.

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

The Independent Assessment Contractor assesses a participant's needs, functional abilities, and performance of activities of daily living during the assessment. The DHS PCSP/CC -Nurse ~~RN~~ assesses a participant's preferences, risks, dangers, and supports during the meeting with the participant to develop a person-centered service plan. In addition, the service plan development process includes assessment of risk factors and strategies to mitigate risk conducted in a manner that is sensitive to the waiver participant's preferences and the responsibilities required to reduce risk. The risk mitigation includes factors regarding the participant's functioning ability, ADL performance, support systems in place, risk of falls, environmental factors, and other dangers. This information is included on the person-centered service plan and in the participant's record. Services are started as soon as possible in order to mitigate risk.

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

Routine monitoring of Living Choices in Homecare participants also helps to assess and mitigate risk. DHS PCSP/CC Nurses ~~RNs~~ make at least annual contact with participants and take action to mitigate risks if an issue arises.

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

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

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

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

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

During completion of the person centered service plan, the participant or representative must sign the Freedom of Choice form to show that no change in providers was made. The provider

listing does not need to be initialed if there are no changes in providers. However, if a participant wishes to change providers ~~at reassessment~~, both the Freedom of Choice form and provider listing must be signed and initialed indicating this change. Participants may request a change of providers at any time during a waiver year.

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

DHS PCSP/CC ~~RNs~~ Nurses leave contact information with participants at each visit. The participant may contact the DHS PCSP/CC ~~RN~~ Nurse at any time to find out more information about providers.

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

All waiver service plans are subject to the review and approval by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) and the Division of Medical Services (DMS) (Medicaid agency).

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval and are available by the operating agency upon request. ~~DAABHS~~ DMS reviews a ~~statistically~~ validation ~~random~~ sampleing of participant records which includes the person-centered service plan.~~,~~ For the validation review, ~~and~~ DMS reviews twenty percent (20%) of the records reviewed by DAABHS. For the provider file sample, the Raosoft online calculator is used to determine a statistically valid sample with a~~t~~ ninety-five percent (95%) confidence level and a margin of error of +/- five percent (5%). Every nth name is selected for review until the sample size is reached. The sample is then divided into twelve (12) groups for monthly review by DMS. Reviewed service plans are compared to policy guidelines, the functional assessment, and the narrative detailing the participant's living environment, physical and mental limitations, and overall needs. ~~All service plans are subject to the approval of the Medicaid Agency and are made available by the operating agency upon request. DMS randomly reviews service plans through several authorities within the Medicaid Agency, such as Program Integrity and the Quality Assurance unit.~~

DHS RN Reviewer ~~sSupervisory~~ staff also conduct record reviews drawing ~~foam~~from a ~~A~~ statistically valid random sample ~~of service plans is determined,~~. ~~using~~ Using the Raosoft software calculations program, a statistically valid sample with at ninety-five percent (95%) confident level and a margin of error of +/- five percent (5%). ~~for review monthly by the DHS RN supervisory staff~~Records are reviewed to assess the appropriateness of the service plan, to validate service provision, to ensure that services are meeting the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS PCSP/CC Nurse ~~RN~~ addresses any needed corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the Office of Medicaid Inspector General.

~~Each year, DAABHS reports to the DPSQA Waiver Quality Management Administrator the findings of the service plan review process.~~

Information reviewed by both DAABHS and DMS during the record review process includes without limitation: development of an appropriate individualized service plan, completion of updates and revisions to the service plan and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

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

☐	**Medicaid agency**
■	**Operating agency**
☐	**Case manager**
■	**Other** *Specify:*
	The service plan is maintained by the DHS PCSP/CC ~~RN~~ Nurse in the participant's record and by the Living Choices Assisted Living waiver service providers.

Appendix D-2: Service Plan Implementation and Monitoring

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) employs Registered Nurses ~~(DHS RNs)~~ who are responsible for monitoring the implementation of the person-centered service plans (PCSP). When the DHS PCSP/CC ~~RN~~ Nurse sends the person-centered service plan to the provider for implementation, he/she also sends a start of care form along with the PCSP. The provider is required to document the date the service began and return the form to the DHS PCSP/CC Nurse~~RN~~. If the start of care form is not returned to the DHS PCSP/CC ~~RN~~ Nurse within 10 business days, the DHS PCSP/CC Nurse ~~RN~~ contacts the provider about the status of implementation. If the provider is unable to provide the service, the DHS PCSP/CC Nurse ~~RN~~ contacts the participant and offers other qualified providers for the service. The DHS PCSP/CC Nurse ~~RN~~ is only required to have one start of care form per service in the participant record if services remain at the same level by the same provider when reassessed. If the amount of service changes or the provider of the service changes a new start of care form is required.

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

At each ~~assessment and reassessment~~ person-centered service plan meeting, the DHS PCSP/CC Nurse ~~RN~~ provides the participant with their business card with contact information, an Adult Protective Services (APS) brochure to provide information and the toll-free APS hotline for reporting abuse, maltreatment or exploitation. This information may be utilized by the participant or guardians/family members to report any issues they deem necessary, so that DAABHS can ensure prompt follow-up to problems.

LIVING CHOICES PROVIDERS:

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting, and documentation requirements. Providers are required to report any changes in the participant's condition to the participant's DHS PCSP/CC ~~n~~Nurse~~RN~~.

INFORMATION EXCHANGE:

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

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

The following reports are used to compile monitoring information and reported as indicated:

1. Monthly Reports - compiled by each DHS PCSP/CC Nurse and reported monthly to DHS RN Supervisor. All monitoring visits are reported.

2. DHS RN Reviewer Report - compiled by each DHS RN Reviewer and reported monthly to the Nurse Manager. All monitoring visits are reported.

3. Monthly Record Reviews - performed monthly by DHS RN Reviewers and reported monthly to Nurse Manager.

4. DMS Monthly Record Reviews - performed monthly by DMS and reported monthly to DAABHS.

5. DMS Annual QA Report - compiled annually by DMS and reported to DAABHS.

~~The Division of Medical Services QA review reflects internal review of the billing process by Living Choices Medicaid providers. DAABHS conducts a record review on a monthly basis to monitor accuracy and completeness of the record, service plan implementation, service delivery, and the health and welfare of the participant, and DMS reviews 20% of the records reviewed by DAABHS. The DAABHS review completes a systematic random sampling of the active case population whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.~~

Quality Improvement: Service Plan

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

i. Performance Measures

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

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

Performance Measure:	***Number and percent of service plans that were reviewed and updated by the DHS PCSP/CC ~~RN~~ Nurse according to changes in participants' needs before the waiver participants' annual review date. Numerator: Number of participants service plans that were reviewed and revised by the DHS PCSP/CC ~~RN~~ Nurse before annual review date; Denominator: Number of records reviewed.***
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify:	

Case Record Review			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	■ *Operating Agency*	☐ *Monthly*	■ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	■ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	*DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.*
		■ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

State:	
Effective Date	

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

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

i. Performance Measures

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

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

Performance Measure:	***Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	

Case Record Review			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*

	■ *Operating Agency*	☐ *Monthly*	■ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	■ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	*DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.*
		■ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

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

Performance Measure:	***Number and percent of waiver participant records reviewed with an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with a choice between institutional care and waiver services and among waiver services; Denominator: Number of records reviewed.***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Case Record Review	

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

Data Aggregation and Analysis

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

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

State:	
Effective Date	

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

Individual records are reviewed monthly by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report. ~~A Division of Medical Services (DMS) (Medicaid agency) QA audit is also conducted from a review of 20% of the records reviewed by DAABHS, to confirm that service plans are updated and revised as warranted by changes in participants' needs.~~

Start of Care forms are reviewed to confirm the appropriateness of service delivery.

Finally, records are reviewed to assure that a Freedom of Choice form was presented to the participant and that a complete, up-to-date list of providers has been made available to the participant.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Monthly chart reviews check for the presence of justification for requested changes and proper documentation and data is summarized for the Chart Review Summary.

Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers.

Remediation is performed on service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the DHS RN ~~supervisor~~ Reviewer and is a part of the ~~chart~~ record review process.

DHS RN ~~Reviwers~~Reviewers~~DAABHS supervisory sta ff~~ uses the Raosoft calculation system to determine appropriate sample size for Living Choices Record Review and selects every ninth name on the list to be included in the sample.

~~The Division of Medical Services (DMS) QA review reflects internal review of the billing process by Medicaid providers of ALF. DMS conducts a record review on a monthly basis of 20% of the records reviewed by DAABHS to monitor accuracy and completeness of the record, service plan implementation, service delivery, and the health and welfare of the participant.~~

~~DAABHS supervisory staff uses the Raosoft calculation system to determine appropriate sample size for Chart Review and selects every "nth" name on the list to be included in the sample.~~

Record reviews of the overall program files are thorough and include a review of all required documentation regarding compliance with the service plan development assurance and service plan delivery. Reviews include, but are not limited to completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services;

consideration of participants in the service plan development process; clarity and consistency; and, compliance with program policy regarding all aspects of service plan development, changes and renewal.

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

The State Medicaid Agency assures compliance with the service plan subassurances through the review of 20% of the records reviewed by DAABHS. DAABHS provides DMS with copies of any data analysis of the findings and plans for remediation of data analysis, including trend identification. DMS and DAABHS participate in team meetings to review findings and discuss resolution.

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations), ~~the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for provider certification and quality assurance),~~ and the Division of Medical Services (Medicaid agency) – ~~all three of which~~both are part of the Arkansas Department of Human Services (DHS) – participate in team meetings as needed to discuss and address individual problems related to service plans, as well as problem correction and remediation. DAABHS~~, DPSQA,~~ and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver.

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Applicant and participant appeals are the responsibility of the Department of Human Services Office of Appeals and Hearings. DHS uses the Notice of Action to provide notice to a participant when an adverse action is taken to deny, suspend or terminate eligibility for Living Choices. The Notice of Action explains the action taken; the effective date of the action; and the reason(s) for the action. It also explains the appeal process, including how to request an appeal; that the participant has the right to request a fair hearing; the time by which an appeal and a request for a hearing must be submitted; and that if the participant files an appeal within the timeframe specified in the notice, his or her case will automatically remain open and any services and benefits he or she had been receiving will continue until the hearing decision is made, unless the participant informs DHS that he or she does not wish to continue receiving the benefits pending the appeal hearing decision. The Notice of Action also informs the participant that if he or she does not elect to discontinue benefits and the appeal hearing decision is not in his or her favor, he or she may be liable for the cost of any benefits received pending the appeal hearing decision. Notices of Action and the opportunity to request a fair hearing are kept in the participant's case record. An applicant's request for an appeal must be received by the DHS Office of Appeals and Hearings no later than 30 days from the date on the Notice of Action.

Participants have the right to appeal if they were not provided a choice in institutional care or waiver services, or a choice of providers. During the person-centered service plan development process, the DHS PCSP/CC Nurse explains to the participant or the participant's family member or representative that the participant has the right to choose institutional care or waiver services and his or her provider. The participant or another person authorized to sign for participant, signs the service plan to verify the exercise of participant choice between waiver services or institutional care. During the process, participants choose a provider from a list provided by the DHS PCSP/CC Nurse. The participant's choice of provider is documented on the Freedom of Choice form and the participant or his or her authorized family member or representative signs the list of

providers to verify that the choice was made. NOTE: During the development of the person-centered service plan, if no change in provider is requested, the provider list is not signed by the participant.

Waiver participants have the right to appeal any action that involuntarily reduces or terminates some or all their services or benefits, even if their eligibility remains active. The DHS Office of Appeals and Hearings is responsible for these types of appeals. Information regarding hearings and appeals is included with the participant's service plan. Requests for appeals must be received by the DHS Office of Appeals and Hearings no later than 30 days from the date on the ~~on~~of the Notice of Action.

The Notice of Action is kept in the participant's electronic case record. the Notice of Action will be retained for five years from the date of last approval, closure, or denial.

Fair hearings for applicants and participants are the responsibility of the Department of Human Services Office of Appeals and Hearings. This information and the contact information for the Office of Appeals and Hearings is provided on the form the Notice of Action. The form and the system-generated Notice of Action are available in Spanish and large print formats.

Living Choices participants' Medicaid eligibility and services will automatically continue during the appeal process and until the hearing decision when the administrative appeal is timely filed, unless the participant elects to have the benefits discontinue. The participants are informed of their option when they are notified of the pending adverse action. If the appeal decision is not in the participant's favor, and if the services and benefits were continued pending the appeal decision, DHS may recover the cost of services furnished pending the appeal decision. The Notice of Action informs participants that they may be liable for the costs of continued services if they have not elected to have services discontinued pending the appeal decision and if the appeal decision does not favor them.

The Office of Medicaid Provider Appeals is responsible for hearing service provider appeals. Requests for appeals must be received by the Office of Medicaid Provider Appeals no later than thirty (30) days from the date on the Notice of Action.

~~Appeals are the responsibility of the Department of Human Services Appeals and Hearings section. Waiver applicants are advised on the DCO-707 (Notice of Action) or the system-generated Notice of Action by the County Office of their right to request a fair hearing when adverse action is taken to deny, suspend or terminate eligibility for Living Choices. The notice is issued by the LTSS caseworker, and explains the participant's right to a fair hearing, how to file for a hearing and the participant's right to representation. Notices of adverse actions and the opportunity to request a fair hearing are kept in the participant's case record. Applicants must make their request for an appeal no later than 30 days from the date on the DCO-707.~~

~~The DCO-707 Notice of Action is kept in the participant's county office case record. If the DCO-707 is a request for information only, the form may be discarded when all the needed information is~~

received. If the information requested is not received, the form may be discarded five years from the month of origin. Otherwise, the DCO-700 will be retained for five years from the date of last approval, closure or denial.

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

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

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

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

During the assessment and person centered service plan development process, the DHS nurse RN explains these rights to the participant, family member or representative. Signatures on the service plan verify that the choice between waiver services or institutional care was exercised. Also, during this process, participants choose a provider from a list provided by the DHS nurseRN. Choices of provider are documented on the Freedom of Choice form, and the participant signs the list of providers showing that the choice was made. At reassessmentsDuring the development of the person centered service plan, if no change in provider is requested, the provider list is not signed by the participant.

Appendix F-3: State Grievance/Complaint System

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

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAABHS Central Office or their DHS PCSP/CC Nurse~~RN~~. When a DHS PCSP/CC Nurse ~~RN~~ is contacted regarding a complaint or dissatisfaction, the DHSPCSP/CC Nurse ~~RN~~ explains the complaint process to the participant, and completes the HCBS Complaint Intake Report (AAS-9505). Any DAABHS staff receiving a complaint must complete the HCBS Complaint Intake Report.

The HCBS Complaint Intake Report (AAS-9505), along with the complaint database, is used to track any dissatisfaction or complaint, including complaints against DAABHS staff and ~~DPSQA~~ providers. The record of complaint includes the date the complaint was filed.

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

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

Complaints concerning abuse and neglect are routed to Adult Protective Services ~~immediately~~ for appropriate action.

State law allows HCBS staff and APS staff to share information concerning clients on a need to know basis, but that information may not be re-disclosed to a third party. A.C.A. 12-12-1717(a)(9) allows disclosure of reports to “the department” (DHS) for founded reports and A.C.A. 12-12-1718(a) and (b)(1)(A) allow disclosure of pending and screened out reports to “the department".

The HCBS Complaint Intake Report (AAS-9505) must be completed within five (5) working days ~~of~~ from when the DAABHS staff ~~receiving~~ received the complaint. Complaints must be resolved within thirty (30) days from the date the complaint was received. If a complaint cannot be resolved by an DHS RN ~~supervisor~~Supervisor, the information is forwarded to the DAABHS central office ~~administrative staff~~Nurse Manager to resolve. To ensure that participants are safe during these time frames, the DHS PCSP/CC ~~n~~Nurse ~~RN~~ may put in place the backup plan on the participant’s service plan or report the situation to Adult Protective Services, if needed.

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

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

If a participant is dissatisfied with the resolution of a complaint, a fair hearing request may be made at the local ~~DHS county~~Division of County Operations office. The DHS PCSP/CC Nurse ~~RN~~ explains the hearings and appeals process to the participant at this time.

DHS PCSP/CC Nurses ~~RNs~~ follow-up with participants after a complaint has been made at evaluation or monitoring contact. DHS RN ~~s~~Supervisors may also participate in follow up. Depending on the type of complaint, the DHS PCSP/CC Nurse ~~RN~~ may take action to assure continued resolution by revising the participant's service plan or assisting the participant in changing providers.

A complaint received on a DHS PCSP/CC Nurse ~~RN~~ is reported to his or her supervisor, who investigates the complaint.

~~The Complaint Intake Report must be completed within five working days from when DAABHS staff receives the complaint. Complaints must be resolved within 30 days. To ensure that participants are safe during these time frames, the DHS RN may put in place the backup plan on the participant's service plan or report the situation to Adult Protective Services, if needed.~~

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

~~Reporting requirements for providers:~~

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

~~(a) Abuse~~
~~(b) Neglect~~
~~(c) Exploitation or Misappropriation of Property~~
~~(d) Unnatural Death~~
~~(e) Unauthorized use of restrictive interventions~~

~~(f) Significant Medication Error~~
~~(g) Elopement/Missing Person~~
~~(h) Other: Includes but is not limited to abandonment, serious bodily injury, incidents that require notification to police or fire department.~~

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

Reporting requirements for DHS employees and contractors:

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

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

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

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

The DHS PCSP/CC Nurse ~~RN~~ provides waiver applicants and their families with an Adult Protective Services (APS) brochure when initial contact is made. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including to the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DHS PCSP/CC Nurses ~~RNs~~ review this information with participants and family members during the development of the person-centered service plan. In addition, providers are required to post information about how to report a complaint to APS and the Adult Maltreatment Hotline in a visible area on their premises.

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

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

Adult Protective Services (APS) Responsibilities:

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

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

APS communicates with the waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation. Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.

APS communicates with the Living Choices waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. ~~Operating agency and waiver~~ Living Choices staff are also interviewed by APS and asked to provide any necessary documentation for the investigation. ~~Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.~~

Division of Provider Services and Quality Assurance (DPSQA) Responsibilities

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

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

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

DPSQA will forward failed provider practices that are regulated by other entities to the appropriate regulating entity or entities.

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

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

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

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

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

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

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

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

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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

●	**The state does not permit or prohibits the use of restraints** Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
	The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restraints ~~or seclusion~~. This oversight is conducted through incident reports received; monitoring of the participant by the DHS PCSP/CC Nurse~~RN~~, if needed. DHS PCSP/CC Nurses reassess participants annually.
○	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

b. Use of Restrictive Interventions

●	**The state does not permit or prohibits the use of restrictive interventions** Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
	The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted through incident reports received and monitoring of the participant by the DHS PCSP/CC ~~n~~Nurse~~RN~~, if needed.
○	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-b-ii.

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

●	**The state does not permit or prohibits the use of seclusion** Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
	The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. This oversight is conducted through incident reports received and monitoring of the participant by the DHS PCSP/CC Nurse~~RN~~, if needed.
○	**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

Quality Improvement: Health and Welfare

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

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

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

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

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

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

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

The process for reporting abuse as established in Ark. Code Ann. § 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult

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

~~The DPSQA QA audit reflects internal review of the billing process by Living Choices Medicaid providers. The DPSQA QA audit completes a systematic random sampling of the active case population whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.~~

b. Methods for Remediation/Fixing Individual Problems

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

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

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

In cases where critical incidents were not reported within required time frames, DAABHS provides remediation, including reporting the critical incident ~~immediately~~ upon discovery, and providing additional training and counseling to staff.

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

DAABHS provides remediation in cases of investigation and review of unexplained, suspicious and untimely deaths that did not result in identification of preventable and unpreventable causes to include

staff and provider training, implementing additional services and imposing provider sanctions. The Unexpected Death Report ensures that remediation of preventable deaths is captured and that remediation data is collected appropriately.

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

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

Appendix H: Quality Improvement Strategy

H.1 Systems Improvement

a. **System Improvements**

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

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

As a result of the discovery processes:

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

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

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

~~A separate Quality Assurance Unit was formed within DPSQA to monitor and advise the operating agency for Home and Community-Based Waiver Programs.~~

i. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
■ **State Medicaid Agency**	☐ **Weekly**
■ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Quality Improvement Committee**	■ **Annually**
☐ **Other** Specify:	■ **Other** Specify:
	Ongoing, as needed

b. **System Design Changes**

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

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

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

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

H.2 Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one):*

- ● No
- ○ Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ HCBS CAHPS Survey;
- ○ NCI Survey;
- ○ NCI AD Survey;
- ○ Other *(Please provide a description of the survey tool used)*:

Appendix I: Financial Accountability

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

MMIS claims data are audited periodically for program policy alignment, and claims processing worksheets are audited, processed, and returned on a daily basis. Discovery and monitoring also includes an ongoing review of annual CMS-372S reports and quarterly CMS-64 reports. Division of Medical Services (DMS) (Medicaid agency) reviews are validation reviews of twenty percent (20%) of the records reviewed by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) and include a review of the services billed and paid when compared with the services listed on a participant's person-centered service plan.

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

~~In accordance with waiver participants' service plans, sampling is pulled on a random basis as described in the waiver.~~

~~An independent audit is required annually of the provider agency when:~~

~~• State expenditures are $100,000 or more;~~

~~• Federal expenditures are $300,000 or more; or~~

~~• The contract the Department of Human Services (DHS) has with the provider agency requires an independent audit, regardless of funding level.~~

~~If the federal expenditures are $300,000 or more, the audit must be performed in accordance with OMB Circular A133, which implemented the Single Audit Act as amended. A Government Auditing Standards (GAS) audit must be performed if DHS funding provided is $100,000 or more of federal, state, or federal and state combined.~~

~~The DHS Office of Chief Counsel, Audit Section is responsible for reviewing all independent audits. The provider's audit report is reviewed by the Audit Section to determine whether requirements of applicable authorities and those contained in agency policy were met; material weaknesses in internal control exist; material noncompliance with the provision of grants, contracts, and agreements occurred; and the report included findings, recommendations, and responses thereto by management.~~

~~Material weaknesses and non-compliance, other findings, recommendations and responses are recorded and communicated to the DAABHS Deputy Director, who will take appropriate action to resolve audit findings within 90 days of the referral of the finding from the Audit Section. If applicable, through audit requirements regarding provider organizations and thresholds of funding, the DHS Office of Quality~~

~~Assurance (OQA) maintains a database of audit due dates. Each provider selects an independent auditor. The auditor completes a report and submits the report to the provider and to the DHS OQA. The DHS OQA submits a monthly report indicating findings to the DHS Executive Staff.~~

~~DPSQA Quality Assurances also reviews the services billed compared to the services listed on a participant's service plan. DPSQA record reviews include a review of the billing by LCAL providers. A systematic random sampling of the active case population is drawn whereby every nth name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the nth integer, the sample is divided by the population. Those names are drawn until the sample size is reached.~~

~~DAABHS receives a report from DPSQA on a monthly basis with overpayments. DAABHS verifies all overbilling and sends out for recoupment. DAABHS also receives a quarterly overlapping report and no service report. DAABHS reviews and verifies the report for overlapping of services or no services being billed within 30 days.~~

~~Paid claims are compared to the person-centered service plan (PCSP) during the chart review process. Any claims paid over the authorized amount of services on the PCSP are recouped from the provider. Underutilization of services is researched to determine why the provider did not fully meet the PCSP authorized amounts and documented in the client's chart. If necessary, the PCSP is revised to reflect the actual amount of services needed to care for the beneficiary.~~

~~The Division of Medical Services (DMS) reviews a random selection of 20% of the charts reviewed by DAABHS during the chart review process. DMS verifies that the PCSP correlate to what the provider has billed. By the 15th day of each month, DMS requests the client charts. By the end of the month, DAABHS uploads the client charts selected. DMS compares the monthly amount paid to the Assisted Living Facility as shown in the database Cognos with the patient liability amount shown in MMIS for the past 12 months. DMS reports via a transmittal to DAABHS through the reporting system any discrepancies in the client chart such as billing, patient liability, dates, signatures, etc. to be sure the PCSP is in compliance with the waiver. At this point, DAABHS is responsible for any discrepancies, and if there is any remediation needed, DAABHS has up to 14 days to resolve the issue in order to complete the transmittal.~~

~~Desk audits are performed to review provider documentation that supports billing for the services. A random sampling approach is used in determining which provider to audit, with at least 10% of all providers selected annually for review of beneficiary files. Desk audits may also be performed when DAABHS becomes aware of potential irregularities, concerns, or complaints regarding a provider's billing practices. Desk audits will not evolve into on-site reviews. If DAABHS identifies an irregularity or concern in the course of a desk audit, the issue will be referred to the Office of Medicaid Inspector General (OMIG) for further review. Providers are notified of the desk audit findings by letter. Claims paid for services that are not documented according to the Medicaid policy are recouped and corrective action plans are required to be implemented for all providers with billing errors~~.

APPENDIX I-2: Rates, Billing and Claims

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

Assisted Living Facility Rate Determination Methods: This amended waiver reforms the payment rate determination method for assisted living facilities (ALFs) serving waiver participants. For purposes of this waiver, "assisted living facility" means a Medicaid-certified and enrolled assisted living facility with a Level II license. As described below, a rate change took~~akes~~ effect 01/01/2019, with the implementation of the rate phased-in over two years.

Methods Employed to Determine Rates: To establish the new assisted living facility payment methodology, the State employed two methods:

1. An actuarial analysis by the Arkansas Medicaid program's contracted actuaries. This included a cost survey of assisted living facilities and consideration of other states' federally-approved rate methods and rate levels; direct care cost factors (e.g., direct care work wages and benefits, direct care-related supervision and overhead); Arkansas labor market wage levels; rate scenarios; and Arkansas' minimum and prevailing assisted living facility staffing levels. The actuary's report is available to CMS upon request through the Division of Aging, Adult, and Behavioral Health Services (DAABHS).

2. Negotiations with representatives of the State's participating assisted living facilities.

The rate methodology excludes reimbursement of room and board costs.

The new methodology and resulting new per diem rates provide for payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough assisted living facility providers, as required under 42 U.S.C. 1396a(a)30(A) and 42 CFR §447.200-205.

Uniform, Statewide Rate Methodology: The rate methodology is uniform and applies statewide to all Level II licensed assisted living facilities serving waiver participants.

Opportunities for Public Comment: Before submitting this ~~amended~~ waiver renewal to CMS for federal review and approval, DHS engaged in various opportunities for public comment and consultations with assisted living facility providers and other interested stakeholders. This includes webinars and regional public meetings. These are in addition to the public comment process for this amended waiver and the revised provider manual. Further, both the amended waiver and the revised provider manual undergo prior review by Arkansas legislative committees.

Entities Responsible for Rate Determination and Oversight of Rate Determination Process: The assisted living facility rate methodology is determined by the Division of Aging, Adult, and Behavioral Health Services (DAABHS), in consultation with the

~~Division of Provider Services and Quality Assurance (DPSQA) and the~~ contracted actuaries, and with oversight by the Division of Medical Services (DMS). As the Medicaid agency, DMS is responsible for oversight of all Medicaid rate determinations and for ensuring that provider payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers. DAABHS (as the operating agency responsible for day-to-day waiver administration, service planning, and access and care delivery in the waiver). and DPSQA (as the operating agency responsible ~~for ALF licensure, ALF Medicaid certification,~~ Living Choices provider accountability, quality of care, inspections, and auditing) jointly monitors to ensure that assisted living facility payments are consistent with the requirements of 42 U.S.C. § 1396a(a)30(A) and 42 CFR § 447.200-205.

Implementation of New Assisted Living Facility Rates:

Effective after January 1, 2019, assisted living facilities are reimbursed on a fee-for-service basis according to a single statewide per diem rate, determined by DAABHS according to the rate determination methods (actuarial analysis and negotiations) described in this Appendix.
Rates are posted in the fee schedule in the associated Medicaid provider manual and reviewed on a regular basis.
~~On the effective date of this amended waiver four-tier payment model provided for under the current waiver is discontinued. Thereafter, assisted living facilities will be reimbursed according to the new single, statewide per diem rate method. For purposes of assisted living facility payments, waiver participants will no longer be assigned a rate tier level. The discontinued four-tier payment model was initially developed in 2002 prior to the use of comprehensive assessment instruments, is inconsistent with the new assessment system, is administratively cumbersome and unnecessary, and may foster unintentional incentives misaligned with the objectives of appropriate access and service use, facility efficiency, active and independent living, and optimal medication therapy management.~~

~~The current previous payment rate for WY1 WY3 includes included rates for four payment tiers, based on the participant's acuity. The current rates are $70.89, $75.48, $81.89, and $85.35. The state's actuary calculated a composite average of these four rates, adjusted to reflect the distribution of participants between the four tiers, of $80.33. The payment rate recommended by the actuary is $62.89, which is a 20.7% decrease from the $80.33 composite average rate. Because this wasis such a significant decrease, the state is proposeding to phase-in the new rate over the remaining two years of the previous waiver cycle, to allow providers and participants time to adjust and adapt to the new rate. The phase-in schedule that the state is currently proposeding is to move to a single payment tier effective January 1, 2019, at the composite average rate of $80.33, and then reduce the rate by $4.36 every six months: On July 1, 2019, the rate will decreased to $75.97; on January 1, 2020, the rate will decreased to $71.61; on July 1, 2020, the rate will decreased to $67.25; and on January 1, 2021, for the final month of the waiver, the rate will decrease to the actuary's recommended rate of $62.89.~~

~~This rate may be interim, in that DAABHS intends to review the rate methodology in the first half of WY4. The purpose of this review is to gain a greater percentage of provider~~

~~response to the provider surveys distributed by the Arkansas Medicaid program's contracted actuaries. The contracted actuaries will review the new round of provider survey results, and then make recommendations for changes as appropriate. If the review results in revision to the rate, DAABHS will submit a waiver amendment to effectuate the revised rate.~~

~~Beyond the review in the first half of WY4,~~ DAABHS will review the rate methodology no later than the end CY 2021. During the last two years of the current 5-year waiver term (CY 2019-2020), as data from the ~~new Arkansas Independent Assessment (ARIA) system~~approved assessment instrument and use of the Task and Hour Standards for personal care-type services are accumulated and assessed, DAABHS will consider whether an acuity-adjusted methodology is appropriate. If a methodology change is determined appropriate, it will be addressed in a subsequent waiver amendment or the waiver renewal application.

Appendix 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:	Nursing Facility					
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total G+G**
1	~~20112.22~~$17,243.46	~~2249.00~~$4,727.00	~~22361.22~~**$21,970.46**	~~40826.00~~$61,295.00	~~2249.00~~$5,818.00	~~43075.00~~**$67**
2	~~20119.88~~$17,243.46	~~2316.00~~$5,185.00	~~22435.88~~**$22,428.46**	~~42046.00~~$67,792.00	~~2316.00~~$6,412.00	~~44362.00~~**$74**
3	~~20127.91~~$17243.46	~~2385.00~~$5678.00	~~22512.91~~**$22,921.46**	~~43303.00~~$74,707.00	~~2385.00~~$7,033.00	~~4568800~~**$81**
4	~~19722.61~~$17,243.46	~~2457.00~~$6,217.00	~~22179.61~~**$23,460.46**	~~44598.00~~$81,953.00	~~2457.00~~$7,702.00	~~40755.00~~**$89**
5	~~17516.60~~$17,243.46	~~253000~~$6,783.00	~~20046.60~~**$24,026.46**	~~45931.00~~$89,739.00	~~2530.00~~$8,433.00	~~48461.00~~**$98**

Appendix J-2: Derivation of Estimates

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

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	~~1300~~1725	~~1300~~1725
Year 2	~~1300~~1725	~~1300~~1725
Year 3	~~1300~~1725	~~1300~~1725
Year 4 (only appears if applicable based on Item 1-C)	1725	1725
Year 5 (only appears if applicable based on Item 1-C)	1725	1725

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

The average length of stay on the waiver is estimated to be ~~255~~291 days. This average was calculated as days of eligibility from the MMIS segments, using the Medicaid DSS. ~~(BusinessObjects).~~ These numbers were determined by reporting the total days of waiver service (based on service eligibility days within the waiver year) for all participants and dividing by the unduplicated count of participants.

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

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

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

The unduplicated cap of ~~1300~~1725 was used as the number of users for WY1-WY~~3~~5 ~~as it is believed this cap will be reached each year. For WY4-WY5, the intent of the state is to expand the unduplicated cap to an amount sufficient~~ to allow for full-year participation of each available ~~slott~~slot. Given the average length of stay of ~~255~~291 days, the state calculates ~~1,717~~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 ÷ 2~~55~~91 days (avg. length of stay) = 1,~~717~~505

This exact amount was used for the estimated number of users in Appendix J-2-d. ~~The state currently has a waiting list for this waiver, and the state does not expect demand for waiver services to decrease. Therefore, the state believes that an estimate of maximum usage is appropriate.~~

~~For purposes of calculating the requested increase in the unduplicated cap in Appendix B-3-a, the state rounded this amount up to 1,725 to allow for a small margin of error.~~

Extended Medicaid State Plan Prescription Drug costs were estimated based on actual costs from the previous ~~6~~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 following factors were considered in the estimates:~~

~~- The number of users for SFY 2015 was 96. Since the point-in-time cap is being increased by 20%, the number of users is projected to increase by 4% in each of the 5 waiver years.~~
~~- An average of the units used per user over the last 6 years was determined to be 15.~~
~~- The average cost per unit over the past 6 years was determined to be $62. There has been an average growth rate of 5.61% over the last 6 years, which is applied to the average cost per unit in each year of the waiver to allow for inflation of Rx drug costs. Please note that the average cost of drugs is not a rate set by the state, but is based on a negotiation between Arkansas Medicaid and prescription drug companies.~~

~~The current payment rate for WY1-WY3 includes rates for four payment tiers, based on the participant's acuity. The current rates are $70.89, $75.48, $81.89, and $85.35.~~ The state's actuary calculated a composite average of ~~these~~ the four (4) tier rate ~~s~~used during the previous renewal cycles, adjusted to reflect the distribution of participants between the four tiers, of $80.33. The payment rate recommended by the actuary is $62.89, which is a 20.7% decrease from the $80.33 composite average ~~rate.~~

Because this is such a significant decrease, the state ~~is proposing to~~ phased-in the new rate ~~over the remaining two years of the waiver, to allow providers and participants time to adjust and adapt to the new rate~~. The phase-in schedule that the state is currently proposing is to move to a single payment tier effective January 1, 2019, at the composite average rate of $80.33, and then reduce the rate by $4.36 every six months: On July 1, 2019, the rate ~~will~~ decreased to $75.97; on January 1, 2020, the rate ~~will~~ decreased to $71.61; on July 1, 2020, the rate ~~will~~ decreased to $67.25; and on January 1, 2021, for the final month of the waiver, the rate ~~will~~ should have decreased to the actuary's recommended rate of $62.89, but did not due to restrictions under the CARES act. ~~. This phase-in schedule is the reason that the average unit cost for the composite tier in WY5 is lower than WY4~~Currently the state is operating under regulations of the CARES Act, which precludes the state from further reductions, so the rate remains at $67.25 until these regulations are lifted.~~.~~

The state is currently conducting a rate study and will submit an amendment request should the rate study yield a new rate for this service.

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

Factor D' was computed based on Actual Expenditures that were extracted from the decision support system (DSS) component of the MMIS for CY 2019. Using the market basket forecasts inflation rate of 3.26% that is based on an average rate for 3 years and the related expenditure report from the DSS system of all waiver eligible recipients' annual expenditures. Note: Costs are indicated for State Category of Service AL (Living Choices), and AX (Extension of 3 prescriptions for Living Choices beneficiaries).~~Factor D' was computed based on what was done in prior years. Using the market basket forecasts and the related Living Choices report of all waiver eligible recipients annual expenditures were extracted from the decision support system (DSS) component of the MMIS. Note: Costs indicated for State Category of Service AL (Assisted Living Facility), and AX (Extension of 3 prescriptions for Assisted Living) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the ALF waiver recipients.~~

~~Medicare Part D has been in effect for approximately 10 years. Arkansas Medicaid has not paid for prescription drugs for Medicare recipients during this time. Thus, prescription drug costs of individuals receiving Medicare Part D are not contained in our source documents. Therefore, they do not need to be removed.~~

~~For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G, and G' in section J are the product of applying a geometric mean to three years of this BLS data.~~

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

Factor G is computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS for SFY 2020. Using the average annual expenditures for nursing home recipients and the market basket forecasts ~~for the next 5 years~~inflation rate of 3.26% that is based on the average rate for 3 years. Factor G was computed for each of the 5 years of the waiver.

~~For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G, and G' in section J are the product of applying a geometric mean to three years of this BLS data.~~

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

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

~~For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G,~~

~~and G' in section J are the product of applying a geometric mean to three years of this BLS data.~~

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

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

d. Estimate of Factor D.

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

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Extended Medicaid State Plan Prescription Drugs Total:					**~~$$93,000.00~~292,500.00**
~~Extended Medicaid State Plan Prescription Drugs Total:~~~~Extended Medicaid State Plan Prescription Drugs~~	~~1 Month~~	~~100~~	~~15~~	~~$62.00~~	**~~$292,500.00~~** ~~$93,000.00~~
Extended Medicaid State Plan Prescription Drugs	1 Month	250	15	78.00	$292,500.00
Living Choices Assisted Living Services Total:					**$29,452,473.75** **~~$26,052,883.35~~**
Living Choices Assisted Living Service1 Day150529167.25$29,452.75Extended Medicaid State Plan Prescription Drugs1 Month2501578.00$292,500.00**Living Choices Assisted Living Services Total:$29,452,472.75**Living Choices Assisted Living Service~~Extended Medicaid State Plan Prescription Drugs~~~~Tier Level 2~~	1 Day~~1 Month~~~~1 Day~~	1505~~250~~~~45~~~~5~~	291~~15~~~~255~~	67.25~~78.00~~ ~~$75.48~~	$29,452~~.~~,473.75~~$~~ ~~292,500.00~~ ~~$8,757,567.00~~

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
~~Extended Medicaid State Plan Prescription Drugs Total:~~ ~~Tier Level 3~~	~~1 Day~~	~~481~~	~~255~~	~~$81.89~~	~~$292,500.00~~ ~~$10,044,217.95~~
~~Extended Medicaid State Plan Prescription Drugs~~ ~~Tier Level 4~~	~~1 Month~~ ~~1 Day~~	~~250~~ ~~182~~	~~15~~ ~~255~~	~~78.00~~ ~~$85.35~~	~~$292,500.00~~ ~~$3,961,093.50~~
~~Extended Medicaid State Plan Prescription Drugs Total:~~ ~~Tier Level 1~~	~~1 Day~~	~~182~~	~~255~~	~~$70.89~~	~~$292,500.00~~ ~~$3,290,004.90~~
Living Choices Assisted Living Service~~Extended Medicaid State Plan Prescription Drugs~~ ~~Composite Tier~~	1 Day~~1 Month~~ ~~1 Day~~	1505~~2500~~	291~~150~~	67.25~~78.00~~ ~~$80.33~~	$29,452,473.75~~$ 292,500.00 $~~
GRAND TOTAL:					~~$29,744,973.75$ 26,145,883.35~~
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725~~1300~~
FACTOR D (Divide grand total by number of participants)					$17,243.46~~20,11 2.22~~
AVERAGE LENGTH OF STAY ON THE WAIVER					~~255~~291

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:					~~$102,960.00~~**$292 ,500.00**
Extended Medicaid State Plan Prescription Drugs~~Extended Medicaid State Plan Prescription Drugs~~	1 Month~~1 Month~~	250~~104~~	15~~15~~	78.00~~$66.0 0~~	$292,500.00~~$102 ,960.00~~
Living Choices Assisted Living Services Total:~~Living Choices Assisted Living Services Total:~~					**$29,452,473.75 ~~$26,052,883.35~~**
Living Choices Assisted Living Service~~Tier Level 2~~	1 Day~~1 Day~~	1505~~455~~	291~~255~~	67.25 ~~$75.48~~	$29,452,473.75 ~~$8,757,567.00~~
Extended Medicaid State Plan Prescription Drugs~~Tier Level 3~~	1 Month~~1 Day~~	250~~481~~	15~~255~~	78.00 ~~$81.89~~	$292,500.00 ~~$10,044,217.95~~
~~Tier Level 4~~	~~1 Day~~	~~182~~	~~255~~	~~$85.35~~	~~$3,961,093.50~~
Living Choices Assisted Living Services Total:~~Tier Level 1~~	~~1 Day~~	~~182~~	~~255~~	~~$70.89~~	**$29,452,473.75** ~~$3,290,004.90~~

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Living Choices Assisted Living Service~~Composite Tier~~	1 Day~~1 Day~~	1505~~0~~	291~~0~~	67.25 ~~$80.33~~	$29,452,473.75 ~~$ -~~
GRAND TOTAL:					**$29,744,973.75~~$ 26,155,843.35~~**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725~~1300~~
FACTOR D (Divide grand total by number of participants)					$17,243.46~~$20,119~~
AVERAGE LENGTH OF STAY ON THE WAIVER					291~~255~~

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:~~Extended Medicaid State Plan Prescription Drugs Total:~~					**$292,500.00~~$113,400.00~~**
Extended Medicaid State Plan Prescription Drugs~~Extended Medicaid State Plan Prescription Drugs~~	1 Month~~1 Month~~	250~~100~~	15~~15~~	78.00 ~~$70.00~~	$292,500.00~~$113 400.00~~
Living Choices Assisted Living Services Total:~~Living Choices Assisted Living Services Total:~~					**$29,452,473.75 ~~$26,052,883.35~~**
Living Choices Assisted Living Service1 Day150529167.25$29,452.75Extended Medicaid State Plan Prescription Drugs1 Month2501578.00$292,500.00**Living Choices Assisted Living Services Total:$29,452,472.75**Living Choices Assisted Living Service~~Tier Level 2~~	1 Day~~1 Day~~	1505~~455~~	291~~255~~	67.25 ~~$75.48~~	$29,452,473.75 ~~$8,757,567.00~~
Extended Medicaid State Plan Prescription Drugs Total:~~Tier Level 3~~	~~1 Day~~	~~481~~	~~255~~	~~$81.89~~	**$292,500.00** ~~$10,044,217.95~~

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Extended Medicaid State Plan Prescription Drugs~~Tier Level 4~~	1 Month~~1 Day~~	250~~182~~	15~~255~~	78.00 ~~$85.35~~	$292,500.00 ~~$3,961,093.50~~
~~Tier Level 1~~	~~1 Day~~	~~182~~	~~255~~	~~$70.89~~	~~$3,290,004.90~~
Living Choices Assisted Living Services ~~Composite Tier~~	1 Day~~1 Day~~	1505~~0~~	291~~0~~	67.25 ~~$85.35~~	$29,452,473.75 ~~$ -~~
GRAND TOTAL:					**$29,744,973.75~~$ 26,166,283.35~~**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725~~1300~~
FACTOR D (Divide grand total by number of participants)					$17,243.46~~$20,1 27.91~~
AVERAGE LENGTH OF STAY ON THE WAIVER					291~~255~~

Waiver Year: Year 4					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:~~Extended Medicaid State Plan Prescription Drugs Total:~~					**$292,500.00~~$124 320.00~~**
Extended Medicaid State Plan Prescription Drugs~~Extended Medicaid State Plan Prescription Drugs~~	1 Month~~1 Month~~	250~~100~~	15~~15~~	78.00 ~~$74.00~~	$292,500.00~~$124 ,320.00~~
Living Choices Assisted Living Services Total:~~Living Choices Assisted Living Services Total:~~					**$29,452,473.75 ~~$33,897,185.70~~**
Living Choices Assisted Living Service1 Day150529167.25$29,452.75Extended Medicaid State Plan Prescription Drugs1 Month2501578.00$292,500.00**Living Choices Assisted Living Services Total:$29,452,472.75**Living Choices Assisted Living Service1 Day150529167.25$29,452.75**Extended Medicaid State Plan**	~~1 Day~~	~~0~~	~~0~~	~~$75.48~~	**$29,452,473.75~~$ 0.00~~**

Waiver Year: Year 4					
Waiver Service / Component	Col. 1 Unit	Col. 2 # Users	Col. 3 Avg. Units Per User	Col. 4 Avg. Cost/ Unit	Col. 5 Total Cost
Prescription Drugs Total:$292,500.00 Extended Medicaid State Plan Prescription Drugs1 Month2501578.00$292,500.00**Living Choices Assisted Living Services Total:**~~Tier Level 2~~					
Extended Medicaid State Plan Prescription Drugs Total:~~Tier Level 3~~	~~1 Day~~	~~0~~	~~0~~	~~$81.89~~	**$292,500.00**~~$0.00~~
Extended Medicaid State Plan Prescription Drugs~~Tier Level 4~~	1 Month~~1 Day~~	250~~0~~	15~~0~~	78.00 ~~$85.35~~	$292,500.00~~$0.00~~
~~Tier Level 1~~	~~1 Day~~	~~0~~	~~0~~	~~$70.89~~	~~$0.00~~
Living Choices Assisted Living Services~~Composite Tier~~	1 Day~~1 Day~~	1505~~1717~~	291~~255~~	67.25~~77.42~~	$29,452,473.75~~$33,897,185.70~~
GRAND TOTAL:					**$29,744,973.75~~$34,021,505.70~~**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725~~1725~~
FACTOR D (Divide grand total by number of participants)					$17,243.46~~$19,722.61~~
AVERAGE LENGTH OF STAY ON THE WAIVER					291~~255~~

Waiver Year: Year 5					
Waiver Service / Component	Col. 1 Unit	Col. 2 # Users	Col. 3 Avg. Units Per User	Col. 4 Avg. Cost/ Unit	Col. 5 Total Cost
Extended Medicaid State Plan Prescription Drugs Total:					**$292,500.00~~$136,890.00~~**
Extended Medicaid State Plan Prescription Drugs	1 Month~~1 Month~~	250~~100~~	15~~15~~	78.00 ~~$78.00~~	$292,500.00~~$136,890.00~~
Living Choices Assisted Living Services Total:					**$29,452,473.75 ~~$30,079,264.50~~**
~~Tier Level 2~~	1 Day150529 167.25$29,452.75**$292,500.001** Month2501 578.00$292,	1505~~0~~	291~~0~~	67.25 ~~$75.48~~	$29,452,473.75~~$0.00~~

Waiver Year: Year 5					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
	500.001 Day~~1 Day~~				
~~Tier Level 3~~	~~1 Day~~	~~0~~	~~0~~	~~$81.89~~	**$292,500.00**~~$0.00~~
~~Tier Level 4~~	1 Month~~1 Day~~	250~~0~~	15~~0~~	78.00 ~~$85.35~~	$292,500.00~~$0.00~~
~~Tier Level 1~~	~~1 Day~~	~~0~~	~~0~~	~~$70.89~~	~~$0.00~~
Living Choices Assisted Living Services~~Composite Tier~~	1 Day~~1 Day~~	1505~~1717~~	291~~255~~	67.25~~$68.70~~	$29,452,473.75~~$30,079,264.50~~
GRAND TOTAL:					**$29,744,973.75~~$30,2016,154.50~~**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725~~1725~~
FACTOR D (Divide grand total by number of participants)					$17,243.46~~$17,516.60~~
AVERAGE LENGTH OF STAY ON THE WAIVER					291~~255~~