EXHIBIT H

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: AR Choices in Homecare Renewal

DESCRIPTION:

Statement of Necessity

The Center for Medicare and Medicaid Services approves Home & Community Based Services waivers for a period of five years. The AR Choices in Homecare waiver expired January 31, 2021, but continued operating under a temporary extension. DHS proposed a waiver renewal with the Centers for Medicare and Medicaid Services (CMS) and filed a proposed rule in July 2021. The extension also allowed DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021, a date CMS expressed interest in establishing as well.

The proposed rule went through a public comment process. A public hearing was held on July 13, 2021. DHS received public comments, and revisions to the rule resulted. The rule proceeded to review in September 2021 before the Committees on Public Health, Welfare and Labor; the Administrative Rules Subcommittee; and the Arkansas Legislative Council, all of which reviewed and approved. At that time, DHS stated it would resubmit the rule for review if CMS required changes necessitating such. The rule was not final filed following legislative review as it was not yet approved by CMS. CMS conducted a lengthy review of the Waiver renewal. CMS approved the AR Choices in Homecare waiver on March 10, 2022, but required changes from the proposed rule that had been adopted during legislative review; accordingly, the rule proceeded to a second public comment period and will again be presented for legislative review.

Rule Summary

The roles and responsibilities of the operating agencies (Division of Medical Services, Division of Aging, Adult, & Behavioral Health Services, Division of Provider Services and Quality Assurance, and Division of County Offices) are clarified with this waiver renewal. The AR Choices Manual reflects the functional eligibility determinations and evaluations listed in the AR Choices waiver. The Personal Care Manual has been updated to remove duplication of AR Choices rules and references AR Choices Manual. The appeals process language is updated throughout as necessary to reflect the automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for services are updated for the next five years and additional waiver slots are added. The Service Budget Limits are updated, and the Provisional Service Plan option is removed. The waiver renewal updates Service Budget Limits, Established Change of Condition Processes and a Process for Granting and Exception to the maximum SBL. The financial impact is $12,992,412 for State Fiscal Year (SFY) 2022 and $13,615,716 for SFY 2023.

The state share of increasing the Attendant Care and In-Home Respite Care rates is $3,699,914 for SFY 2022 and $3,864,140 for SFY 2023.

PUBLIC COMMENT: A public hearing was held on this rule on July 13, 2021. The initial public comment period expired on August 2, 2021. The agency provided the public comment summary for the initial public comment period:

Commenter's Name: Luke Mattingly, CEO/President, on behalf of CareLink

1: ARChoices Section 212.000(D) – Refers readers to the approved assessment manual. When reviewing this current on-line manual, there is no mention of ARChoices or how the tiers for LTSS are established and applied. Also, the eligibility rules have been red-lined and the rules only now reference the State Administrative Rule for level of care. This revision lacks transparency within the waiver for how the eligibility process is established, changed, and controlled. **RESPONSE:** Thank you for your comment. The approved assessment tool manual is referenced to provide transparency in relation to the tool. Notwithstanding the final tier determination, the Level of Care eligibility is made by the Division of County Operation. The assessment of functional need is used as part of the process to determine medical eligibility and in the development of the PCSP. We have included reference to the State Administrative Rule to avoid possible incongruence should there be future rule change.

2: ARChoices Section 240.000 Prior Authorization – There is very little detail in this section. It needs to be changed to reflect the same language as the Personal Care Manual. **RESPONSE:** Thank you for your comment. DHS will update this section to clarify that the authorization mechanism for the ARChoices program is the Person-Centered Service Plan. Additionally, sections 212.320 and 212.323 include language that the PCSP serves as the authorization for ARChoices waiver services.

3: ARChoices Section 262.300 Billing Instructions – The requirement for providers to supply the documentation proving that services were rendered at a time before or after the hospital discharge occurred has always been administratively burdensome. Medicaid has the information as a payor and has access to admission and discharge data. Unskilled home health providers do not have direct access to the information being requested. It requires significant administrative effort to obtain the required documentation.

With the implementation of state-wide requirement for Electronic Visit Verification systems, Medicaid has access to all information required to compare data and verify that services occurred before admission or after discharge without additional provider input. This section needs to be revised to eliminate the provider requirement and to reflect that Medicaid will verify that services have been provided before admission or after discharge. All information to verify this is within state data systems available to Medicaid.

RESPONSE: Thank you for your comment. It is the provider's responsibility to develop and maintain sufficient written documentation to support each service for which billing is made.

4: Methods for Remediation / Fixing Individual Problems – References an Intra-agency agreement between AADHS and DMS. What are the parameters of this agreement and where can this agreement be reviewed? **RESPONSE:** Thank you for your comment. Providers may request a copy of this agreement through the Freedom of Information process.

5: Appendix J Cost Neutrality – It is interesting to note that the state projects a 2.5% annual inflationary factor for SNF's in factor D derivation. The state makes no such annual inflationary consideration for ARChoices providers. There are always several years between rate changes for ARChoices services. This 2.5% annual inflationary consideration is not applied to ARChoices waiver provider operational inflationary costs/expense, however the 2.5% increase for SNF's is directly applies to inflationary expenses related to operations. This is yet another inequity between SNF's and HCBS. **RESPONSE:** Thank you for your comment.

6: Rate for service – While the rate increase in the waiver is desperately needed, the rate setting methodology for In-home services is derived from "what is the minimum Medicaid can pay for this service" resulting in low wages and minimal benefits for workers. The rate setting process does not provide the opportunity to build a career ladder for in-home Aides nor does it focus on paying a wage that attracts high quality candidates. The rate is such that providers can only offer minimum wage or close to minimum wage pay. This is not conducive to providing high quality services and results in high turnover rate for this occupation, which is detrimental to participant care.

The state needs to engage in a more open conversation about this occupation and what skill sets would be preferable to deliver high quality customer care. This in turn would help ascertain what wage rate needs to be in place to support this high-quality care and in turn what rate would support the wage. Instead, the base assumption starting point for determining the rate is minimum wage, which here in Arkansas is $ 11.00 per hour.

RESPONSE: Thank you for your comment. Under Executive Order 19-02 rates are reviewed on a regular cycle utilizing a standard rate review methodology.

7: Removal of Provisional Plans of Service – What is the plan to make ARChoices readily available to eligible participants? SNF's have the ability to begin services and then retro bill to first day of service after deemed eligible. No such provision is in place for ARChoices. With average processing of ARChoices initial applications exceeding 45 days or more it leaves many families with no choice but to select a facility placement over HCBS. **RESPONSE:** In order to be determined eligible for the ARChoices waiver, individuals must meet both financial and medical eligibility requirements. Allowing for services to begin prior to determination of both financial and medical eligibility places both providers and individual at financial risk. Individuals with active full Medicaid

benefit plans may receive services under state plan personal care until waiver services are approved.

8: Additional Requirements/Access to Services – In addition to topics already mentioned which fall into this category, the inability of DHS to issue a Prior Authorization at the same time as issuing the approved PCSP is detrimental to service providers and places participant services at risk. The prior authorization (PA) should be issued and coincide with the issuance of the PCSP. A prior authorization is required for a provider to be reimbursed for services. DHS issues the PCSP and expects providers to start services immediately upon receipt, but the Prior Authorization is not issued until a later date. **RESPONSE:** Thank you for your public comment. DHS is reviewing internal processes to improve efficiency in systems. The authorization for services continues to be the Person-Centered Service Plan which is sent to the provider by the DHS PCSP/CC nurses.

9: Service Budget Caps – Tier 1: $ 34,000; Tier 2: $ 23,000; Tier 3: $ 6,000

All service caps are set to low to ensure that participants in that particular level of care has a reasonable opportunity to remain in their homes as long as possible. In Tier 1 allowing only $34,000 annually to someone that is totally dependent and requires extensive assistance is not sufficient to ensure Home and Community Based care will assist the individual from being institutionalized. Likewise Tier 2 participants need additional supports than the budget cap allows. However, the $ 6,000 cap for Tier 1 services is the most egregious. These individuals meet the functional needs requirements to be eligible for ARChoices. This service cap barely provides any services at all. The cap should be at least doubled to ensure a level of care that keeps participants in their home and delays progression into Tiers requiring more care or institutionalization. The service budget cap should at least be doubled to $ 12,000.

RESPONSE: The Service Budget Limit (SBL) amounts were adjusted to incorporate rate increases to ensure clients continued to receive services authorized, notwithstanding subsequent rate increases. SBL's limit the maximum dollar amount of services that may be authorized based on medical determination by the Division of County Operation. Section 212.200 outlines the process for adjustments to the SBL based on change in condition.

Commenter's Name: Jacque McDaniel, Executive Director, on behalf of East Arkansas Area Agency on Aging

1: Section 200.120-262.410 – The Personal Care policy changed "beneficiary" to "client". The ARChoices policy changed "Beneficiaries" and "individuals" to "participants". Why was different terminology utilized? **RESPONSE:** Notwithstanding any difference in the terminology the individuals referenced are the same.

2: Section 213.540 E – There are three applicable rules listed—Section 215.350, 215.351 and 262.100. Is there a Section 262.100? **RESPONSE:** Thank you for your comment. The reference to Section 262.100 has been removed.

3: Section 200.120-262.410 of the Personal Care policy changed "beneficiary" to "client". The ARChoices policy changed "Beneficiaries" and "individuals" to "participants". Why was different terminology utilized between Personal Care and ARChoices policies? **RESPONSE:** Notwithstanding any difference in the terminology the individuals referenced are the same.

4: Section 212.000 Item B – The last sentence of this paragraph may have an error with the change from 'individual' to 'participant'. **RESPONSE:** Language has been reviewed to ensure consistency in the manual.

5: Section 212.000 Item I – The policy states the "program provides for the entrance of all eligible persons on a first-come, first-served basis, once participants meet all functional and financial eligibility requirements." Should "functional" be changed to "medical"? **RESPONSE:** Thank you for your comment. The language has been updated.

6: Section 212.000 Item I states eligible persons will be served on a first-come, first-served basis. With the elderly, behavioral health (BH) and development disabled (DD) populations being combined in one waiver, should the slots be segregated to the different populations to assure availability for the elderly population? The average length of program eligibility for elderly waiver clients is much shorter than the BH and DD populations. **RESPONSE:** The ARChoices waiver is a distinct waiver and has not been combined with BH or and DD waivers. The slots available under the ARChoice waiver are available only to those beneficiaries who have been determined eligible for the ARChoices waiver.

7: Section 212.200 "Waiver Renewal Process" – Item C states "unless one of the following conditions applies:" then lists item 1, item 2, item 3 "or the participant disenrolls from the ARChoices Waiver program." Should this last item actually be numerated as item 4? **RESPONSE:** This item is listed as item 4.

8: Section 212.300 lists the acronym for person-centered service plan (PCSP) several times, but some of the listings were transposed as PCPS in Items A and C. **RESPONSE:** Thank you for your comment. The manual has been updated.

9: Section 262.300 Billing Instructions – With the detailed requirements for caregivers to utilize electronic visit verification for documenting and billing services, the policy requiring a provider to gather documentation to prove what time the participant was admitted to a facility needs to be changed. The state should have the information to determine what time the participant was admitted to a facility instead of placing another burden on the lowest paid provider to gather this information. **RESPONSE:** Thank you for your comment. It is the provider's responsibility to develop and maintain sufficient written documentation to support each service for which billing is made.

10: Appendix 1-2: Rates, Billing and Claims – Rate Determination Methods: Even though various methodologies were used for rate determination, the rate is inadequate to

support the services in our state when the minimum wage increase and other costs far exceeded the percentage increase in the rate. The added stress of low unemployment rates and shortage of workers with the ever-increasing older population has seriously threatened the viability of Home and Community-Based Services in our state.
RESPONSE: Thank you for your comment. Under Executive Order 19-02 rates are reviewed on a regular cycle.

The rule was reviewed and approved by the Administrative Rules Subcommittee on September 17, 2021. CMS subsequently required changes to the proposed rule. The agency implemented these changes and opened a second public comment period. The second public comment period expired on August 14, 2022. Due to its length, the public comment summary for this second public comment period is provided separately.

The proposed effective date is October 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, this rule implements a federal rule or regulation. The cost to implement the federal rule or regulation is $12,992,412 for the current fiscal year ($3,699,914 in general revenue and $9,292,498 in federal funds) and $13,615,716 for the next fiscal year ($3,864,140 in general revenue and $9,751,576 in federal funds). The total estimated cost to state, county, and municipal government is $3,699,914 for the current fiscal year and $3,864,140 for the next fiscal year. The agency indicated that these amounts represent the state share of increasing the Attendant Care and In-Home Respite Care rates.

Per the agency, this rule will result in a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

CMS approves HCBS waivers for a period of 5 years. The AR Choices in Homecare waiver expired 12/31/2020 and is currently operating under a temporary extension. This extension will allow DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021. The roles and responsibilities of the operating agencies (DMS, DAABHS, DPSQA, & DCO) will be clarified with this waiver renewal. The AR Choices and Personal Care Provider Manuals will now reflect the functional eligibility determinations and evaluations listed in the AR Choices waiver. In addition, the appeals process is changing to an automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for attendant care and in-home respite services are being updated to align with the personal care rate. The Service Budget Limits are being updated and Individual Service Budgets are defined. The Provisional Service Plan option is being removed.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

CMS approves HCBS waivers for a period of 5 years. The AR Choices in Homecare waiver expired 12/31/2020 and is currently operating under a temporary extension. This extension will allow DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021. The roles and responsibilities of the operating agencies (DMS, DAABHS, DPSQA, & DCO) will be clarified with this waiver renewal. The AR Choices and Personal Care Provider Manuals will now reflect the functional eligibility determinations and evaluations listed in the AR Choices waiver. In addition, the appeals process is changing to an automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for attendant care and in-home respite services are being updated to align with the personal care rate. The Service Budget Limits are being updated and Individual Service Budgets are defined. The Provisional Service Plan option is being removed.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

CMS approves HCBS waivers for a period of 5 years. The AR Choices in Homecare waiver expired 12/31/2020 and is currently operating under a temporary extension. This extension will allow DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021. The roles and responsibilities of the operating agencies (DMS, DAABHS, DPSQA, & DCO) will be clarified with this waiver renewal. The AR Choices and Personal Care Provider Manuals will now reflect the functional eligibility determinations and evaluations listed in the AR Choices waiver. In addition, the appeals process is changing to an automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for attendant care and in-home respite services are being updated to align with the personal care rate. The Service Budget Limits are being updated and Individual Service Budgets are defined. The Provisional Service Plan option is being removed.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

There are no less costly alternatives.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

DHS Responses to Public Comments Regarding ARChoices in Homecare Renewal

Catherine Burks, RN, Compliance Officer

AbsoluteCare Management Corporation

Comment: Will the provider be able to get a copy of the THS used by the DHS PCSC/CC Nurse? When this form was first developed, we had no problem obtaining a copy. Recently, some DHS nurses have told us that they are no longer permitted to provide this to us. In the past we have found the THS to be very helpful in working with waiver participants to set up their plan of care. As the T&H indicates the tasks, and time per task, the DHS-RN used to determine the number of hours the participant is eligible to receive it greatly assists the client, and the provider, with the development of their individual service plan. We feel the T&H is an excellent tool that allows for good continuity of care for waiver recipients. We respectfully request that this form be available to providers.

Response: Yes, providers will be able to access the Task & Hours Standard online. Thank you very much for your comment.

Robert Moore

Comment: My name is Robert Moore and I've been on the ARchoices since 2004, and it has been the most important factor in staying as healthy as possible for as long as I have. I live with locked-in syndrome, meaning my mind is lucid but my body is totally bereft. I'm unable to walk or speak, I cant chew and can barely swallow so all my food must be pureed, meaning I require total assistance with all activities. So getting the excellent care I receive at home is vital to my well-being since I wouldn't get that level of care anywhere else. I love this program because it affords me the opportunity to stay in my home, receive the best care possible, and have some quality of life. I am able to be involved in activities inside and outside the home I wouldn't otherwise be able to if I wasn't able to live at home.

Every year that I have been in the program DHS has deemed me totally dependent on others for all my needs, and I have been placed in the highest benefit allotment. Any reduction or deviation in my benefit would radically alter my quality of life in a negative way. Because of the severity of my condition and my immense height I require special equipment for my care that isn't available anywhere but my house. The ARchoices program helped me in a big way acquire this specialized equipment. The intent of this program is to allow those with the most severe, chronic conditions to live where they choose, not force them into living somewhere ill-equipped to take care of them. In the past, I have always been grandfathered in so to retain my original benefit alottment, any deviation to this would affect me greatly in a negative way.

Response: Thank you for your comment. The Waiver Renewal provides a "Process for Granting an Exception to the $34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

Ann Ledgerwood

Comment: It is with a heavy heart that I am again writing a public comment on the AR Choices program. I can't understand why we are continually having to address the same issues waiver after waiver, with each waiver threatening a shortage of hours, services or budgets. We are talking about total care patients, patients who could face being put into an institution The latest proposed waiver has removed the grandfather clause on budgets. Clients who depend on these budgets are facing a fear of stability in their lives, which adds anxiety and fear to an already difficult life. I understand there is an avenue to "possibly" receive a higher budget, but there are not any guarantees that anyone will receive the higher budget. I am speaking of persons who have received a level of care for years and have become dependent on these services in order to maintain a quality of life at home and among the community, rather than being placed in an institution.

I believe every parent has hopes and dreams for their children. I feel confident in saying that most parents want their children to be God fearing, good citizens who had a good childhood with school activities, college a career, a family etc. What if you were told when your child was born that he or she would never walk, or sit up and would need to be cared for all of their lives? This was our life. Our prayer became that we could give him the closest thing to a normal life possible. The AR Choices program was a wonderful program that enabled our son to be an active part of the community and gave him a quality of life that most take for granted. Our biggest fear as a parent, has been that he would end up in a nursing home and would lose what bit of normalcy that he has been able to enjoy. He has been on the program since 2002 (different names of course) and has been thankful for the program. We were blessed for years to receive services without any fears of keeping him in his home and giving him the best care possible, but the last few waivers have threatened that care. We are not unique in our situation, as we know many others who have compelling stories. I am pleading that you add the grandfather clause or give assurances to those who rely on the budgets they currently receive. Arkansas has a surplus, yet we are looking at possible cuts to a group of our most vulnerable population AGAIN! I believe we can and should do better than this.

Response: Thank you for your comment. The Waiver Renewal provides a "Process for Granting an Exception to the $34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

Bradley Ledgerwood

Comment: My name is Bradley Ledgerwood, I am very upset that I'm having to make public comments again on the AR Choices program. The old saying "if it aint broke don't fix it", comes to mind. We had a program that worked very well and it seems as if we have come full circle trying to fix a very well ran program, is it any wonder that we feel as if the state just want cuts to be made? I have been on this program since 2002 and it worked perfectly until 2015 when changes started being made to improve a well working program. I have yet to see any changes for the positive. I have always received a minimum of 8 hours a day 7 days a week of care. I can not understand how I have received this care since 2002 and my condition has only worsened but now I am being told I might not receive the care that has always been deemed necessary. I am sure if you are not a recipient of this program, you can not know or

understand the frustration level of those of us who rely on these services. AR Choices give meaning and purpose to so many of the disabled community. I am able to serve on the Cash City Council, I am able to serve on the Client Voice Council and I am able to be very active in the community. The struggles a totally dependent person incurs would sometimes make us feel as if we are worthless and can not contribute anything to society, but because of this program we can have meaning and feel like part of the community, whether it be cheering for someone at a ballgame, attending worship services, or being active in politics. A very insignificant thing such as going to the store or watching family ballgames can be a highlight for someone who lives their lives on the sidelines.

I know that it was mentioned that the grandfather clause was not fair to someone new coming onto the program. I would address to that comment, why can we not give everyone who qualifies for total care enough hours to keep them comfortably in their homes, secondly although I would want everyone to receive the ability to live in their homes, I also realize that many of us have an expectation of the care we have received and taking away our budget would take away our stability. Nursing home care is considerably higher than in home care, which actually saves the state money. I am aware that your estimates for nursing home care are 69,190, which is less than what we find in our areas. I have had elderly family that lived in a nursing home and I speak from experience when I say that I receive much much better care and a better quality of life living in my own home for less cost. My parents are my hands and feet and are available 24/7. I have one on one attention to my needs, there is not any possible way to receive this care in a nursing facility. I implore you to please add the grandfather clause into this waiver or change the budget limits. I can not understand if a nursing home cost is near 70,000 why we would cap budgets to less than 35,000. I am also aware that the DDS waiver now allows clients to keep their caregivers when they are in the hospital and I would like to see this in the AR Choices program as well. A caregiver does so much more than hospital staff. Would it not be in violation of the Olmstead Case to say a person needs a certain level of care and cap the budget and not allow the person to receive the care they need, forcing them into an institution?

The state has a surplus, why would we want to with hold care for individuals who only want to live comfortably in their homes rather than live in an institution? I hope we get direct answers to our comments rather than a canned answer, like we have received in prior public comments. Finally the public comment period should be advertised to all participants, so that everyone who would want to make a comment is able to speak, I know many people who are unaware of the changes or the need for public comment.

Response: Thank you for your comment.

1) The Waiver Renewal provides a "Process for Granting an Exception to the $34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

2) Currently, DHS has begun the process of seeking a Waiver Amendment from CMS to allow for the provision of Attendant Care Services in Inpatient Settings for ARChoices clients.

3) Public comments are sought pursuant to current Arkansas law, including publication of notice in a statewide newspaper and public notice and access at the DHS homepage.

Luke Mattingly CEO/President

CareLink

Comment: Selection of Entrants to Waiver Appendix B-3 f
The services are provided on a first come first served basis. The state combined the Adults with Physical Disabilities (AAPD) and Elderchoices (EC) waiver programs into one waiver (AR Choices) in 2016. Prior to the combined waiver the Elderchoices program, those age 65 and over, constituted approximately 70% of waiver slots. The combination of the waivers and the first come first serve approach over time will have a disparate impact on the elderly population. The length of time a participant receives services is vastly different between these two populations. The younger disabled population receives services for many years while the elderly population only averages a couple of years. As the elderly population drops off services and frees up open slots much more frequently than younger disabled participants the first come first serve approach will severely restrict the elderly populations availability to maintain waiver slots over time.
It is unlikely that the state of Arkansas will uncouple these two populations for purposes of the waiver. However, it should be a requirement that the Arkansas Department of Human Services produce public reports at least quarterly that detail the number of active cases by county and how many of those cases are in the age categories of 21 to 64 and 65 plus. Further, the impact on the elderly population since 2016 should be analyzed for disparate impact and a future trend analysis established on the likelihood of the younger disabled consuming a larger statistical portion of slots over time compared to statistical percentages prior to the waiver merger.
Of course, another solution to offset any potential disparate impacts would be to significantly increase the number of available participant slots.

Response: Thank you for your comment. Under this waiver, as indicated in Table J-2-a, the Total Unduplicated Number of Participants increases by 75 with each successive Waiver Year.

Comment: Barriers to Entry Appendix B-6
Elderly applicants and their families seeking in-home services endure a lengthy, multi-level, highly bureaucratic process. The elderly who requests these services are most often in a place where receiving timely care is critical. Applicants face the following approval layers: 1. Assessment by a nurse at the county office, 2. Assessment by the selected providers nurse, 3. Assessment by the third-party nurse (Optum), 4. Review by a DHS nurse to approve the plan of care. 5. Financial review by DHS. 6. Approval and PA assignment. This process is highly redundant and seems unnecessary. As a result, applicants are neglected of critical care in a timely manner. Our records reflect an approximate 120 day wait period for services. This is too long, especially for 90-year-old applicant who is in desperate need of services. Often the case, frustrated, applicants resort to what they see is the only option left, institutional care (skilled nursing facilities) where the process is far more simplified and timely.

Response: Thank you for your comment. DHS is currently conducting an internal Long-Term Services and Supports process review to further identify and address efficiency and timeliness.

Comment: Additional Limits on the Amount of Waiver Services Appendix C-4 Methodology for determining the SBL(Service Budget Limit) C
DHS will monitor and take steps necessary to update these SBL amounts when waiver rates change.

SERVICE BUDGET LIMIT (SBL) means the limit on the maximum dollar amount of waiver services that may be authorized for and received by each specific participant.
First, the service rates should be changing with this waiver submission which would affect the SBL's. (See comments for section Appendix J-2) Secondly, the service rates should not be the only driving factor which constitutes SBL amounts. DHS has always taken the position that the SBL limits, specifically the maximum limit, cannot exceed the Arkansas expenditure portion of the cost for institutional placement. It is abundantly clear that institutional costs have skyrocketed over the last three years. (See Appendix J-1 plus numerous published articles) Additionally, the Arkansas Legislature recently changed the bed capacity limit for institutions from 80% to 60%, with a gradual increase up to 70% as a new set point, which equates to an additional sixty million dollars of annual costs reimbursement for institutions. (Exhibit from the Arkansas Legislative Public Health Committee 7/5/2022) This will further increase the divide on what is spent on institutional care vs HCBS in Arkansas. Analyzing and reviewing this new data on institutional costs should trigger an increase to SBL's to provide equitable adjustment for HCBS participants. Since the waiver is being amended at this time, DHS should increase each tier of HCBS SBL's to be more equitable with increased expenditures on institutional care. Further, institutions have a built-in rate adjustment based upon inflationary factors and actual expenditures. (2.5% inflationary costs is referenced in Appendix J-2) To make services equitable the SBL's should also be changed annually to reflect inflationary factors and service levels available to participants.
Question: In Appendix J-1, when considering the inflationary factors of G and G' – was the bed rate % reduction approved by the legislature calculated into the projections?
When analyzing data from Appendix J-1 (which was mostly based upon 2019 data prior to an even greater increase in institutional costs in 2020, 2021 and 2022) it is clear that the disparity between Nursing Home care costs and AR Choices waiver costs continues to favor the institutions.
When comparing year 1 column 4 (Total AR Choices waiver cost per participant) to year 1 column 8 (Difference in total nursing home costs vs waiver costs) the variance between nursing home costs and AR Choices average costs is 52.6 %. Year 5 brings the variance up to 55.5%, further exacerbating the division of funding spent on nursing homes vs HCBS. (Column 8 – column 4 / column 8) This limits the amount of care HCBS participants can receive.
Also, Waiver service costs are projected to increase by 5.6% over the 5-year period while inflation indicators, especially in healthcare, are much greater. If the state is committed to HCBS the variance would be getting smaller and SBL limits would be increasing and reducing the divide between institutional expenditures. Increasing SBL limits and HCBS rates would rebalance this disparity.

Response: Thank you for your comment. DHS will continue to consider balance of service delivery models across various levels of care and numerous unique populations in need.

Comment: Rates for services Appendix J-2 6 through 14
A waiver amendment is being submitted, which is the perfect opportunity for the state to present to CMS adjustments to rates to combat current unprecedented inflationary and labor cost increases and labor shortages. These comments will address the Home Delivered Meal, Attendant Care and Respite rates. The most striking indicator from the five-year plan is that the rate for all services remains the same, not accounting for or allotting any funding for inflationary considerations whatsoever over the five-year period. This implies providers will have a zero increase in labor costs, health insurance, transportation, compliance related matters, software, PPE, communications, supplies, and other needs required to operate. Economic conditions are quite challenging for providers at the moment, so we encourage DHS to review this assumption.

Home Delivered Meal Rate:
This rate has remained unchanged since 2009. Everyone is aware of cost inflation impacting food, fuel, and labor costs – the main components of meal rates. Two providers, Baptist Health, and Mom's Meals have stopped providing this service due to untenable reimbursement rates. A rate review and update is overdue. Per Appendix J-2, the number of meals served through the program have declined, despite the aging population of Arkansans. If the CPI food index from 2010 –2022 percentage of increase/decrease (https://www.in2013dollars.com/Food/price-inflation) were applied to the 2009 $5.97 rate the new rate would be $8.19. Of course, HDM costs are primarily food, labor, and fuel. Providers are losing money on every meal served therefore a rate increase cannot be delayed.

Response: Thank you for your comment. DHS' Division of Medical Services is currently considering service rates and adjustments thereto.

Comment: Attendant Care and Respite Care Rate:
The rate setting methodology for In-home services is derived from "what is the minimum Medicaid can pay for this service" resulting in low wages and minimal benefits for workers. The rate setting process does not provide the opportunity to build a career ladder for in-home Aides nor does it focus on paying a wage that attracts high quality candidates. The rate is such that providers can only offer minimum wage or close to minimum wage pay. This is not conducive to providing high quality services and results in high turnover rate for this occupation, which is detrimental to participant care. Labor shortages and inflation, on top of the Arkansas minimum wage increases that resulted in an $11.00 per hour minimum, have severely impacted the ability of providers to recruit and retain workers. Individuals can make $14 to $18.50 working at a fast-food restaurant or retailer, and those entities can raise prices to offset the increased labor costs. In-home Medicaid providers have no such ability to pass along increased costs to the consumer. Providers rely on Medicaid to recognize the market shift and increase the rate paid for in-home services. To this end Medicaid in Arkansas has ignored the plight of in-home services providers. The rate needs to be set so that providers can compete in the local marketplace against other industries that hire workers with similar education and skills. It is clear, when reviewing restaurants and retailers starting wages, that the lowest possible wage that should be offered to a Home Care Aide is $14.00 per hour. The Arkansas Human Development Centers are starting their Aides at $14.42 per hour. The state recognizes these wage pressures at services that it provides directly but does not reciprocate that thought process to providers in HCBS. Using the Milliman formula from the 2018 rate assessment a $14.00 per hour wage would provide for a $6.40 unit rate or $ 25.59 per hour. (Providers assert that this is still too low, but it was the methodology utilized by the state in the previous review) Another simple projection is to take the current rate of $20.48, divided by the minimum wage of $11.00 to produce a 1.86% variant. Apply the current variant from minimum wage to the proposed new minimum of $14.00 per hour and a new the hourly rate would be $26.04 per hour or a $6.51 unit rate.
Medicaid services are steeped in heavy regulatory burdens and mandated positions other than Aides, software, and various compliance costs in addition to normal operational costs such as payroll, billing, human resources, and administration. These factors drive the need for the cost of business variant between what service workers are paid and the total reimbursement rate. The current 86% variant, as demonstrated in the paragraph above, is the lowest in the nation. So, the stipulated $26.04 per hour reimbursement rate is still not adequate, but that is the methodology DHS utilized during the last rate review. There are several states that mandate what the minimum rate is for a Home Care Aide, separate from the overall state minimum. If the rate were adjusted appropriately (around $26.00 per hour) CareLink would support placing the $14.00 per hour minimum rate for Aide in policy or statute. Also, all other payors for this service, already pay a rate of approximately $25.00 to $27.00 per hour. There is a

real problem when the Medicaid rate pays a 20% to 25% lower than rate for the same service. This is unsustainable.
Since it is already submitting an amendment to the waiver, this is a unique opportunity for Arkansas DHS to immediately respond to unprecedented wage and inflationary pressures affecting the Home and Community Based sector. It is assumed that DHS will ignore this request and indicate that a rate study was conducted in 2019 and these rates were adjusted in January 2021. To counter that, I would point out that the rate study utilized old data and did not even fully account for the final minimum wage increase that went to $ 11.00 per hour. (Also, providers contend that the study was flawed) There have been unprecedented inflationary pressures since this study was completed. Additionally, it is based on minimum wage! Workers in this field deserve to be recognized for their considerable achievements in keeping participants at home. Now is the time to act. To further demonstrate market labor pressure, see below:
Starting pay facts for retailers and fast food:
Human Development Centers run by the state of Arkansas start a minimum wager $14.42 per hour
https://humanservices.arkansas.gov/careers/job-listings/job-opportunities/human-development-centers/
Hobby Lobby as of January 1, 2022, started a minimum wage of $ 18.50 per hour for full-time employees.
https://www.usatoday.com/story/money/shopping/2021/12/14/hobby-lobby-minimum-wage-increase/8897355002/
Amazon has a minimum starting wage of $ 15.80 per hour
https://hiring.amazon.com/jobDetail/en-US/Amazon-Fulfillment-Center-Warehouse-Associate/Little-Rock/a0R4U00000DKQ6gUAH#/jobDetail?jobId=a0R4U00000DKQ6gUAH&locale=en-US&seoIndex=1
Target has a minimum stating wage of $ 15.00 per hour
https://corporate.target.com/press/releases/2020/06/Target-Increases-Starting-Wage-to-15-Thanks-Frontl
Best Buy has a minimum stating wage of $ 15.00 per hour
https://corporate.bestbuy.com/best-buy-provides-updates-on-evolution-of-employee-pay-and-sales-performance/
Costco has a minimum starting wage of $ 17.00 per hour.
https://www.4029tv.com/article/costco-raised-its-minimum-wage-to-dollar17-an-hour/38093969#
MacDonald's $15.00 per hour minimum starting wage at company stores
https://www.arkansasonline.com/news/2021/may/14/mcdonalds-setting-15-an-hour-wage-at-company/
Taco Bell $ 15.00 per hour minimum starting wage at company stores
https://www.forbes.com/sites/aliciakelso/2021/12/14/taco-bell-commits-to-a-15-an-hour-minimum-wage-at-company-owned-restaurants/?sh=306037095d0e

Response: Thank you for your comment. DHS' Division of Medical Services is currently considering service rates and adjustments thereto. DHS can confirm the wage, costs, and inflationary pressures you mention are all too real and present significant difficulties in all areas.

Comment: In conclusion, Arkansas does a really poor job of supporting Home and Community Based services. As evidenced by the CMS Medicaid Long Term Services and Supports Report, December 9, 2021, based upon data from Federal FY 2019. Arkansas ranks in the bottom ten of all states for spending on institutions vs HCBS. In fact, the national average is that states spend 58.6% on HCBS and 41.4% on

institutional care. Arkansas only spends 44% on HCBS but spends 56% on institutions, the reverse of the majority of the rest of the nation.
CareLink implores DHS and the Arkansas Legislative body to insist that the service budget limits and rates be adjusted during committee review prior to being submitted to CMS. Further, we ask CMS to thoroughly review the waiver Service Limits and Service rates in the spectrum of rebalancing institutional care and HCBS and require Arkansas DHS to stipulate how this waiver plan moves Arkansas closer to the CMS stated goal of a minimum 50/50 split between HCBS and Institutional care. Without a HCBS increase spending offset the percentage of spend on institutions will only continue to grow and move Arkansas even further away from the national rebalancing goal of a 50/50 spend.

Response: Thank you for your comment. Please be assured DHS continues to strive for improvement in all service delivery areas and to maximize results for clients, providers, and taxpayers, while responsibly managing budgetary allocations.

Kevin Hoover

Comment: Below you will find my comments and questions about the changes that you are wanting to make to the AR Choices program regarding the budgets of people on the program.
These changes are nothing more than a bullying attempt by DHS and a big pain in the rear as well as a slap in the face of us elderly, disabled, and our caregivers who provide the care we need. The purpose of the AR Choices program in to help us stay in our homes and get the care we need and be an active part of society instead of being confined to a Nursing Home or other type of facility. With these changes we have to worry about getting an infection, bedsores, laying in filth and even our own body waste for extended periods of time due to our budget/hours being cut It seems to me that the real purpose of these changes are for us to be put in a nursing home so that more of the state's money can be spent on our care and make us feel useless and unwanted.
I have been on the AR Choices program for 13 years and have never seen something as crazy as this is. I am paralyzed from the waist down and my condition has not changed other than a pressure sore reopening. If these budget changes go into effect my hours will drop significantly when nothing has changed. The changes to the budget that is proposed would drop my care budget from around $45,000 down to around $20,000 a year at the least. This would be because of the the changes to my budget when this is not currently an isssue because my budget is grandfathered in because I have been on the program since 2009. My caregiver does not get to just work 6 hours and go home or to another job because she lives here and is on call 24/7 to take care of my needs that could include turning every 2 hours, changing my bed if I have an accident, dumping a urinal, or changing the bandage on my pressure sore, and fixing me something to eat if I get hungry at 2:00 am. There is no one to come in and take over and there are some nights I'm up every 2 hours. I myself have had regular jobs with benefits, and they were not as stressful as it is being on this program and having to worry about my care being affected because of a money number. With this new Budget and taking out the Grandfathering in clause you are proposing it would drastically affect the care I receive as well as make my caregiver have to look else where to make ends meat because the budget will differ dramatically, talk about discrimination and a bullying tactic.
You can not just group people into 3 categories and set a budget limit for their care because everyone's care is different and it takes some people more time than others. These new changes that are being proposed is just as bad as the Algorithm if not worse. These changes want to limit the care I receives by basically putting a value on the care we receive and the time it takes to take a bath, get dressed, eat,

and even how often they can take a shower which is totally unacceptable. These changes are putting the peoples health at risk and takes more time away from me being able to live my life. After reading and researching it seems to me what is really going on with DHS is that they don't want to take care of the elderly and disabled. Instead they want to cut their budgets/hours and let them get sick so they can continue to put money in their pockets at the expense of other people's health. With these new changes the maximum budget for tier 3 is $34,000 a year and teir 2 is roughly $20,000 a year which is totally a slap in the face to both the caregiver and client. Seems to me this is nothing more than discrimination, not only for the people on the AR Choices program their caregivers to, as well as being a form of elder abuse and neglect on DHS. I was also told that if a system/program is working don't mess with it and leave it alone but if it's broken then fix it. Well the system wasn't broke but thanks to the new changes that are being proposed it is now. So it's time to fix it and this time leave it alone.
You need to put yourselves in our shoes as both clients and caregivers and see how you would like being in this situation and how you would deal with being told what amount of money someones health is worth. What if it was your family member? Putting budget limits on a persons care a d health is not just wrong, its wrong and aays hey your life has a price and thats all you a worth a year to us and causes unwanted stress on both the client and caregiver and causes them to rush and puts the client at risk of injury. If anything make the budgets fit the diagnosis because everyone is different. Don't put people in a one size fits all box and also think about increasing the pay caregivers receive and bring back nurse discretion because it does work and stop putting a price on people's lives. If you want the system to be fair do away with the budgets so that everyone is equal.
QUESTIONS:
Do you think these budgets will provide people with the care they truly need?

Response:

The Waiver Renewal provides a "Process for Granting an Exception to the $34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

Comment: Will DHS be responsible if a client gets sick, has a pressure sore, or heaven forbid passes away due to these changes? With this new system how will it determine how many times someone can have a shower or get dressed? For example what if they have a bowel movement and need another bath or their clothes changed. Does it account for that or does the client just have to sit in their own waste until their next scheduled bath? Why set a budget cap when every persons care is different? Is this because you are trying to save money to put in yalls pockets or you just don't care? Why are you not only discriminating against the people on the program but their caregivers as well? Since budgets are not currently in place why change it after 20 years? Do you just want the people on AR Choices to just give up and be put in a Nursing Home due to not receiving adequate care at home due to the reduction of hours because of the Budgets? If his condition hasn't changed then why is his budget being threatened? What about all this surplus money that DHS has? Where is it going? What's it being used for? Why place a dollar amount on our care now? What if it was your family being treated this way? Do yall not want to take care of the disabled?

Response: Thank you for your comment. Please be assured DHS continues to strive for improvement in all service delivery areas and to maximize results for clients, providers, and taxpayers, while responsibly managing budgetary allocations. The ArChoices program was designed to address care and client benefits while still allowing for individual flexibility. The Waiver Renewal provides a "Process for Granting an Exception to the $34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

Tracy Baxter RN

Education and Compliance Manager, White River Area Agency on Aging

Comment: Selection of Entrants to Waiver Appendix B-3 f:

At one time the ElderChoices program, those ages 65 and over, constituted approximately 70% of the waiver slots. The combination of the waivers in 2016 and the first come first serve approach over time will have a disparate impact on our senior population. It makes sense that a younger, disabled population would receive services for many more years than a senior would. As the elderly population drops off services and frees up open slots, if the first come first serve approach is used, it will restrict the senior population's availability to maintain waiver slots over time.

To offset any potential disparate impacts on seniors, the available participant slots could be increased. The Arkansas Department of Human Services should monitor the number of active cases by county and how many of those cases are in the age categories of 21 to 64 and 65 plus to avoid the loss of slots for our seniors. Our seniors must have the choice to remain in the community with home-based services.

Response: Thank you for your comment. Under this waiver, as indicated in Table J-2-a, the Total Unduplicated Number of Participants increases by 75 with each successive Waiver Year.

Comment: Barriers to Entry Appendix B-6:

Applicants and their families seeking in-home services endure a lengthy, multi-level, 'long road to approval' process. We need to remember that applicants who request these services are most often in a place where receiving timely care is critical to remaining in the community and as independent as possible. Its basic knowledge that seniors avoid asking for help until they are facing tough choices because they fear losing their independence and they fear institutionalization even more. The application process is highly redundant and as a result, applicants face institutional placement and sometimes even death before being approved. Arkansas - We can do better!

Response: Thank you for your comment. DHS is currently conducting an internal Long-Term Services and Supports process review to further identify and address efficiency and timeliness.

Comment: Additional Limits on the Amount of Waiver Services Appendix C-4 Methodology for determining the SBL (Service Budget Limit) C:

The service rates should be changing with this waiver submission, which would affect the SBL's. The service rates should not be the only driving factor, which constitutes SBL amounts. Analyzing and reviewing this new data on institutional costs should trigger an increase to SBL's to provide equitable adjustment for HCBS participants. Since the waiver is being amended at this time, DHS should increase each tier of HCBS SBL's to be more equitable with increased expenditures on institutional care. Further, institutions have a built-in rate adjustment based upon inflationary factors and actual expenditures. (2.5% inflationary costs are referenced in Appendix J-2) To make services equitable, the SBL's should also be changed annually to reflect inflationary factors and service levels available to participants. A solution would be to increase SBL limits and HCBS rates.

Response: Thank you for your comment.

The Waiver Renewal provides a "Process for Granting an Exception to the $34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

DHS' Division of Medical Services is currently considering service rates and adjustments thereto.

Comment: Rates for services Appendix J-2 6 through 14:

A waiver amendment is being submitted, which is an opportunity for the state to present to CMS adjustments to the rates to combat current unprecedented inflationary and labor cost increases along with labor shortages. Attendant care and Respite care rate setting methodology for In-home services results in low wages and minimal benefits for workers. The rate-setting process does not provide the opportunity to build a long career for in-home aides nor does it attract high quality applicants. The rate is such that providers can only offer a minimum wage or close to a minimum wage. This is not conducive to providing high-quality services and results in a high turnover rate for this occupation, which is detrimental to participant care. When our agency reviews ways to recruit, hire and retain caregivers, the root problem that we face is the reimbursement rate. Unfortunately, the HCBS participants are the ones who pay the ultimate price. We respectfully ask that DHS and the Arkansas Legislative body insist that the service budget limits and rates be adjusted during committee review before being submitted to CMS. We ask CMS to thoroughly review the waiver service limits and service rates in the spectrum of rebalancing institutional care and HCBS and require Arkansas DHS to stipulate how this waiver plan moves Arkansas closer to the CMS stated goal of a minimum 50/50 split between HCBS and institutional care. Without a HCBS increase-spending offset, the percentage spent on institutions will only continue to grow and move Arkansas even further away from the national rebalancing goal of a 50/50 spend.

Response: Thank you for your comment. Please be assured DHS continues to strive for improvement in all service delivery areas and to maximize results for clients, providers, and taxpayers, while responsibly managing budgetary allocations.

Melissa Harville

Comment: Below you will find my comments and questions about the changes that you are wanting to make to the AR Choices program regarding the budgets of people on the program.
These changes are nothing more than a bullying attempt by DHS and a big pain in the rear as well as a slap in the face of the elderly, disabled, and their caregivers who provide the care they need. The purpose of the AR Choices program in to help these people stay in their homes and get the care they need and be an active part of society instead of being confined to a Nursing Home or other type of facility. With these changes they have to worry about getting an infection, bedsores, laying in filth and even their own body waste for extended periods of time after their caregivers leave because most do not have family or friends they trust to come in and take up the slack. It seems to me that the real purpose of these changes are for the people to be put in a nursing home so that more of the state's money can be spent on their care.
I have been a caregiver for 13 years and have never seen something as crazy as this is. My client/boyfriend is paralyzed from the waist down and his condition has not changed other than a pressure sore reopening. If these budget changes go into effect his hours will drop significantly when nothing has changed. The changes to the budget that is proposed would drop his budget from around $45,000 down to around $20,000 a year at the least. This would be because of the the changes to his budget when this is not currently an isssue because his budget is grandfathered in because he has been on the program since 2009. I don't get to just work 6 hours and go home or to another job because I live here and am on call 24/7 to take care of his needs that could include turning him in bed every 2 hours, changing his bed if he has an accident, dumping a urinal, or changing the bandage on his pressure sore, and fixing him something to eat if he gets hungry at 2:00 am. There is no one to come in and take over and there are some nights I'm up every 2 hours. I have had regular jobs with benefits, and they were not as stressful as it is being a caregiver and the pay was a lot better.
With this new Budget and taking out the Grandfathering in clause you are proposing it would drastically affect the care I give my client as well as make ends meat because the budget will differ dramatically, talk about discrimination and a bullying tactic. You can not just group people into 3 categories and set a budget limit for their care because everyone's care is different and it takes some people more time than others. These new changes that are being proposed is just as bad as the Algorithm if not worse. These changes want to limit the care a person receives by basically putting a value on the care they receive and the time it takes someone to take a bath, get dressed, eat, and even how often they can take a shower which is totally unacceptable. These changes are putting the patients health at risk and takes more time away from the client being able to live their lives.
After reading and researching it seems to me what is really going on with DHS is that they don't want to take care of the elderly and disabled. Instead they want to cut their budgets/hours and let them get sick so they can continue to put money in their pockets at the expense of other people's health. With these new changes the maximum budget for tier 3 is $34,000 a year and teir 2 is roughly $20,000 a year which is totally a slap in the face to both the caregiver and client. Seems to me this is nothing more than discrimination, not only for the people on the AR Choices program their caregivers to, as well as being a form of elder abuse and neglect on DHS.
I was also told that if a system/program is working don't mess with it and leave it alone but if it's broken then fix it. Well the system wasn't broke but thanks to the new changes that are being proposed it is

now. So it's time to fix it and this time leave it alone. You need to put yourselves in our shoes as both clients and caregivers and see how you would like being in this situation and how you would deal with being told what amount of money someones health is worth. What if it was your family member? Putting budget limits on a persons care a d health is not just wrong, its wrong and aays hey your life has a price and thats all you a worth a year to us and causes unwanted stress on both the client and caregiver and causes them to rush and puts the client at risk of injury. If anything make the budgets fit the diagnosis because everyone is different. Don't put people in a one size fits all box and also think about increasing the pay caregivers receive and bring back nurse discretion because it does work and stop putting a price on people's lives. If you want the system to be fair do away with the budgets so that everyone is equal.
QUESTIONS:
Do you think these budgets will provide people with the care they truly need? Will DHS be responsible if a client gets sick, has a pressure sore, or heaven forbid passes away due to these changes? With this new system how will it determine how many times someone can have a shower or get dressed? For example what if they have a bowel movement and need another bath or their clothes changed. Does it account for that or does the client just have to sit in their own waste until their next scheduled bath? Why set a budget cap when every persons care is different? Is this because you are trying to save money to put in yalls pockets or you just don't care? Why are you not only discriminating against the people on the program but their caregivers as well? Since budgets are not currently in place why change it after 20 years? Do you just want the people on AR Choices to just give up and be put in a Nursing Home due to not receiving adequate care at home due to the reduction of hours because of the Budget changes? If his condition hasn't changed then why is his budget being threatened?

Response: Thank you for your comment. The ArChoices program was designed to address care and client benefits while still allowing for individual flexibility.The Waiver Renewal provides a "Process for Granting an Exception to the $34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

Trevor Hawkins, Attorney

Economic Justice Practice Group Leader, Legal Aid of Arkansas - Jonesboro

Comment: Legal Aid of Arkansas offers these comments to the proposed rules issued on July 15, 2022, pertaining to the ARChoices and Independent Choices programs, including both the proposed waiver and the related provider manual. The proposed changes range from changing who may be eligible for the program to what level of services a given beneficiary may receive. Legal Aid of Arkansas offers these comments based on expertise gained over the last eight years representing hundreds of clients with a wide range of issues relating to the ARChoices program. Many of these problems relate to the program's present form, as introduced in 2019. Legal Aid has four main concerns that center around how the program will function under the new rules.

DHS has removed the pathway for ARChoices eligibility for those who have a diagnosis of Alzheimer's disease or dementia from the Provider Manual. Currently, applicants with a diagnosis of Alzheimer's disease or dementia who do not otherwise meet the ARChoices physical eligibility criteria—assistance with eating, toileting, or mobility—can still be eligible for ARChoices if they have a medical diagnosis of dementia and exhibit behaviors that pose a serious health or safety concern. Specifically, Section 212.000 of the proposed Provider Manual, titled "eligibility for the ARChoices Program," eliminates the provision that provides eligibility through a diagnosis of Alzheimer's disease or dementia. Furthermore, Section 212.050 removed the definition of Functional Eligibility, which provides that someone with a diagnosis of Alzheimer's disease or dementia may be eligible. It is unclear whether this is intentional or an oversight because references to the eligibility pathway remain in the proposed Waiver (p. Appendix B-6: 16) and the proposed ARIA Manual (p. 57-58). This change is significant because many Arkansans with a diagnosis of Alzheimer's disease or dementia would otherwise be ineligible for Medicaid without the ARChoices program. This cognitive impairment provision acknowledges that Alzheimer's disease and dementia are unique conditions, and that the normal evaluation process may not accurately consider the kinds of assistance such a person may need. A recent study noted that those with a diagnosis of Alzheimer's disease or dementia have a unique utilization of services than others from programs like ARChoices. 1 Many of these individuals rely on services like medical equipment and transportation rather than attendant care. 2 For many, these services allow them to remain at home longer than they otherwise would be able to.This change could profoundly affect those who are already on the program under this provision, as they would now need to re-establish eligibility under the remaining criteria. Because those with conditions such as Alzheimer's disease and dementia do not necessarily have the same needs for physical, hands-on assistance, many would experience terminations from the program. Notably, when asked, DHS was unable to provide numbers for how many are eligible under this pathway. As a result, it is difficult to ascertain how many would be affected and whether the agency considered the impact of such a change to the policy. Those who become ineligible as a result of the change will unexpectedly lose access to vital benefits that allow them to remain in the home and community as well as access to Medicaid altogether. Such changes would be life altering and would likely lead to a risk of institutionalization for most. For many of Legal Aid's clients with Alzheimer's disease or dementia, the attendant care and other services and supports make it possible forthem remain in their home. If attendant care is lost, then those in the beneficiary's life, whether family or close friends, must choose between work and care for the beneficiary during those lost attendant care hours. Additionally, the loss in other benefits leads to an increased financial burden that requires those same unpaid caregivers to work more to afford the lost products and services. Such an outcome is directly counter to the ARChoices program goal of providing home and community bases services as an alternative to nursing home placement. The proposal does not justify the deletion of this eligibility pathway, nor does it consider the impact that it will have on existing beneficiaries.

Response: Thank you for your comment. The comment misreads the legal effect of the changes proposed in the ARChoices Provider Manual. Eligibility for ARChoices has always been conditioned on the applicant requiring an intermediate level of care in a nursing facility. DHS is not proposing any substantive change to this requirement or to the criteria or definitions for determining whether an individual requires an intermediate level of care in a nursing facility. Nor is DHS proposing any substantive change to consideration of Alzheimer's Disease or related dementia in determining eligibility. Rather, DHS is proposing to remove duplicative language in the ARChoices Provider Manual. The criteria and definitions for determining intermediate level of care are set forth in the Procedures for Determination of Medical Need for Nursing Home Services, which is an existing rule promulgated by the

DHS Office of Long-Term Care. These Procedures are referenced in the new language added at the end of Section 211.000 in the ARChoices Provider Manual.

Comment: The proposed Individual Service Budgets appear to arbitrarily limit services deemed medically necessary and incentivize institutional care.
The amount of attendant care, respite care, and personal care hours that a beneficiary receives each year will be determined by the Task and Hour Standards form as completed by the DHS registered nurse. Completing this form requires RN to look at the Needs Intensity Score, Frequency, and time that a beneficiary needs for all thirteen activities of daily living to figure the level of benefits the person should receive. However, even if the Standards determine that a person needs, for example, 8 hours of attendant care per day, the Individual Service Budget may not allow a person to actually receive that much care. The proposed budget levels are set at $6,000, $23,000, and $34,000. DHS's methodology for setting the $34,000 cap is not based on the actual overall cost of nursing home care. Other estimates show that the overall cost of nursing home care in Arkansas is significantly higher. In Appendix J of the proposed Waiver (p. Appendix J-1:1), DHS puts the average annual cost of nursing home care at $69191 ($5,766 per month). This roughly accords with the 2021 estimate from a survey by Genworth Financial that put the annual cost at $72,966 ($6,083 per month).3 Considering the cost of the long-term care equivalents, $34,000 appears to be a gross underestimate. DHS originally derived the $30,000 limit by including only the costs to the state's general revenue fund and the associated federal match rate. For the new proposal, DHS simply adds an additional 13% to arrive at the proposed $34,000 figure. However, this figure accounts for only 49% of the average cost of nursing home care for an individual. The remainder comprises the patient liability, the Quality Assurance fee, and the federal match on the Quality Assurance fee. In essence, DHS has constructed its budget limits to externalize the costs of nursing facility care. Thus, the additional cost will be borne not only by the federal government and providers but also by the beneficiary through the infringement of their preference for community-based living. The effect of the artificially low budget caps is that it places individuals at increased risk of institutionalization. While the maximum budget is only $34,000, very few beneficiaries may fall into this category because of the high bar that is set. To be eligible for the maximum budget limit, the individual must require extensive physical assistance with eating, toileting, and mobility. The issue Legal Aid's clients have commonly faced is that the definition of extensive assistance with eating is difficult to meet. If the beneficiary can arguably take a utensil from a prepared plate to her mouth—irrespective of the difficulty in doing so or their ability to get food on the utensil—then they would never meet the definition of needing extensive physical assistance with this task. As a result, such a person would be limited to the $23,000 budget and an absolute maximum of 105 attendant care hours per month. Another example is for those who have established eligibility for the program under the Alzheimer's disease or dementia diagnosis pathway. As discussed above, this pathway does not look at the person's needs regarding eating, toileting, and mobility in determining whether they are eligible for the program. Instead, it focuses on their diagnosis and behaviors that are exhibited as a result. The Individual Service Budget process ignores this difference in criteria, opting to only look at the eating, toileting, and mobility ADLs. Therefore, without the need for extensive, hands-on physical assistance with two of the three—eating, toileting, or mobility—a person with Alzheimer's disease or dementia will effectively be limited to a maximum of $6,000 in program services. Legal Aid has many clients with serious medical conditions that are not adequately considered by the budget criteria, many of which would experience a cut of as much as 131 hours of attendant care per month if their grandfathered status was taken away. Put another way, some of Legal Aid's clients would go from having 7 or 8 hours of care each day to only 3.5

hours of care each day, with no one else to rely on for the lost time. Such an individual, without a waiver of the budget limits, would be required to enter a nursing facility.4 Therefore, the low budget caps could implicate—and, indeed, violate—the Americans with Disabilities Act's mandate for community integration recognized in the U.S. Supreme Court's Olmstead decision. The proposal fails to address the effects of these changes on those with the most acute needs or provide consideration of reasonable alternatives like matching the service budgets with the cost of nursing facility care.

Response: As noted above, the Waiver Renewal provides a "Process for Granting an Exception to the $34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

Comment: DHS's proposed budget exception request lack adequate protections for ARChoices Beneficiaries.

The proposed Waiver (Appendix C-4:6) and the proposed Provider Manual Section 212.200 include a new process for a beneficiary to request either a move to a higher budget Service Budget or an exception to the maximum Service Budget Limit of $34,000, but this process may fall short of meeting the needs of the ARChoices program. First, the proposed policy omits any description of how beneficiaries should be provided notice of the budget exception process and where these requests should be made. Additionally, there does not appear to notification requirements once the panel has issued a decision. For many of Legal Aid's clients, this process will dictate whether they are able to live independently at home so clear notice of how to participate and when a decision is made is important. Second, the new policy omits any procedural safeguards for the beneficiaries that make such requests. For example, the process only allows for an initial 60-day modification of the individual's service budget while several administrative processes play out to see if it should be granted. This includes, in most cases, a new ARIA assessment by an independent contractor and an undescribed amount of paperwork to be submitted for review by the DHS RN. Afterwards, the policy states that a panel of DHS RN's will review each case individually and determine whether the request should be granted. If the agency fails to complete these steps within the 60-day period, then the beneficiary will be required to revert to her previous Service Budget Limit and presumably start the process all over again. The proposed Waiver and Provider Manual does not appear to contemplate what procedures will be in place to ensure timely processing of these budget exception requests, the approval of which may very well decide whether a beneficiary must be institutionalized or not. Third, the proposal also eliminates a provision that has provided a "grandfathered" status to those that received more than $30,000 in services prior to 2018. This provision has provided a great deal of stability for many of Legal Aid's clients that have been on the program the longest. As discussed above, without this provision, many of the grandfathered beneficiaries would receive a reduction in services of as much as 131 hours per month. This translates to going from having a caregiver with you for 7 hours per day to 3.5 hours per day on a seven day schedule. The grandfathering rule acknowledged that those on the program with the highest acuity was at risk of institutionalization under the new service budget limits and therefore exempted them from it. Now these "grandfathered" beneficiaries will be directed to the new proposed budget exception request to maintain the level of services that they have received for many years. Omitted from the new budget exception request is any consideration for these individuals and the profound effect such a reduction would have on them. Additionally, the proposal lacks any mention of whether these specific beneficiaries would be notified of the new process or whether their previous grandfathered budgets will be part of the consideration for the DHS RN panel that reviews

the request. Finally, the proposal does not address how a beneficiary's budget will be handled in the years following approval of a budget exception request. It would be very burdensome on both the beneficiary and the agency to have to participate in this multi-step, 60-plus day-long process each year to determine the level of care that a beneficiary should receive. Stability is a very important factor, and the risk of fluctuations that might occur year to year if treated as a one-year exception would be untenable. Legal Aid has regularly heard beneficiaries express concern about the yearly prospects of major changes in program services received and how that might impact their lives. Such a lack of consideration for these issues runs counter to the program's goals at providing independent living in the home and community rather than the alternative of nursing home placement

Response: Thank you for your comment. DHS will take your comments under advisement and consider your input as it relates to the processes mentioned.

Comment: The proposed ARChoices Waiver and related provider manuals remove definitions vital for program operations.
The ARChoices program requires an applicant or beneficiary to be both financially and functionally eligible for the program. In evaluating whether a beneficiary is functionally eligible for the program, the agency relies on a set of specific terms that are commonly not understood by the individual seeking to establish eligibility for the program. Section 212.050 of the proposed Provider Manual removes the following important definitions:

- 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.
- 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.
- 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.
- LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.
- SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.
- SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.
- 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.

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

Terms like "limited physical assistance," "extensive physical assistance," "total dependence," "locomotion," "eating," and "transferring" are vital to the determination of both eligibility and the level of services received. Without a proper understanding of these terms, the beneficiary may not be able to convey her needs during the assessment process accurately and would then receive a denial of eligibility. Likewise, the failure to adequately describe her needs may still lead to eligibility for the program but could still severely limit the level of services that she may receive on the program.

The removal of these definitions is crucial for purposes of due process rights as well. Those that receive a denial of services have the right to a fair hearing to contest such agency decisions. The removal of these important definitions restricts a beneficiary's ability to receive adequate notice of the agency's decision and as well as her ability to present evidence to the impartial hearing officer that her understanding of these important terms is the same as the agency's. Legal Aid has represented well over one hundred beneficiaries where eligibility or the level of services turned simply on the understanding of these definitions. The proposal lacks any reasoning for the deletion of these vital terms and therefore, it is unclear whether this was an oversight or a choice to create ambiguity in the program's operation.

Response: Thank you for your comment. The comment misreads the legal effect of the changes proposed in the ARChoices Provider Manual. DHS is not proposing any substantive change to the criteria or definitions for determining whether an individual requires an intermediate level of care in a nursing facility. Rather, DHS is proposing to remove duplicative language in the ARChoices Provider Manual. The definitions referenced in the comment are set forth in the Procedures for Determination of Medical Need for Nursing Home Services, which is an existing rule promulgated by the DHS Office of Long-Term Care. The Procedures are referenced in the new language added at the end of Section 211.000 in the ARChoices Provider Manual.

Comment: Conclusion

Legal Aid's clients rely on this program the maintain a safe and happy life in their homes and communities rather than in a nursing home facility. As such, it is important that the program provide adequate care to meet the needs of its beneficiaries in an understandable and consistent manner. The proposed removal of eligibility pathways, arbitrarily constrained services, and ambiguity in procedures and terms appears to run counter to the program's goals and pose a risk of institutionalization for many that receive services through the program. DHS has options that would remedy each of these concerns at its discretion.

Response: Thank you for your comments. DHS will take your comments under advisement and consider your input further.

Division of Medical Services
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: July 15, 2022

SUBJ: AR Choices in Homecare Renewal

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than August 14, 2022.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective October 1, 2022:

DMS renews the ARChoices in Homecare waiver as required by § 1915(c) of the Social Security Act ("the Act"). The five-year renewal was approved March 10, 2022. To effectuate the renewal, DMS issues changes to the waiver, the ARChoices provider manual, and Personal Care provider manual as follows:

- Clarification of the roles and responsibilities of the operating agencies within DHS.
- Harmonization of the ARChoices Provider Manual to reflect the functional eligibility determinations and evaluations listed in the ARChoices waiver.
- Revision of the Personal Care Manual to remove duplication of ARChoices rules; refers to ARChoices Provider Manual.
- Updated language as necessary to reflect the automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out.
- Increase to the service rates to $5.12.
- Removal of the Provisional Service Plan option.
- Addition of Waiver slots to ARChoices annually

The financial impact is $12,992,412 for State Fiscal Year (SFY) 2022 and $13,615,716 for SFY 2023. The state share of increasing the Attendant Care and In-Home Respite Care rates is $3,699,914 for SFY 2022 and $3,864,140 for SFY 2023.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule on the Medicaid website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed -rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than August 14, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. 4502035775

Elizabeth Pitman, Director
Division of Medical Services

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.6

Includes Changes Implemented through January 2019

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

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

PURPOSE OF THE

HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors.

State:	
Effective Date	

1. Request Information

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

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

ARChoices in Homecare
AR.0195.R06

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:** 07/01/2021

Approved Effective Date *(CMS Use):*

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

☐	**Hospital** *(select applicable level of care)*	
	○	**Hospital as defined in 42 CFR §440.10** If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

	○	**Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160**
■	**Nursing Facility** *(select applicable level of care)*	
	●	**Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155** If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:
		Individuals requiring a skilled level of care are not eligible for the ARChoices in Homecare waiver program. The state's definition of "skilled level of care" is explained in b-6-d.
	○	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
☐	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID facility level of care:	

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

Select one:

○	**Not applicable**			
●	**Applicable**			
	Check the applicable authority or authorities:			
	☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**		
	☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*		
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
	☐	**A program operated under §1932(a) of the Act.**		

		Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:
	☐	**A program authorized under §1915(i) of the Act.**
	■	**A program authorized under §1915(j) of the Act.**
	☐	**A program authorized under §1115 of the Act.** *Specify the program:*

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of the ARChoices in Homecare (ARChoices) waiver is to offer cost-effective, person-centered home and community based services as an alternative to nursing home placement to persons aged 21 to 64 years with a physical disability or 65 and older who require and intermediate level of care in a nursing facility, and who do not require a skilled level of care, as defined by State administrative rule which is set forth in B-6-d. ~~Through person-centered service plans managed by state-employed registered nurses (DHS RN), the waiver allows Medicaid-eligible participants to remain at home; promotes dignity, autonomy, privacy, and safety; fosters community inclusion; and precludes or postpones institutionalization.~~

~~Initial applications for ARChoices are processed to determine financial and functional eligibility for the waiver. The Division of County Operations (DCO) Long-Term Services and Supports (LTSS) unit processes the applications. LTSS eligibility workers are responsible for determining financial eligibility and referring applicant information to the operating agency for an independent assessment of functional eligibility.~~

Services are provided according to individualized person-centered service plans (PCSPs). ARChoices services include Attendant Care, Adult Day Services, Adult Day Health Services, Home-Delivered Meals, Personal Emergency Response System (PERS), Environmental Accessibility Adaptations/Adaptive Equipment, Prevocational Services, and Respite Care (in-home and facility-based). Individual PCSPs are developed in coordination with the participant based on the Arkansas Independent Assessment (ARIA) assessment or evaluation and a discussion of their preferences, goals, desired outcomes, and risk factors.

The independent assessment is performed by the Independent Assessment Contactor utilizing the Arkansas Independent Assessment (ARIA) instrument to assess functional need. This assessment of functional need is used as part of the process to determine if the person is medically and financially eligible as well in the development of a participant's PCSP. At least every 12 months, an evaluation will be completed in conjunction with the participant to determine continued evidence of established medical and functional need or a change in medical condition that may impact continued eligibility. The evaluation may result in a reassessment being requested if it is determined that there is evidence of a material change in the functional or medical need of the participant. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system.

ARChoices is operated by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) under the administrative authority of the Division of Medical Services (DMS), the State Medicaid agency. DAABHS and DMS are all under the umbrella of the Arkansas Department of Human Services (DHS). DMS is responsible for monitoring the operations of ARChoices, promulgation of the provider manuals and regulations governing the waiver, reimbursement of licensed waiver providers, and oversight of all waiver-related delegated functions. DAABHS is responsible for developing and implementing internal, administrative policies and procedures to operate the waiver, overseeing the development and management of PCSP, and providing care coordination to waiver participants.

~~ARChoices is administered by three state operating agencies, the 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). DAABHS, DCO and DPSQA operate under the authority of the Division of Medical Services (DMS), the state 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 the 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. DCOis responsible for the final determination of level of care. DPSQA is responsible for provider certificationand licensure for ARChoices services such as adult day service and adult day health service, 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.~~

~~Initial evaluations of functional eligibility for the waiver are determined using results from an assessment performed by the Independent Assessment Contractor. The Independent Contractor's team of registered nurses completes the Arkansas Independent Assessment (ARIA) functional evaluation. If an applicant is determined both functionally and financially eligible the DHS county office approves the application. The annual evaluation of functional eligibility is initiated by the DHS RN. DHS RNs use the DHS 703 form as the evaluation tool. Should this evaluation result in a change of condition, a referral for completion of the ARIA by the Independent Contractor will be made as the results of ARIA system influence the development of the person-centered service plan. The results from the ARIA system are forwarded to DCO for final determination of continuing functional eligibility for the waiver.~~

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

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

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

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

●	**Not Applicable**
○	**No**
○	**Yes**

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

●	**No**
○	**Yes**

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

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

5. Assurances

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

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

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

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

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

~~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 public testimony. After legislative review, the regulations, policies, rules and procedures are adopted and incorporated into the appropriate document. All provider manuals containing program rules are available to providers and the general public via the DMS website.~~

The public notice for this amendment was published in the Arkansas Democrat-Gazette for three consecutive days from July 4 through July 6, 2021. ~~on January 12-14, 2020.~~ The 30--day comment period ended ~~February 10, 2020.~~August 2, 2021. A public Hearing was held by remote access at 11:00a.m. on July 13, 2021. Physical copies of the proposed waiver ~~amendment~~ renewal were mailed to constituents upon request and were posted on the DHS website on the proposed rules page at https://humanservices.arkansas.gov/do-business-with-dhs/proposed -rules/. The entire proposed waiver renewal was also emailed to an Interested Parties list. Commenters could submit comments to either an email address or a physical address. ~~Copies were also published on the state's Medicaid and DHS websites at the following links, respectively: https://medicaid.mmis.arkansas.gov/general/comment/comment.aspx and https://humanservices.arkansas.gov/resources/promulgation-of-new-rules .~~
There were 16 individuals, besides the presenters, who attended the Zoom public hearing on July 13, 2021, at 11:00 a.m. A PowerPoint presentation of the changes was conducted. No one provided comments during the public hearing. Attendees were reminded of how to provide public comments in writing. DHS received public comments from two commenters, both are directors of Area Agencies on Aging in Arkansas. Most of the comments related to amendments to the ARChoices and Personal Care provider manuals, which are also being updated with the waiver. Most of the comments were requesting more detail regarding certain processes. The provider manuals are being changed to match the requests.

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

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

7. Contact Person(s)

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

Last Name:	~~Golden~~Pitman				
First Name:	~~Mac~~Elizabeth				
Title:	~~Deputy Chief Office of Policy Coordination and Promulgation~~ Director				
Agency:	Arkansas Department of Human Services, Division of Medical Services				
Address :	P.O. Box 1437, Slot S-~~295~~401				
Address 2:					
City:	Little Rock				
State:	Arkansas				
Zip:	72203-1437				
Phone:	501- ~~563-7643~~244-3944	**Ext:**		☐	**TTY**
Fax:	501-682-8009				
E-mail:	Elizabeth.Pitman@dhs.arkansas.gov~~Mac.E.Golden@dhs.arkansas.gov~~				

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

Last Name:	~~Fisher~~Gann				
First Name:	~~Ashley~~ 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:					
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				
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:

~~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 type of service covered by the approved waiver and received by any current 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 RN.~~

~~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 eligibilitycriteria that persons requiring skilled care (as defined in the state rule) are not eligible for the waiver. This restates existing policy and is incorporated in the assessment and eligibility determination processes.~~

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

~~There are no new limitations on the amount of wavier 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 RN. Re-assessments of existing participants will be performed through the ARIA process when referred by the DHS RN.~~

~~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 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 and the opportunity to opt out of the hearing:~~

~~Participants who receive negative determinations regarding eligibility determinations, person-centered service plans, and Individual Services Budgets, will automatically have the denials appealed by DHS. Participants will have the ability to opt out of this automatic appeal.~~

~~Current notification processes will be updated to notify participants of the automatic Fair Hearing, as well as how to opt out of the hearing.~~

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

~~Determined following their reassessment by a DHS RN~~. Denials of eligibility, services, and Individual Service Budgets, will be automatically appealed by DHS on behalf of the participant. Current notification processes will be updated to reflect the automatic appeal and to provide information on opting out of the appeal.

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 Division of Medical Services (DMS, the State Medicaid Agency) is responsible for monitoring the operations of ARChoices, promulgation of provider manuals and regulations governing the waiver, reimbursement of licensed waiver providers, and oversight of all delegated waiver-related functions. The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for developing and implementing internal administrative policies and procedures to operate the waiver, overseeing the development and management of PCSPs, and providing care coordination to waiver participants.

DMS delegates the following responsibilities to the following Divisions under the Arkansas Department of Human Services (DHS):

Division of County Operations (DCO) is responsible for processing ARChoices applications, determining medical and financial eligibility, and assigning levels of care for waiver services; and

Division of Provider Services and Quality Assurance (DPSQA) is responsible for provider licensure compliance.

To oversee and monitor the functions performed by DAABHS, DCO and DPSQA in the administration and operation of the waiver, DMS will conduct monthly team meetings 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.

DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) sys

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

~~DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver related functions delegated to DAABHS, 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 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.~~

~~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.*
	~~A contractor ("Independent Assessment Contractor") will perform independent assessments that gather functional eligibility information about each ARChoices waiver applicant and participant using the Arkansas Independent Assessment (ARIA) instrument. The information gathered is used to determine the individual's level of care, the number of medically necessary hours of attendant care, and the tier level (which is intended to help inform waiver program oversight and administration and person-centered service planning).~~ The independent assessment is performed by the Independent Assessment Contractor utilizing the Arkansas Independent Assessment (ARIA) instrument to assess functional needs.
○	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

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

●		**Not applicable**
○		**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
	☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*

	☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:

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 ~~the Division of Medical Services (~~DMS~~)~~ ~~the State Medicaid Agency), along with the Division of Aging, Adult, and Behavioral Health Services (~~ and DAABHS~~)~~, 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~~DMS 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 and ~~,~~ tier recommendations. determinations.~~, and recommended attendant care services hours according to the Task and Hour Standards for a statistically significant number of cases.~~ The Independent Assessment Contractor is required to include the results of the quality monitoring and assurance process in the monthly reports submitted to the Contract Monitor in the format required by DHS.

The monthly reports include the following:
1. Demographics about the beneficiaries who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all assessments ; and
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.;

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	■	■	☐	☐

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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: Administrative Authority

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

i Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:	**Number and percent of participants with delivery of at least one waiver service per month as specified in the service ~~plan~~ PCSP 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:*

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 of active and unduplicated participants ~~and number of unduplicated participants~~ served within approved limits specified in the approved waiver. Numerator: Number of active and unduplicated participants served within approved limits; Denominator: Number of active and ~~/~~unduplicated participants.**
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify: ***MMIS***	

	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 Report of Active Cases (Point in Time)**

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	■ *100% Review*
	☐ *Operating Agency*	■ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	■ *Other Specify:*	☐ *Annually*	
	Division of County Operations	☐ *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 policies and/or procedures developed by DAABHS that are reviewed and approved by the Medicaid Agency (DMS) prior to implementation. Numerator: Number of policies and procedures developed by DAABHS that are**

	reviewed and approved by DMS 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: ***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 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 claims on the Overlapping Services Report having the same date of service as ~~paid correctly on the same date of service~~ as a claim for institutional services ~~as specified in the waiver application~~which correctly paid only for the date of discharge. Numerator:

	Number of waiver claims on the Overlapping Services Report which correctly paid only for the date of discharge. ~~correctly~~; Denominator: Number of waiver claims
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify: ***Overlapping Services Report or similar data preferred by Operating Agency and approved by Medicaid Agency***	

	Responsible Party for data collection/generation *(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 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.*

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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) the Division of Provider Services and Quality Assurance (DPSQA) (operating agency),~~ and the Division of Medical Services (DMS) (Medicaid agency) participate in monthly 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. Problems are identified, documented, and tracked for remediation by DMS and DAABHS.

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

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

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

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

ii Remediation Data Aggregation

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

c. Timelines

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

●	**No**
○	**Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Select one Waiver Target Group		Target Group/Subgroup	Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
■	**Aged or Disabled, or Both - General**				
	■	Aged (age 65 and older)	65		■
	■	Disabled (Physical)	21	64	
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

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

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

Appendix B-2: Individual Cost Limit

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

- ● **No Cost Limit**. The state does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*. The limit specified by the state is *(select one)*:
  - ○ **%** A level higher than 100% of the institutional average
    Specify the percentage:
  - ○ Other *(specify)*:
- ○ **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
- ○ **Cost Limit Lower Than Institutional Costs**. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.

  The cost limit specified by the state is *(select one)*:
  - ○ **The following dollar amount**:
    Specify dollar amount:

    The dollar amount *(select one)*:
    - ○ **Is adjusted each year that the waiver is in effect by applying the following formula:**
      Specify the formula:
    - ○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**
  - ○ **The following percentage that is less than 100% of the institutional average:**

	○	**Other:** *Specify:*

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

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

☐	**The participant is referred to another waiver that can accommodate the individual's needs.**
☐	**Additional services in excess of the individual cost limit may be authorized.** Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	**Other safeguard(s)** *(Specify)*:

Appendix B-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	**11350**
Year 2	~~11350~~**11425**
Year 3	~~11350~~**11500**
Year 4 (only appears if applicable based on Item 1-C)	~~11350~~**11575**
Year 5 (only appears if applicable based on Item 1-C)	~~11350~~**11650**

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

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

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

Table B-3-b	
Waiver Year	**Maximum Number of Participants Served At Any Point During the Year**
Year 1	**9434**
Year 2	~~94349~~**9496**
Year 3	~~94349~~**9559**
Year 4 (only appears if applicable based on Item 1-C)	~~94349~~**9621**
Year 5 (only appears if applicable based on Item 1-C)	~~94349~~**9683**

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

○	**Not applicable**. **The state does not reserve capacity.**
●	**The state reserves capacity for the following purpose(s).** Purpose(s) the state reserves capacity for:

Table B-3-c

	Purpose (provide a title or short description to use for lookup):
	Arkansas Money Follows the Person (MFP) Program
	Purpose (describe):
	Reserved for individuals transitioning from the nursing facilities to the community via the Arkansas Money Follows the Person (MFP) program. At CMS's recommendation, Arkansas MFP will be intensifying efforts through the end of the program, which is currently scheduled to end September 30, 2024. The reserved slots will ensure that transitioned individuals will have access to more cost-effective services.
	Describe how the amount of reserved capacity was determined:
	The number of MFP participants who have historically transitioned into the waivers which ARChoices in Homecare represents has ranged from 25-36 per year. The 100 slots will allow a substantial buffer to account for the intensified activity level.
Waiver Year	**Capacity Reserved**
Year 1	100
Year 2	100
Year 3	100
Year 4 (only if applicable based on Item 1-C)	100
Year 5 (only if applicable based on Item 1-C)	100

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

●	**The waiver is not subject to a phase-in or a phase-out schedule.**

○	**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an *intra-year* limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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

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

B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. Phase-In/Phase-Out Time Schedule. Complete the following table:

Beginning (base) number of Participants:

Phase-In or Phase-Out Schedule			
Waiver Year:			
Month	**Base Number of Participants**	**Change in Number of Participants**	**Participant Limit**

c. Waiver Years Subject to Phase-In/Phase-Out Schedule *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

d. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

●	§1634 State
○	SSI Criteria State
○	209(b) State

2. Miller Trust State.

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

○	No
●	Yes

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
■	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☐	Optional state supplement recipients		
■	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	○	100% of the Federal poverty level (FPL)	
	●	%	of FPL, which is lower than 100% of FPL Specify percentage: 80%
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
■	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
☐	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
■	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:		
	SSI recipients with disabilities who work and have continued Medicaid under 1619(b)		

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*	
○	**No**. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
●	**Yes**. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.
○	All individuals in the special home and community-based waiver group under 42 CFR §435.217
●	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:
■	A special income level equal to (select one):
●	300% of the SSI Federal Benefit Rate (FBR)
○ %	A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:
○ $	A dollar amount which is lower than 300% Specify percentage:
☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
☐	Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)
☐	Aged and disabled individuals who have income at: *(select one)*
○	100% of FPL
○ %	of FPL, which is lower than 100%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

■	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act. *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

●	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state elects to (*select one*):	
	●	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The state uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

○	The following standard included under the state plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○ %	**A percentage of the FBR, which is less than 300%** Specify the percentage:	
		○ $	**A dollar amount which is less than 300%.** Specify dollar amount:	
	○	%	A percentage of the Federal poverty level Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	Other Specify:			

ii. **Allowance for the spouse only** (*select one*):			
○	**Not Applicable**		
Specify the amount of the allowance (*select one*):			
○	**SSI standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. Allowance for the family *(select one)*:	
○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:
a. Health insurance premiums, deductibles and co-insurance charges   b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.   Select one:

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

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

c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

- ○ The following standard included under the state plan *(select one)*
  - ○ The following standard under 42 CFR §435.121
    Specify:
  - ○ Optional state supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % A percentage of the FBR, which is less than 300%
      Specify percentage:
    - ○ $ A dollar amount which is less than 300% of the FBR
      Specify dollar amount:
  - ○ % A percentage of the Federal poverty level
    Specify percentage:
  - ○ Other standard included under the state Plan (specify):
- ○ The following dollar amount: $ Specify dollar amount: If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance
  Specify:
- ○ Other (specify)

ii. <u>Allowance for the spouse only</u> (*select one*):

- ○ Not Applicable (see instructions)
- ○ The following standard under 42 CFR §435.121
  Specify:
- ○ Optional state supplement standard

○	Medically needy income standard		
○	The following dollar amount: Specify dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula: *Specify:*		

iii. <u>Allowance for the family</u> *(select one)*

○	Not applicable *(see instructions)*		
○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount: Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula: *Specify:*		
○	Other (specify):		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

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

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

Select one:

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

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- ○ The following standard included under the state plan *(Select one):*
  - ○ **SSI standard**
  - ○ **Optional state supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons** *(select one):*
    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ ____ % **A percentage of the FBR, which is less than 300%** Specify the percentage:
    - ○ $ ____ **A dollar amount which is less than 300%.** Specify dollar amount:
  - ○ ____ % **A percentage of the Federal poverty level** Specify percentage:
  - ○ **Other standard included under the state Plan** Specify:
- ○ **The following dollar amount** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:** Specify:
- ● **Other** Specify:

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

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

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

Specify the amount of the allowance (*select one*):	
○	**SSI standard**
○	**Optional state supplement standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ If this amount changes, this item will be revised. Specify dollar amount:
○	**The amount is determined using the following formula:** *Specify:*
iii. Allowance for the family *(select one)*:	
○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
●	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. Select one:	
○	**Not applicable *(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
●	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

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

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

- ○ The following standard included under the state plan *(Select one):*
  - ○ **The following standard under 42 CFR §435.121:** *Specify:*
  - ○ **Optional state supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons** *(select one):*
    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ ____ % **A percentage of the FBR, which is less than 300%** Specify the percentage:
    - ○ $ ____ **A dollar amount which is less than 300%.** Specify dollar amount:
  - ○ ____ % **A percentage of the Federal poverty level** Specify percentage:
  - ○ **Other standard included under the state Plan** Specify:
- ○ **The following dollar amount** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:** Specify:
- ○ **Other** *Specify:*

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

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

	Specify:

Specify the amount of the allowance (*select one*):

○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. Allowance for the family *(select one)*:

○	**Not Applicable *(see instructions)***		
○	**AFDC need standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		
○	**Other** *Specify:*		

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

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

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

Select one:

○	**Not applicable *(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

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

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

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

i. Allowance for the personal needs of the waiver participant

*(select one)***:**

○	**SSI Standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
●	**Other** *Specify*:		
	The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.		

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

Select one:

●	**Allowance is the same**
○	**Allowance is different.** *Explanation of difference:*

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

a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under state law but not covered under the State's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. *Select one:*	
○	**Not applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
●	**The state does not establish reasonable limits.**
○	**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

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

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State – 2014 through 2018. The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the state plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○ %		**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○ $		**A dollar amount which is less than 300%.** Specify dollar amount:
	○	%		**A percentage of the Federal poverty level** Specify percentage:
	○	**Other standard included under the state Plan** Specify:		

○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.

○	**The following formula is used to determine the needs allowance:** Specify:
○	**Other** Specify:

ii. <u>Allowance for the spouse only</u> (*select one*):

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

Specify the amount of the allowance (*select one*):

○	**SSI standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. <u>Allowance for the family</u> *(select one)*:

○	**Not Applicable *(see instructions)***		
○	**AFDC need standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		
○	**Other** *Specify:*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. Select one:	
○	**Not applicable *(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

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

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the state plan *(Select one):*			
	○	**The following standard under 42 CFR §435.121:** *Specify:*		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○	$	**A dollar amount which is less than 300%.** Specify dollar amount:
	○	%	**A percentage of the Federal poverty level** Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		

○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The following formula is used to determine the needs allowance:** Specify:		
○	**Other** *Specify:*		

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

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

Specify the amount of the allowance (*select one*):

○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. Allowance for the family *(select one)*:

○	**Not Applicable *(see instructions)***		
○	**AFDC need standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

○	**Other** *Specify:*

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

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

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

Select one:

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

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

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

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

i. <u>Allowance for the personal needs of the waiver participant</u>

*(select one)***:**

○	**SSI Standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify***:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. Select one:	
○	**Allowance is the same**
○	**Allowance is different.** *Explanation of difference:*
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses. *Select one:*	
○	**Not applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

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

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

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

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

1

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

- ● **The provision of waiver services at least monthly**
- ○ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**
  If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

- ○ **Directly by the Medicaid agency**
- ● **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**
  Specify the entity:
- ○ **Other**
  Specify:

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

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

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

~~Level of Care Definitions:~~ DEFINITIONS:

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

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

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

~~EVALUATION means the process completed, at a minimum, of every twelve (12) months, by the DHS RN to determine continued functional eligibility or a change in medical condition that may impact continued functional eligibility.~~

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

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

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

MEDICAL ELIGIBILITY means the level of care needed to receive services through the waiver rather than in an institutional setting considering the participants functional needs. To be determined to meet medical eligibility, an applicant/participant must not require a skilled level of care.

Level of Care Criteria:

The ~~functional~~ medical eligibility ~~criteria~~ for ARChoices ~~in Homecare waiver eligibility~~ is ~~are~~ established in administrative rule~~s and the ARChoices manual,~~ as promulgated by the Arkansas Department of Human Services (DHS). Please see DHS ~~rule 016.06 CARR 057 (2017) (~~Procedures for Determination of Medical Need for Nursing Home Services as established by the DHS Office of Long Term Care. Beneficiaries who are determined to require a skilled level of care are not eligible for this waiver program. All state laws, regulations, and policies concerning the level of care criteria

and the level of care instrument/tool are available to CMS upon request throu the Medicaid agency on the operating agency, including the instrument/tool utilized.~~)~~.

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

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

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

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

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

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

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

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

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

b. Intravenous injections and hypodermoclysis or intravenous feedings;

c. Levin tubes and nasogastric tubes;

d. Nasopharyngeal and tracheostomy aspiration;

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

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

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

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

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

j. Ventilator care and maintenance; and

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

Level of Care Evaluation for Institutional Care:

The institutional level of care evaluation form 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 a 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 participant's medical history.

The ARIA instrument will be used to collect information to evaluate functional eligibility. Registered nurses from the Independent Assessment Contractor will use the ARIA instrument to conduct face-to-face, in-home assessments and reassessments.

A participant who is otherwise eligible for waiver services shall not 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.

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

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

~~Instrument/Tool Used: The Arkansas Independent Assessment (ARIA) collects information to evaluate level of care. DHS RNs will conduct face-to-face, in-home evaluations and reevaluations. Using the information collected during the assessment, DCO will evaluate whether an individual meets the State's functional eligibility criteria.~~

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

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

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.

DEFINITIONS:

ARKANSAS INDEPENDENT ASSESSMENT (ARIA)) INSTRUMENT means DHS approved the instrument used by registered nurses employed by the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan (PCSP).

INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the approved ARIA instrument for the purpose of collecting information used in determining level of care and developing the PCSP.

INDEPENDENT ASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the ARIA instrument to assess functional need. This assessment of functional need is used by DHS as part of the 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 in conjunction with the participant, at a minimum of every twelve (12) months, to determine continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility. The evaluation may result in a reassessment being requested if there is evidence of a material change in the medical need of the participant.

REASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the ARIA instrument to assess functional need when requested, based on evidence of a material change in medical eligibility documented at the evaluation. 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, is used in the development of the PCSP.

Level of Care Instrument for Institutional Care:

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

Level of Care Instrument for Waiver Program:

The Arkansas Independent Assessment (ARIA) system will be used to collect information to evaluate functional eligibility. Registered nurses from the Independent Assessment Contractor

will use the ARIA instrument to conduct face-to-face, in home assessments and reassessments. Using the information collected during the assessment, the Division of County Operateions will evaluate whether an individual meets the State's level of care criteria~~support the level of care determination process for initial assessments.~~

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

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

The evaluation initiated at a minimum of every twelve (12) months, uses the DHS-703 form to make a determination of continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility. The evaluation may result in a reassessment being requested if there is evidence of a material change in the medical need of the participant.

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

~~The state ensures that ARIA is valid and reliable through multiple stages of testing. The Independent Assessment Contractor conducts its own system testing via automated test scripts as well as business testing to validate outcomes. In addition, the state provides mock assessments for a blinded validation analysis. The mock assessments are designed to test the validity of ARIA-assigned tiers (0, 1, 2, 3) compared to the nursing home level of care criteria for waiver functional eligibility. The mock assessments are uploaded to ARIA and tracked, and the ARIA results are compared to the expected tier levels identified by the state. This testing is single-side blinded so that the Independent Assessment Contractor is not aware of the expected tiers before the tests are run.~~

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.~~

~~Each waiver applicant needing an evaluation and each waiver participant needing a reevaluation will receive an individual assessment performed by the Independent Assessment Contractor. Each assessment is performed by a licensed registered nurse (RN) using the Arkansas Independent Assessment (ARIA) instrument. The ARIA tool will generate a proposed level of care evaluation. The Division of County Operations DHS RNs will review the ARIA results and the ARIA-recommended tier level, and make the final level of care determination. Functional eligibility is valid for twelve (12) months, unless a shorter period is specified by DHS.~~

~~As described in B-6-e, the Independent Assessment Contractor's RNs will complete the ARIA instrument for each initial assessment and subsequent re-assessment, 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 every twelve (12) months, with the functional eligibility reaffirmed or revised and a written determination issued by DCO . 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, said nurse's supervisor, or the DAABHS deputy director (or his/her designee). In cases where a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), an evaluation will be performed by the DHS RN, who may request a reassessment to be completed by the Independent Assessment Contractor, as appropriate. In the manner specified in the DHS Independent Assessment Manual, a participant (or their legal representative) or the participant's physician may request that the DAABHS deputy director (or his/her designee) order a re-assessment.~~

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

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

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

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

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

These indications notwithstanding, the final determination of Level of Care and functional eligibility is made by DHS.

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

DEFINITIONS:

DHS ELIGIBILITY NURSE means a registered nurse authorized by DMS to perform reviews of all medical information available and, based on available information, to make a medical eligibility determination and then, if determined financially eligible, the application will be approved for ARChoices. DHS eligibility nurses are also responsible for reviewing evaluation documentation for material changes to medical need and requesting a reassessment if warranted.

DHS PERSON CENTERED SERVICE PLAN/CARE COORDINATOR (PCSP/CC) NURSE means a registered nurse authorized by DMS to perform evaluations, develop PCSP, and serve as the primary care coordinator and DHS contact for assigned participants.

Each waiver applicant to the ARChoices program will be assessed by the Independent Assessment Contractor. Each assessment is performed by a registered nurse using the ARIA instrument. Medical eligibility is valid for twelve (12) months, unless a shorter period is specified.

Evaluations will continue to be performed by a registered nurse employed by DHS at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. 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, and based on the review of the evaluation, a reassessment utilizing the ARIA instrument may be requested.

The Arkansas Independent Assessment (ARIA) instrument is used by registered nurses employed by the Independent Assessment Contractor to collect information to evaluate functional eligibility for individuals applying for ARChoices. The information collected along with the tier determination, and any additional information collected are utilized by

~~registered nurses within the Division of County Operations to evaluate whether the individual meets the states level of care criteria and to determine the level of care.~~

~~The DHS-703 form (Evaluation of Medical Need Criteria) is used at a minimum of every 12 months, or more frequently based on reported changes in medical condition, by registered nurses employed by the Division of Aging, Adult and Behavioral Health Services to determine continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility.~~

~~If there is evidence of a change in medical condition that may impact continued medical eligibility, based on the evaluation completed using the DHS-703 form, a referral may be made for an independent assessment utilizing the ARIA instrument. The information collected through the reassessment process, utilizing the ARIA instrument along with the tier determination, and any additional information are utilized by registered nurses within the Division of County Operations to evaluate whether the individual continues to meet the states level of care criteria and to determine any changes to the level of care. No change in level of care will occur without the use of the ARIA instrument.~~

~~The ARIA instrument will recommend tiers designed to help further differentiate participants by need. The tiers do not replace the Level of Care criteria referenced in B-6-d, waiver eligibility determinations, or the PCSP process.~~

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

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

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

~~These indications notwithstanding, the final determination of Level of Care and medical eligibility is made by the Division of County Operations (DCO).~~

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

○	**Every three months**
○	**Every six months**
●	**Every twelve months**
○	**Other schedule** *Specify* the other schedule:

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

●	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
○	**The qualifications are different.** *Specify the qualifications:*

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

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

~~Specifically, DAABHS uses an online tracking tool with an integrated dashboard functionality DHS RNs and RN Supervisors use to monitor upcoming review data and service plan expirations. The process of evaluation begins at a minimum of two months prior to the expiration date of the current person-centered service plan or minimum of two months prior to the annual anniversary date of the last functional eligibility determination functional eligibility determination evaluation, whichever is earlier.~~

~~On at least a monthly basis, the DHS RN will identify participants who are due for an evaluation. The DHS RN will add the cases to the evaluation schedule The DHS RN will use the the online tracking tool referenced above to monitor both the need for evaluation, and The DHS RN will carry out the evaluation reassessment. Once the evaluation is completed and a functional determination of the level of care is revised as appropriate, the DHS RN begins development of the new person-centered service plan.~~

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

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

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

DCO has established and maintains procedures for tracking review dates and initiating timely evaluations prior to each participant's respective level of care review date and prior to the expiration of the participant's current PCSP.

Specifically, DCO uses online tracking tools with an integrated dashboard functionality to monitor level of care expirations. The process of evaluation begins at a minimum of two

months prior to the annual anniversary date of the last medical eligibility determination or financial eligibility determination, whichever is earlier.

On at least a monthly basis, participants who are due for an evaluation will be identified. Reports are used to determine if the assessment is current or has expired. Patterns of noncompliance are documented, and disciplinary action is taken if necessary.

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

~~Records of evaluations and reevaluations of level of care are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS), the primary authority for the daily operation of the waiver program, and the Division of County Operations, which is responsible for the level of care evaluations and reevaluations. DAABHS maintains records for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations, or court cases are resolved for a participant, whichever is longer.~~

Records of assessments conducted as part of the initial application process to inform level of care determination, evaluations completed at least every 12 months to determine continued evidence of established medical and functional eligibility or change in condition, and reassessments based on evidence of a material change in medical eligibility documented at the evaluation are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of County Operations (DCO). Records are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations, or court cases are resolved for a participant, whichever is longer.

Quality Improvement: Level of Care

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: **Level of Care Assurance/Sub-assurances**

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

i. Sub-assurances:

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

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 applicants who had a LOC indicating need for nursing facility LOC prior to receipt of services. Numerator: Number of applicants who received level of care prior to service; Denominator: Total number of records reviewed.**~~ Number and percent of all applicants for whom there is a reasonable indication that services may be needed in the future who receive an evaluation for LOC. Numerator: Number of all applicants for whom there is a reasonable indication that services may be needed in the future who receive an evaluation for LOC; D: Number of applicants for whom there may be need in the future that were 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*
[redacted]	■ *Operating Agency*	☐ ■ *Monthly*	■ *Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*	[redacted] × *Representative Sample; Confidence Interval =*
[redacted]	☐ *Other Specify:*	☐ *Annually*	[redacted] *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*	[redacted] ☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	[redacted]

				☐ *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:*

b ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in 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 waiver participants who received an annual redetermination of LOC eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC re-evaluation. Numerator: Number of participants receiving annual redetermination in 12 months; Denominator: Number of records reviewed.***~~ Number and percent of participant annual re-evaluation LOC determinations where the LOC criteria were applied accurately and as required by the approved description. N: Number of participant annual re-evaluation LOC determinations where the LOC criteria were applied accurately and as required by the approved description; D: Number of participant annual re-evaluation LOC determinations 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*	*D~~AA~~AABH~~BH~~S 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:*

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

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 participants LOC determinations made where the LOC criteria were accurately applied. Numerator: Number of participants LOCs with correct criteria; Denominator: Number of participants.**~~ Number and percent of participant LOC determinations reviewed where the LOC processes and instruments were applied accurately and as required by the approved description. N: Number of participant LOC determinations reviewed where the LOC processes and instruments were applied accurately and as required by the approved description; D: Number of participant LOC determinations reviewed
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify: ***Monthly Level of Care 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*
[redacted]	■ *Operating Agency*	■ *Monthly*	☐ ■*Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*	[redacted] ☐ ■ *Representative Sample; Confidence Interval =*DMS uses the Raosoft Calculation System to determine a statistically valid sample with a 95%

				confidence level and a +/- 5% margin of error.
	☐ *Other Specify:*	☐ *Annually*		
		☐ *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 participants annual re-evaluation LOC determination forms that were completed as required by the state. Numerator: Number of participants with LOC with forms completed correctly; Denominator: Number of records reviewed**~~
Data Source *(Select one) (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:*	☐ *Annualy*		~~*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 participants who received an annual redetermination of LOC eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC re-evaluation. Numerator: Number of participants receiving annual redetermination in 12 months; Denominator: Number of records reviewed.***~~ Number and percent of participant annual re-evaluation LOC determinations where the LOC criteria were applied accurately and as required by the approved description. N: Number of participant annual re-evaluation LOC determinations where the LOC criteria were applied

	accurately and as required by the approved description; D: Number of participant annual re-evaluation LOC determinations 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 participants LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed.**~~ Number and percent of participant level of care determinations reviewed that were made by a qualified evaluator. Numerator: Number of participant level of care determinations made by a qualified evaluator; Denominator: Number of participants level of care determinations 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	***Frequency of data aggregation and analysis:***

(check each that applies	*(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.*

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 evaluations and reevaluations performed by the DHS RN. 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 County Operations 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.~~

~~An evaluation of the functional eligibility 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 reevaluated at least once every twelve (12) months. The same record review process, described above, is utilized for the reevaluation process.~~

~~The functional eligibility determination process and instruments described in the waiver are applied appropriately and according to the approved description to determine participant functional eligibility. Record reviews include a review of evaluation and reevaluation 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 AR 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 AR Choices Medicaid providers. The DMS QA review process reviews 20% of the records reviewed by DAABHS. In addition to the record review process, an office review is completed by the DHS RN supervisor, at a minimum, annually for each DHS RN. Office reviews include, but are not limited to: Documentation maintained appropriately; Processing system clearly defined and office organized; Forms completed properly; and Required follow-up for any problems or concerns documented.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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 County Operations (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, 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 evaluations and reevaluations are completed by a registered nurse.

A functional eligibility determination of level of care is required annually. DHS RNs complete the annual evaluation using the approved assessment instrument and applies the functional eligibility criteria. The DHS RN Supervisors complete a regional monthly activity report, which lists the number of evaluations and reevaluations conducted. Remediation efforts are included on the DHS RN Supervisors' monthly report. For ARIA, tThe DHS Independent Assessment Contractor will submit data reports to DMS at least monthly listing the number of assessments conducted. DMS will require the DHS Independent Assessment Contractor to develop a corrective action plan when remediation in this area is needed, and document completion of the corrective action plan.

The DHS RN supervisors complete a review to evaluate trends and identify where additional training is needed for the RNs and the Division of County Operations staff performing level of care determinations. Remediation in these areas includes ongoing training by DAABHS for the Independent Assessment Contractor's RNs who perform these assessments conducted correctly, consistent with the assessment instrument and level of care criteria, and that initial and annual re-evaluation of level of care are completed within the required timeframes. DHS RN supervisors develop a corrective plan when remediation in this area is needed.

To oversee and monitor the functions performed by DAABHS, DCO and DPSQA in the administration and operation of the waiver, DMS conducts monthly team meetings 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.

A functional eligibility determination of level of care is required annually. applying the functional eligibility criteria, with referral for the use of the ARIA instrument in the event of a change of condition that may affect functional eligibility. When referred, the Independent Assessment Contractor conducts a reassessment using ARIA instrument and applies the functional eligibility criteria. The DHS Independent Assessment Contractor will submit data reports to DMS at least monthly listing the number of assessments and reassessments conducted. DMS will require the DHS Independent Assessment Contractor to develop a corrective action plan when remediation in this area is needed, and document completion of the corrective action plan

ii Remediation Data Aggregation

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

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:*

c. Timelines

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

●	**No**
○	**Yes**

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

Appendix B-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 ~~-~~development of the person-centered service plan (PCSP) for~~f~~the waiver participant, the DHS ~~RN~~ PCSP/CC Nurse explains the services available through the ARChoices waiver, discusses the qualified ARChoices providers in the state, and develops an ~~appropriate person-centered service plan~~ PCSP. As part of the ~~service plan~~ PCSP 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~~ PCSP, which includes the signature of the waiver participant (or representative) and the DHS ~~RN~~ PCSP/CC Nurse, and is included in the participant's electronic record.

~~NOTE:~~ For changes to the ~~person centered service plan~~ PCSP, 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 PCSP ~~service plan~~, as entered by the participant or representative, documents that the participant (or representative) has made an informed decision to receive ~~HCBS~~ ARChoices waiver services rather than services in an institutional setting and that ~~HCBS~~ ARChoices services are based on the participant's assessment of needs. Freedom of Choice documentation is tracked through the record review process, all staff performance evaluations and monthly reporting.

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

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

~~Copies of the waiver participant's service plan are maintained with the DAABHS (operating agency) and with the providers chosen by the participant and included on the service plan. Freedom of Choice forms and person-centered service plans are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.~~

Freedom of Choice forms and PCSPs are maintained by DHS for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

Appendix B-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 ~~RN~~ Nurses provide written materials to participants and will read ~~any~~ information to participants if needed. DHS PCSP/CC Nurses~~RN~~s may utilize assistance from other divisions within the ~~Arkansas Department of Human Services (DHS).~~ DHS. 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-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	■	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	■	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
●	Not applicable
○	As provided in 42 CFR §440.180(b)(9), the state requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Adult Day Services
b.	Attendant Care Services

c.	Environmental Accessibility Adaptations/Adaptive Equipment
d.	Home-Delivered Meals
e.	Personal Emergency Response System (PERS)
f.	Prevocational Services
g.	
h.	
i.	

Extended State Plan Services *(select one)*

●	Not applicable
○	The following extended state plan services are provided *(list each extended state plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(check each that applies))*

☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
☐	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
●	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

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).

Adult Day Health
Service Specification

HCBS Taxonomy	
Category 1:	Sub-Category 1:
04 Day Services	04050 Adult Day Health
Category 2:	Sub-Category 2:
11 Other Health and Therapeutic Services	11010 Health Monitoring
Category 3:	Sub-Category 3:
11 Other Health and Therapeutic Services	11120 Cognitive Rehabilitative Therapy
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

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

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

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

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

1. To enable the participant to function physically, mentally and socially at the highest possible level.

2. To enable functionally impaired participants to remain in a supportive home environment instead of entering a nursing home.

3. To improve the health, well-being and quality of life for the participants by providing a rehabilitation program among their peers.

4. To provide support for family and other caregivers to enable them to maintain the impaired participant in the community.

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

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

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

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

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

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

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

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

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian	

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Licensed Adult Day Health Care

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Adult Day Health Care	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.	Providers must be enrolled in the Arkansas Medicaid program as an Licensed Adult Day Health Care provider before reimbursement may be made for services provided to ARChoices participant	

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

Respite Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
09 Caregiver Support	09012 Respite, in-home
Category 2:	Sub-Category 2:
09 Caregiver Support	09011 Respite, out-of-home
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

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

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

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

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

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

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

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

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

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

Respite Care is available in the following locations:

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

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

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

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

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

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

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

Reimbursement is not permitted for Respite Care services provided by a waiver beneficiary's:

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

Respite care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. In accordance with 42 CFR 441.301(b)(1)(ii), ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

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

Respite Care is subject to the following limitations:

1. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with and shall be limited to amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the ~~beneficiary~~ participant in the completed form of the Arkansas Medicaid Task and Hour Standards ("THS"). Any amounts, frequencies, or

durations in excess of the unpaid caregiver assistance amounts identified for the ~~beneficiary~~ participant in the THS are not covered.

2. Respite Care excludes:

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

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

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

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

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

f. Services provided for any task not included in a ~~beneficiary's service plans~~ a participant's PCSP.

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

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

5. Respite care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. In accordance with 42 CFR 441.301(b)(1)(ii), ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Licensed Adult Day Health Care; Licensed Level II Assisted Living

		Facility; Licensed Medicaid Certified Nursing Facility; Licensed Acute Care Hospital; Licensed Class A or Class B Home Health Agency or ~~;~~ Licensed Private Care Agency; Licensed Adult Day Care Agency; Licensed Residential Care Facility

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Adult Day Health Care Agency	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq. Act 1230 of 2001.		

Verification of Provider Qualifications

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

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 as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001.		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Level II Assisted Living Facility	Arkansas Department of Human Services, Division of Medical Service	Annually ~~for recertification; however, DPSQA must maintain a copy of the agency's current Level II Assisted Living Facility license at all times.~~

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Medicaid Certified Nursing Facility	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Medicaid Certified Nursing Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001		

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

der Qualifications

ler	License *(specify)*	Certificate *(specify)*	C Sta *(sp*
sed tal	Licensed Acute Care Hospital	Providers must be enrolled in the Arkansas Medicaid program as an Licensed Acute Care Hospital provider before reimbursement may be made for services provided to ARChoices participant	

cation of Provider Qualifications

der e:	Entity Responsible for Verification:	Frequency of Verification
sed tal	Arkansas Department of Human Services, Division of	Annually ~~for recertification; however, DPSQA must maintain a copy of the agency's current Licensed Acute Care Hos license at all times.~~

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency	Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency as required by Ark. Code Ann. 20-10-807, History: Acts 1987, No. 956, 4; or licensed as a Private Care Agency.		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency	Arkansas Department of Human Services, Division of Medical Services	Annually for recertification; however, DPSQA must maintain a copy of the agency's current license at all times.	

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Adult Day Care Agency	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et. seq.		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Licensed Adult Day Care Agency	Arkansas Department of Human Services, Division of Medical Services	Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Care license at all times.	

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

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

Adult Day Services
Service Specification

HCBS Taxonomy	
Category 1:	Sub-Category 1:
04 Day Services	04060 Adult Day Services (social model)
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

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

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

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

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

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

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

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Care	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et. seq.		

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

Attendant Care Services

Service Specification

HCBS Taxonomy	
Category 1:	Sub-Category 1:
08 Home Based Services	08030 Personal Care
Category 2:	Sub-Category 2:
08 Home Based Services	08040 Companion
Category 3:	Sub-Category 3:
08 Home Based Services	080050 Homemaker
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

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

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

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

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

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

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

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

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

1. Activities of Daily Living (ADLs):

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

b. Toileting;

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

d. Dressing;

e. Bathing or showering; and/or

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

2. Instrumental Activities of Daily Living (IADLs):

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

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

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

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

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

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

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

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

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

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

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

b. Any such health-related tasks performed:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attendant care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. In accordance with 42 CFR 441.301(b)(1)(ii), ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

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

1. The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the beneficiary in accordance with the Arkansas Medicaid Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, or month. Any aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the beneficiary in accordance with the THS are not covered.

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

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

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

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

d. When attendant care services delivered through a home health agency or private care agency are provided by the waiver beneficiary's (i) spouse; (ii) legal guardian of the person; or (iii) attorney-in-fact granted authority to direct the beneficiary's care;

e. On dates of service when the participant:

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

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

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

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

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

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

g. For a task that was not actually performed.

Attendant care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. In accordance with 42 CFR 441.301(b)(1)(ii), ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider; Licensed Home Health Agency

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Private Care Agency Enrolled as an	Licensed by the Arkansas Department of		The attendants hired by the agency must meet the following minimum qualifications:

Arkansas Medicaid Personal Care Provider	Health as a private care agency enrolled as an Arkansas Medicaid Personal Care Provider, as cited in Act 2273 of 2005.		* Be 18 years of age or older; * Be a United States citizen or legal alien authorized to work in the U. S.; * Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime; * Be free from communicable diseases; * Be free from diseases readily transmittable through casual contact; * Be able to read and write at a level sufficient to follow written instructions and maintain records; * Be in adequate physical health to perform job tasks required; and * Have a current signed formal agreement with an eligible * Enrolled in Arkansas Medicaid and obtain a Personal Identification Number (PIN); * Be an ARChoices participant for the provision of agency attendant care services. Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant. Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance

			with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider	Arkansas Department of Human Services, Division of Medical Services	Annually ~~for recertification; however, DPSQA must maintain a copy of the provider's current Personal Care Agency license in the provider file at all times.~~

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Home Health Agency	Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency, as cited in Arkansas Code Annotated section 20-10-809..	Providers must also be enrolled in the Arkansas Medicaid program as an Licensed Home Health Agency provider before reimbursement may be made for services provided to ARChoices participant	The attendants hired by the agency must meet the following minimum qualifications: * Be 18 years of age or older; * Be a United States citizen or legal alien authorized to work in the U. S.; * Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime; * Be free from communicable diseases; * Be free from diseases readily transmittable through casual contact;

			* Be able to read and write at a level sufficient to follow written instructions and maintain records; * Be in adequate physical health to perform job tasks required; and * Have a current signed formal agreement with an eligible *Enrolled in Arkansas Medicaid and obtain a Personal Identification Number (PIN); * Be an ARChoices participant for the provision of agency attendant care services. Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant. Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Licensed Home Health Agency	Arkansas Department of Human Services, Division of Medical Services	Annually ~~for recertification; however, DPSQA must maintain a copy of the provider's current Home Health Agency license in the provider file at all times.~~	

Environmental Accessibility Adaptations/Adaptive Equipment

Service Specification

HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology & Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

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

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

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment provided by a waiver participant~~beneficiary~~'s:
1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the participant~~beneficiary~~'s care.

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

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

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Installer (Builder, Tradesman or Contractor)

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Installer (Builder, Tradesman or Contractor)	If the particular trade has a license available, the installer must be licensed as appropriate for the environmental accessibility adaptation/adaptive equipment provided. Proof of a plumber or electrician's license must be provided prior to performing this type of work.	Providers must also be enrolled in the Arkansas Medicaid program as an ARChoices environmental accessibility adaptations/adaptive equipment provider before reimbursement may be made for services provided to ARChoices participants.	Environmental Accessibility Adaptations/Adaptive Equipment providers must: • Certify that his or her work meets state and local building codes • Be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Installer (Builder, Tradesman or Contractor)	Arkansas Department of Human Services, Division of Medical Services	Annually.

Home-Delivered Meals

Service Specification

HCBS Taxonomy	
Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 Home Delivered Meals
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

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

The goals of home-delivered meals are:

1. To facilitate participant independence by allowing them the choice to remain in their own homes rather than entering a nursing facility.

2. To provide one (1) daily nutritious meal to participants at risk of being institutionalized;

3. To provide a daily social contact to homebound participants to insure the participant's safety and well- being.

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

1. Be homebound which is defined as:

a) A participant with normal inability to leave home without assistance (physical or mental) from another person;
b) The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
c) Leaving home requires considerable and taxing effort by the participant, and
d) Absences of the participant from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment; and

2. Be unable to prepare some or all of his/her own meals, or require a special diet and is unable to prepare it; and

3. Have no other person available to prepare his/her meals, and the provision of a home-delivered meal is the most cost-effective method of ensuring a nutritionally adequate meal; and

4. Have the provision of meals included in the participant's PCSP~~person-centered service plan~~.

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

One unit of service equals one meal. The maximum number of home-delivered meals eligible for reimbursement is one (1) per calendar day. ~~The maximum number of home-delivered meals eligible for reimbursement per month is 31 meals.~~

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

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
~~**Installer (Builder, Tradesman or Contractor)**~~ **Provider of Food Services**		Food Establishment Permit issued by the Department of Health. Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA), as an ARChoices waiver provider of Home Delivered Meals. To be certified, ~~P~~providers must provide a copy of their current food establishment permit issued by the Department of Health.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
~~**Installer (Builder, Tradesman or Contractor)**~~ **Provider of Food Services**	Arkansas Department of Human Services, Division of Medical Services	Annually ~~for recertification; however, DPSQA must maintain a copy of the agency's current Food Establishment Permit at all times.~~

Personal Emergency Response System (PERS)

Service Specification

HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology & Modifications	14010 Personal Emergency Response System (PERS)
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Personal emergency response system (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. The system includes an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. PERS enables an elderly, infirm or homebound participant to secure immediate help in the event of physical, emotional or environmental emergency.

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

The goals of the personal emergency response system are:

1. To provide a high-risk participant with the security and assurance of immediate assistance in an emergency, making it possible for them to remain in their home.

2. To eliminate the need for costly in-home supervision provided by a paid attendant that also affords the participant the emotional satisfaction or independent living.

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

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

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

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian	

Provider Specifications			
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■ Agency. List the types of agencies:
			Alarm or Security Company

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Alarm or Security Company		Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards Providers must provide a copy of their current certificate of compliance for protective signaling services issued by the Underwriters Laboratories Safety Standards. Providers must also be enrolled in the Arkansas Medicaid program as an ARChoices home personal emergency response services provider before reimbursement may be made for services provided to ARChoices participants.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Installer (Builder, Tradesman or Contractor)	Arkansas Department of Human Services, Division of Medical Services	Annually

Prevocational Services
Service Specification

HCBS Taxonomy	
Category 1:	Sub-Category 1:

04 Day Services	04010 prevocational services
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

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

Prevocational services are as follows:

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

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

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

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

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

Reimbursement is not permitted for Respite Care services provided by a waiver beneficiary's:
1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the beneficiary's care.

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

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

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

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

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

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Certified Prevocational Services Vendor

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Prevocational Services Vendor		Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Prevocational Services. Providers must also be enrolled in the Arkansas Medicaid program as Prevocational	

		Services provider before reimbursement may be made for services provided to ARChoices participant	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
~~**Installer (Builder, Tradesman or Contractor)**~~ **Certified Prevocational Services Vendor**	Arkansas Department of Human Services, Division of Medical Services	Annually

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

○	**Not applicable** – Case management is not furnished as a distinct activity to waiver participants.	
●	**Applicable** – Case management is furnished as a distinct activity to waiver participants. Check each that applies:	
	☐	As a waiver service defined in Appendix C-3 *Do not complete item C-1-c.*
	☐	As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
	■	As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
	☐	As an administrative activity. *Complete item C-1-c.*
	☐	As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

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

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

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):
	All ARChoices waiver providers employing persons providing direct services (personal assistants, attendants) shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere to any disqualifying criminal offense. Each ARChoices waiver provider must obtain from each employee and from each applicant for employment a signed authorization permitting disclosures to the ARChoices provider of criminal history information as defined in Ark. Code Ann., Section 12-12-1001. Each provider receiving payment under the ARChoices program must, as a condition of continued participation in the program, comply with the requirement for criminal history checks for new employees, and periodic criminal history checks for agency operators and all employees at least once every five years. The scope of the criminal background checks is national. This requirement applies to any employee who in the course of employment may have direct contact with an ARChoices participant. At the time of initial certification and re-certification, providers must submit a list of all direct care services staff and the dates of their last criminal background check. If the results of the criminal history check establish that the applicant was found guilty of, or pled nolo contendere (no contest) to a disqualifying offense under Ark. Code Ann., Section 20-33-205 ("disqualifying offense"), then the ARChoices waiver provider may not employ, or continue to employ, the applicant. Disqualifying offenses do not include misdemeanors that did not involve exploitation of an adult, abuse of a person, neglect of a person, theft, or sexual contact. According to Arkansas Department of Human Services Policy 1088, DHS shall automatically exclude any provider (or, an employee or subcontractor of that provider) that has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or nolo contendere (no contest), to any crime related to: 1. Obtaining, attempting to obtain, or performing a public or private contract or subcontract, 2. Embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, 3. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony, 4. Federal antitrust statutes, 5. The submission of bids or proposals, or 6. Any physical or sexual abuse or neglect when the offense is a felony.

	In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's ~~claims processing contractor.~~ provider enrollment vendor. All attendant care and respite care direct service providers must enroll with Arkansas Medicaid.
○	**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):
	~~Abuse registry screenings of the direct care of services staff of ARChoices agency providers are monitored at initial certification and re-certification. This is a required part of the certification and re-certification process. In addition, agency providers must submit a list of all direct care of services staff and the dates of their last criminal background checks. Criminal background checks are required for agency providers every five years pursuant to Act 762 of 2009. Providers are required to follow all requirements related to employee criminal background checks discussed in the Medicaid Provider Manual.~~ ~~The Adult Protective Services unit of the Division of Aging, Adult, and Behavioral Health Services is responsible for maintaining the abuse registry.~~ ~~As part of the qualified provider review, verifies that the provider file contains all required documentation, including information regarding the criminal background checks.~~ The Division of Provider Services and Quality Assurance (DPSQA), requires that ARChoices providers conduct adult abuse registry checks on employees prior to providing services. The provider must provide documentation that employees have not been convicted or do not have a substantiated report of abuse. The provider shall, at a minimum, prior to employing any individual or for any individuals working through contract with a third party, make inquiry to the Employment Clearance Registry of 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 years. DHS requires that each provider 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 provider; is employed by the provider to provide care to participants; or is a temporary employee placed by an employment agency with the provider to provide care to participants. The DPSQA Licensing and Surveying Unit ensures that mandatory screenings have been conducted.

	Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule.
○	**No**. The state does not conduct abuse registry screening.

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

●	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following *(check each that applies)*:

Standard	Topic Addressed
Admission policies	☐
Physical environment	☐
Sanitation	☐
Safety	☐
Staff : resident ratios	☐
Staff training and qualifications	☐
Staff supervision	☐
Resident rights	☐
Medication administration	☐

Use of restrictive interventions	☐
Incident reporting	☐
Provision of or arrangement for necessary health services	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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

●	**No**. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

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

○	**The state does not make payment to relatives/legal guardians for furnishing waiver services.**
●	**The state makes payment to relatives/legal guardians under *specific circumstances* and only when the relative/guardian is qualified to furnish services**. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in*

	Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.
	All ARChoices services may be reimbursed if provided by a relative of the participant, subject to the limitations specified below. Individuals who are legally responsible for the participant (i.e., spouse, legal guardian, or attorney-in-fact granted authority to direct the participant's care) are prohibited from receiving any reimbursement for any ARChoices services provided for the participant. All providers, including relatives, are required to meet all applicable ARChoices provider certification requirements and Arkansas Medicaid enrollment requirements, comply with all applicable ARChoices provider manual requirements, and provide services according to the participant's approved service plan and any established benefit limits for that specific service, as identified in Appendix C-1/C-3. Controls are maintained through the required documentation for all service providers. This documentation must support each service for which billing is made and include a copy of the participant's person-centered service plan, a brief description of the specific services provided, the signature and title of the individual providing the service, and the date and actual time services were provided. DHS RN supervisory staff conducts chart reviews to ensure that services were provided according to the service plan. DPSQA performs audits and quality reviews of providers
○	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.
○	Other policy. *Specify*:

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

ARChoices provider enrollment is open and continuous. Those interested in becoming an ARChoices provider can contact the Division of ~~Provider Services and Quality Assurance (DPSQA)~~ Medical Services (DMS) Provider Enrollment Unit for information and to obtain certification materials. There are no restrictions applicable to requesting this information. ~~The provider certification process is open and available to any interested party.~~

~~The DPSQA website lists information for potential ARChoices providers.~~

The Arkansas Medicaid website provides enrollment information for potential ARChoices providers.

Information related to licensure and certification may be found on the Division of Provider Services and Quality Assurance Website.

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 obtain re-certification in accordance with state law and waiver provider qualifications. Numerator: Number of providers with re-certification; Denominator: Total number of providers*~~ *Number and percent of licensed/certified providers, by provider type, whose license/certification renewals are in accordance with state law and waiver provider qualifications. N: Number of licensed/certified providers, by provider type, whose license/certification renewals are in accordance with state law and waiver provider qualifications; D: Total number of license/certification renewals.*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Provider Certification Unit (DPSQA) Provider Database	

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

	(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: DPSQA*	☐ ■ *Annually*	
		■ *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 percentage of providers, by provider type, which obtained the appropriate license/certification in accordance with state law and waiver provider qualifications prior to delivering services. Numerator: number of providers with appropriate license/certification prior to delivery of services; Denominator: Number of new providers*~~ **Number and percent of new licensed/certified providers who obtained license/certification in accordance with state law and waiver provider qualifications prior to delivering services N: Number of new licensed/certified providers who obtained license/certification in accordance with state law and waiver provider qualifications prior to delivering services D: Number of licensed/certified providers.**
Data Source *(Select one) (Several options are listed in the on-line application): Other*	

If 'Other' is selected, specify:			
Provider Certification Unit (DPSQA) Provider Database			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ ■ *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 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:*

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 providers certified by the Division of Provider Services and Quality Assurance (DPSQA). Numerator: Number of current providers certified by DPSQA; Denominator: Number of providers participating in the waiver program.***~~ **Number and percent of non-licensed/non-certified providers which adhere to waiver requirements. Numerator: Number of non-licensed/non-certified providers which adhere to waiver requirements; Denominator: Total number of non-licensed/non-certified providers.**
Data Source *(Select one) (Several options are listed in the on-line application):* ***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:*

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*
☐	☐ *Weekly*

■ *State Medicaid Agency*	
■ *Operating Agency*	■ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other* *Specify:*	☐ ■ *Annually*
	☐ *Continuously and Ongoing*
	☐ *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 agency providers meeting waiver provider training requirement as evidenced by in-service attendance documentation. Numerator: Number of agency providers indicating training by in-service documentation; Denominator: Total number of agency providers***~~ **Number and percent of providers meeting waiver provider training requirement conducted in accordance with state requirement and approved waiver as evidenced by attendance documents. Numerator: Number of providers meeting waiver provider training requirement conducted in accordance with state requirement and approved waiver as evidenced by attendance documents. Denominator: Number of providers.**
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify:	
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:*

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 DPSQA 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.*

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~~ and continuing communication with the Medicaid fiscal agent responsible for provider enrollment functions, and reviewing monthly reports that identify providers whose participation is terminated for inactivity or violations. Participation in provider training is documented and monitored through monthly activity reports.

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

Each month the DHS RN receives a provider list for each county included in their geographical area. This provider list may be used during the development of the person centered service plan to give the

participant a choice of providers for each service included on the service plan. In addition, this list is used to identify the providers who are new or who have been reinstated in the program.

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

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

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

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

~~The 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 AR 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 AR 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.~~

The Medicaid fiscal agent provides DPSQA access to Provider License/Certification Status. If needed, this provides a second monitoring tool for monitoring licensure and certification compliance. The mandatory Medicaid contract, signed by each waiver provider, states compliance with required enrollment criteria. Failure to maintain required certification and/or licensure results in loss of their Medicaid provider enrollment. Each provider is notified in writing at least two months prior to the certification/licensure expiration date that renewal is due and failure to maintain proper certification will result in loss of Medicaid enrollment.

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

~~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 requirements. In cases where providers do not maintain requirements remediation may include 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.~~

DAABHS, DPSQA, and DMS, under the Department of Humans Services (DHS) participate in monthly team meetings to discuss and address individual problems related to qualified providers, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver. In cases where providers do not maintain requirements for provider participation, remediation by DMS may include 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. Providers are notified in writing and documentation is maintained by DMS. The PSCP/CC Nurse would assist the participant in choosing a new provider from the Freedom of Choice List and update the PCSP to indicate chosen 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)*
[redacted]	☐ ■ *State Medicaid Agency*	☐ *Weekly*
	■ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		■ *Continuously and Ongoing*
		☐ *Other: Specify:*

c. *Timelines*

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

●	**No**
○	**Yes** Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies)*.

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

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

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
×	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
	~~Prospective Individual Budget Amount:~~ ~~There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.~~ ~~1. Individual Services Budget (ISB):~~ ~~a. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.~~ ~~b. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by DAABHS for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan~~

~~(including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.~~

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

~~d. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the automatic appeal process if they are denied waiver services as a result of a dollar limit.~~

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

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

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

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

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

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

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

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

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

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

~~d. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. The nurse panel will review and act on the exception request within ten (10) working days from the date that the exception request is received by DAABHS. The exceptions process, including request procedures, documentation, and process for determining exceptions, shall be specified in the ARChoices manual, as promulgated by DHS. This exceptions process is intended as a safeguard to address exceptional circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:~~

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

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

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

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

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

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

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

~~3. Transition Process:~~

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

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

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

~~(a) Waiver eligibility is re-evaluated;~~

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

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

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

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

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

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

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

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

~~4. Methodology for Determining Individual Services Budgets:~~

~~a. The Individual Services Budget amount for a participant is based on that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The DHS RN will use the results of the ARIA Independent Assessment to determine ISB amounts and assign individuals to grouped levels. The three ISB Levels are:~~

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

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

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

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

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

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

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

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

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

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

~~iii. For purposes of this subsection (c), "total waiver expenditures" for a calendar year shall be calculated as the sum total of the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:~~

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

~~(b) Excluding amounts expended for environmental modifications/adaptive equipment.~~

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

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

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

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

~~f. Determination of ISB Amounts:~~

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

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

DEFINITIONS:

PANEL means a team of three medical professionals, comprising DAABHS nurse supervisory staff and a DHS Eligibility Nurse responsible for the determination of eligibility and LOC. Upon referral, the panel completes a review to determine a change in medical condition that may impact continued medical eligibility. The review may result in a temporary increase in the Service Budget Limit (SBL) for a period of 60 days and a reassessment utilizing the ARIA instrument if the panel determines that there is evidence of a material change in the functional or medical need of the participant which may require an increase in the SBL. Final determination of change in SBL is made by the DCO Eligibility Nurse.

Upon referral, the panel completes a review to determine an exception to the $34,000 maximum SBL due to additional medical or behavioral needs, without which the individual is likely to be institutionalized. The review may result in a temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis for 60 calendar days. During the 60-calendar day temporary increase time period, a reassessment must be completed utilizing the ARIA Instrument and a final determination must be made by the panel, based on all information available, whether to grant the exception.

TEMPORARY LEVEL OF CARE criteria means a temporary increase in SBL approved by the panel. The PCSP, ISB, and SBL shall be adjusted to provide additional services on a temporary basis within and up to the participant's new SBL. The temporary PCSP, ISB, and SBL will remain in effect for up to 60 calendar days. Before the end of this 60 calendar days period, a reassessment must be completed using the ARIA instrument and a new SBL determination must be made."

SERVICE BUDGET LIMIT (SBL) means the limit on the maximum dollar amount of waiver services that may be authorized for and received by each specific participant.

Methodology for Determining the SBL:

A. An Independent Assessment Contractor will perform independent assessments that gather functional information about each applicant using the Arkansas Independent Assessment (ARIA)instrument. This assessment is used as part of the process to make a final determination of eligibility and, if the applicant is determined to be eligible, to be used to determine the SBL.

B. For participants, an evaluation is initiated at least every twelve (12) months. Based on the review of the evaluation, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment utilizing the ARIA instrument. This information is used as part of the process to make a final determination of continued eligibility and, if the participant is determined to be eligible, to be used to determine the SBL.

C. The three SBLs are:

1. Intensive: The participant requires total dependence or extensive assistance from another person in all three (3) areas of mobility, feeding and toileting. The maximum SBL for services is $34,000 annually.
2. Intermediate: The participant requires total dependence or extensive assistance from another person in two (2) of the areas of mobility, feeding and toileting. The maximum SBL for services is $23,000 annually.
3. Preventative: The participant meets the functional need eligibility requirements for ARChoices but does not meet the criteria for the ISB Levels of Intensive or Intermediate. The maximum SBL for services is $6,000 annually.

If the projected cost of services identified in the PCSP is less than the applicable SBL amount, this shall not be construed to permit, suggest, or justify approval, coverage, or reimbursement of different or additional waiver services (including changes in amount, frequency, or duration); coverage and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or other actions to increase spending to use the remaining "unused" portion of the SBL amount.

DHS will monitor and take steps necessary to update these SBL amounts when waiver rates change.

3. Individual Service Budget Limit (ISB):

D. Each PCSP shall include an Individual Service Budget (ISB) based upon the determination of Service Budget Limit (SBL) described above. The projected total cost of all authorized services in any PCSP shall not exceed the participant's SBL applicable to the time period covered by the PCSP.

E. For purposes of determining the projected cost of all waiver services in a PCSP, DAABHS shall assume that:
a. The participant will receive or otherwise use all services identified in the PCSP and in their respective maximum authorized amounts, frequencies, and durations; and

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

F. Each participant's ISB and PCSP shall be discussed with the participant.

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

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

I. Adjustments and Considerations Regarding Individual Services Budgets:

1. Process for a Change of Condition within the SBL Level with an increase in ISB: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, steps shall be taken to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition. A face-to-face visit and the task and hours guide shall be completed. If it is determined that the participant may require additional services within the current SBL, the results shall be reviewed with the program supervisor and the supervisor may approve the adjustment of the participant's PCSP and ISB to provide additional services up to the participant's current SBL. If the supervisor approves the additional services, the PCSP and ISB will remain in effect until the participant's next evaluation and determination of eligibility.

2. Process for a Change of Condition with an Increase of SBL Level: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, steps shall be taken to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition. An evaluation and task and hours guide is completed. If it is determined that the participant may be in need of additional services that may require an increase in the participant's SBL, the participant's case will be submitted to the panel for review and approval of temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis within and up to the participant's new SBL. The temporary PCSP, ISB, and SBL will remain in effect no longer than 60 calendar days. Before the end of this 60 calendar days period, a reassessment must be completed using the ARIA instrument and a new SBL determination must be made.

3. Process for a Change in Condition with a Decrease in SBL, ISB or Change in Eligibility: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, and which may result in a decrease in the participant's SBL, ISB, or change in eligibility. An evaluation is initiated and provided 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 utilizing the ARIA Instrument. This information is used as part of the process to make a final determination of continued eligibility and, if the participant is determined to be eligible, to be used to determine the

4. Process for Granting an Exception to the $34,000 Maximum SBL: If a waiver participant , physician, family member, Targeted Case manager, or PCSP/CC Nurse requests an exception to the $34,000 maximum SBL due to additional medical or behavioral needs, without which the individual is likely to be institutionalized, steps will be taken to determine if the exception is to be granted. A participant will be granted an exception to the $34,000.00 maximum Service Budget Limit (SBL) if the participant, due to additional medical or behavioral needs, is likely to be institutionalized but for additional waiver services and the cost of the needed additional waiver services exceeds the $34,000 maximum SBL.

a. The DHS PCSP/CC Nurse will exercise professional medical judgment to make an initial determination of whether the participant may qualify for an exception to the maximum SBL based on:

i. The participant's evaluation utilizing the DHS-703 Form;
ii. Other medical records or information pertinent to the participant's needs and documented in the participant's record;
iii. The participant's physical, mental, or environmental needs observed by the DHS PCSP/CC Nurse and documented in the DHS-703 Form; and
iv. The participant's preferences, risks, dangers, and supports as documented in the DHS-703 Form.

b. If the DHS PCSP/CC Nurse makes an initial determination that the beneficiary may qualify for an exception, the DHS PCSP/CC Nurse will calculate the SBL as the sum of the SBL maximum above, plus the cost of the additional waiver services needed to prevent institutionalization. The participant's case will be submitted to the panel for review and approval of temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis for 60 calendar days. During the 60-calendar day temporary increase time period, a reassessment must be completed utilizing the ARIA Instrument and a final determination must be made by the panel based on all information available whether to grant the exception.

c. The panel shall ensure that:
i. Any temporary increase granted under this section meets the above criteria; and
ii Both temporary increase and exception amounts are determined in an equitable manner across the program, so that participants with comparable needs receive comparable exception amounts

d. In no case may an exception increase the SBL above the cost of institutionalization as set form in Column 5 of Appendix J-1 Factor G.

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

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.

~~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.~~

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

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person Centered Service Plan

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

■	**Registered nurse, licensed to practice in the state**
☐	**Licensed practical or vocational nurse, acting within the scope of practice under state law**
☐	**Licensed physician (M.D. or D.O)**
☐	**Case Manager** (qualifications specified in Appendix C-1/C-3)
☐	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:
☐	**Social Worker** *Specify qualifications:*
☐	**Other** *Specify the individuals and their qualifications:*

b. Service Plan Development Safeguards.

Select one:

●	**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
○	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

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~~(PCSP) development ~~visit~~meeting, the DHS ~~RN~~ PCSP/CC 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~~PCSP development process. Involved in this ~~assessment visit~~PCSP development meeting 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~~ PCSP process ~~or service plan development process~~. It is the participant or family member's responsibility to notify interested parties to attend the ~~service plan~~PCSP development meeting.

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

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

~~The development of the person-centered service plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor within 10 working days of the Independent Assessment~~

~~Contractor receiving a referral from DHS. Evaluations, which will be conducted by the DHS RN will be completed at least every twelve (12) months or more often, if deemed appropriate bby the DHSRN. Following the evaluation , the DHS RN will develop a person-centered service plan. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans are developed and sent to all providers before services may begin.~~

(a) Upon notification of participant eligibility for the ARChoices program, the DHS PCSP/CC Nurse will schedule a meeting with the participant to develop the person-centered service plan (PCSP). The DHS PCSP/CC Nurse will inform participants that they may invite anyone that they choose to participate in the PCSP 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/evaluation, or PCSP 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 Nurse will assist in notifying interested parties if requested by the participant or the representative. The PCSP will be updated at a minimum of every 12 months in coordination with the annual evaluation/reassessment, as appropriate. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances.

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

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

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

~~The assessment is a complete functional 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 RN will assess the participant's preferences, goals, desired outcomes, and risk factors.~~

~~Support systems available to the participant are identified and documented, along with services currently in place. Based on this assessment information, the DHS RN will discuss the service delivery plan with the participant.~~

~~When the service plan development process results in an individual being denied the services or the providers of their choice, the state automatically 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 assessment if the applicant is functionally eligible based on the Independent Assessment Contractor's assessment. The DHS RN must discuss the Provisional Service Plan Policy and have approval from the applicant prior to completing and processing a provisional service plan, which will then be signed by the applicant or the applicant's representative and the DHS RN. The provisional service plan will be provided to the waiver applicant and each provider included on the service plan. The provider will notify the DHS RN via form AAS-9510 (Start of Care Form), indicating the date services begin. No provisional service plans will be developed if the waiting list process has been implemented.~~

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

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

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

(b) The development of the PCSP plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor or an in-person evaluation conducted by the DHS PCSP/CC Nurse. 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 utilizing the Arkansas Independent Assessment (ARIA) instrument. Reassessments, which will be conducted by the Independent Assessment Contractor, if deemed appropriate by the DHS Eligibility Nurse based on a change in condition or circumstance which may result in a change in Level of Care. Evaluations are conducted face-to-face at a minimum of every 12 months or as required based on changes in condition or circumstances using the DHS 703 form.

The results of the Independent Assessment Contractor's functional assessment using the ARIA instrument, or the results of the annual evaluation using the DHS 703 form will be used by the Division of County Operations to evaluate the level of care and by the DHS PCSP/CC Nurse to develop the person-centered service plan. Information collected 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/evaluation is a complete functional assessment and includes a medical history, as well as, the participant's physical, functional, mental, emotional and social status, and will include a medical history to ensure that the service plan addresses the participant's strengths, capacities, health care, and other needs.

The DHS PCSP/CC 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 Nurse will discuss the service delivery plan with the participant. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances.

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

(d) The DHS ~~RN~~ PPCSP/CC 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 ~~RN~~ PCSP/CC Nurse may contact anyone who may be able to provide accurate and pertinent information regarding the participant's condition and functional ability. These individuals participation in the service plan development process also helps to ensure that the participant's goals, preferences and needs are met.

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

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

(e) ~~The participant must choose a provider for each waiver service selected. During the service plan development process, the DHS RN informs the participant or their legal guardian or family member of the available services. The participant or guardian/family member may choose the~~

providers from which to receive services. Documentation verifying freedom of choice was assured is included in the participant's record on the person-centered service plan, and on the provider list. Both documents reflect freedom of choice was given to the participant. The freedom of choice form and all related documents are included in the participant's record and reviewed during the DHS RN supervisory review process. Each service included on the service plan is explained by the DHS RN. The amount, frequency, scope and provider of each service is also discussed and entered on the service plan. The DHS RN sends a copy of the service plan to the waiver provider, as well as the participant. The DHS RN tracks the implementation of each service through the Start of Care form, which includes the date services begin.

Service plans are developed and sent to all providers before services may begin. Services are coordinated by the DHS PCSP/CC Nurse as the primary point of contact or through the Target Case Manager.

(f) Implementation, compliance, and monitoring of the person-centered service plan is the responsibility of DAABHS (Operating Agency), DMS (Medicaid Agency), and providers of ARChoices in Homecare waiver services. Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements and are required to report any change in the participant's condition to the DHS/PCSP/CC Nurse.

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

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

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

(g) Each reevaluation of functional eligibility of level of care and development of a person-centered service plan is completed annually or more often, if deemed appropriate by the DHS RN. The service plan may be revised at any time, based on information relevant to the

~~participant's condition or circumstances. Changes are reported to the DHS RN by the participant, the participant's family or representatives, service providers and Targeted Case Managers. The DHS RN has sole authority for all development and revisions to the waiver service plan. Service plan updates must be based on a change in the participant's status or needs.~~
PCSPs are revised by DHS PCSP/CC Nurses as needed between evaluations, based on reports relative to the participant's condition or circumstances secured through providers, Targeted Case Managers, waiver participants and their support systems. Each evaluation of medical eligibility and development of a PCSP is completed at a minimum of every twelve (12) months or more often, if deemed appropriate.

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

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

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

Also, providers, family members and others who have regular contact with participants are required to report any change in participant condition, or perceived risk or other problem concerning the participant. The DHS PCSP/

CC Nurse ~~RN~~s also re-evaluate potential participant risks during monitoring visits. DHS PCSP/CC Nurses ~~RN~~s and Targeted Case Managers refer any high-risk participants to Adult Protective Services immediately if it is felt that the participant is in danger. DHS PCSP/CC Nurses~~RN~~s also provide patient education on safety issues during each evaluation. ~~and reevaluation~~. The annual contact by the DHS RN is a minimum contact standard. Visits are made as needed during the interim.

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

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

Providers agree to inform the DHS PCSP/CC Nurse 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 PCSP

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

During completion of the ~~person centered service plan~~ annual PCSP, the participant or representative must sign the Freedom of Choice form to show that no change in providers was made. The provider listing does not need to be initialed if there are no changes in providers. However, if a participant wishes to change providers , both the Freedom of Choice form and

provider listing must be signed and initialed indicating this change. Participants may request a change of providers at any time during a waiver year.

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

~~DHS RNs and Targeted Case Managers leave contact information with participants at each visit.~~ The participant may contact the DHS ~~RN~~ PCSP/CC 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 ARChoices in Homecare person-centered service plans are subject to the review and approval of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (Operating Agency), and the Division of Medical Services (DMS) (Medicaid Agency).

The DAABHS Reviewer conducts record reviews drawing from a statistically valid random sample. Using the Raosoft software calculations program, a statistically valid sample with at 95% confident level and a margin of error of +/- 5%. 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 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.

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval and are made available by the operating agency upon request. DMS reviews a validation sample of participants' records which includes the person-centered service plan. For the validation review, DMS reviews 20% of the records reviewed by DAABHS. For the provider file sample, the Raosoft online calculator is used to determine a statistically valid sample size with a 95% confidence level and a margin of error of +/- 5%. Every nth name is selected for review until the sample size is reached. The sample is then divided into twelve groups for monthly review by DMS._Reviewed service plans are compared to policy guidelines, the functional assessment, and the ~~case notes~~ narrative detailing the participant's living environment, physical and mental limitations, and overall needs.

~~DHS RN supervisory staff also conduct record reviews drawing from a statistically valid random sample. Using the Raosoft software calculations program, a statistically valid sample size with a 95% confidence level and a margin of error of +/- 5%. Records are reviewed to assess the appropriateness of the service plan, to validate service provision, to ensure that services are meeting the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS RN addresses any needed corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the Office of Medicaid Inspector General.~~

Information reviewed by both DAABHS and DMS during the record review process includes, ~~but is not limited to~~, without limitation: development of an appropriate individualized ~~person-centered~~ service plan, completion of updates and revisions to the service plan and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

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

○	**Every three months or more frequently when necessary**
○	**Every six months or more frequently when necessary**
●	**Every twelve months or more frequently when necessary**
○	**Other schedule** *Specify the other schedule*:

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

☐	**Medicaid agency**
■	**Operating agency**
☐	**Case manager**
■	**Other** S*pecify:*
	~~The service plan is maintained by the DHS RN in the participant's record and by the ARChoices in Homecare waiver service providers.~~

Appendix D-2: Service Plan Implementation and Monitoring

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

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

DHS ~~RN~~PCSP/CC nurses:

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

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

ARCHOICES IN HOMECARE PROVIDERS:

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

TARGETED CASE MANAGERS:

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

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

numbers, and leave a business card or contact sheet in the participant's home in case of concerns or questions.

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

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

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

Targeted Case Managers review the ~~person-centered service plan~~ PCSPwith the participant during all face-to-face visits to ensure that services are being provided according to the plan. The Targeted Case Manager will also measure the participant's progress toward PCSP ~~service plan~~ goals. The contacts listed above are a minimum requirement. In an effort to assure health and safety, compliance with the waiver PCSP~~person-centered service plan~~, and the integrity of services billed to the Medicaid Program, it is the Targeted Case Manager's responsibility to visit, call and support the waiver participant as much as is needed based on the individual's circumstances and the stability of their services.

INFORMATION EXCHANGE:

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

The DHS ~~RN~~ PCSP/CC Nurse maintains an established caseload, covering certain counties in Arkansas. Each participant knows his or her DHS ~~RN~~ PCSP/CC Nurse and has the DHS PCSP/CC Nurse ~~RN~~'s contact information. ~~DHS RN PCSP/CC Nurse supervisors~~ DAABHS supervisory staff

assist in the resolution of problems, monitor the work performed by the DHS ~~RN~~ PCSP/CC Nurses by making periodic visits with each DHS ~~PCSP/CC~~ Nurse ~~RN~~, and assist in overall program monitoring and quality assurance. Additionally, a record review process is conducted on a monthly basis by ~~DHS RN~~ ~~PCSP/CC Nurse~~ ~~supervisors~~ DAABHS. Records are pulled at random and reviewed for accuracy and appropriateness in the areas of medical assessments, ~~service plans~~ PCSPs, level of care determinations and documentation. Selection begins by reviewing the latest monthly report from the ~~Arkansas Client Eligibility System (ACES).~~ 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. DAABHS supervisory staff uses the Raosoft Calculation System to determine the appropriate sample size for record review with a 95% confidence level and a margin of error of +/-5%, and selects every name on the list to be included in the sample.

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

1. Program reports are available to all nurse DAABHS supervisory staff through integrated software with dashboard functionality and on demand reporting.

2. Monthly Record Reviews - performed monthly by DAABHS and reported monthly to Senior DAABHS Staff

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

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

~~1. Monthly Reports - compiled by each DHS RN and reported monthly to RN supervisor. All monitoring visits are reported.~~

~~2. RN Supervisor Report - compiled by each RN supervisor and reported monthly to the Nurse Manager. All monitoring visits are reported.~~

~~3. Monthly Record Reviews - performed monthly by RN supervisors and reported monthly to Nurse Manager.~~

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

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

b. Monitoring Safeguards. *Select one:*

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

	The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	Service providers are required to follow all guidelines in the Medicaid Provider Manual related to emergencies, including the emergency backup plan process and contact information for emergencies. Providers agree to inform the DHS ~~RN~~ PCSP/CC 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 PCSP ~~person-centered service plan~~. ARChoices in Homecare providers agree to render all services in accordance with the Arkansas Medicaid ARChoices in Homecare Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency); to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS ~~RN~~ PCSP/CC Nursein writing within one week of services being terminated documenting the termination effective date and the reason for termination. ARChoices in Homecare providers assure that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted an ARChoices in Homecare waiver PCSP~~person-centered service plan~~. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the ~~service plan~~PCSP developed by the DHS ~~RN~~ PCSP/CC Nurse. Providers acknowledge that the DHS ~~RN~~ PCSP/CC Nurse is the only authorized individual who may adjust an ARChoices in Homecare waiver participant's ~~PCSP~~~~service plan~~. Providers accept full responsibility for the quality and number of service units provided to an ARChoices in Homecare waiver participant by their staff, and assure DAABHS appropriate management and supervision of services takes place at all times. ~~Person-centered service plans~~ PCSPs are revised by DHS ~~RN~~PCSP/CC Nurses as needed, based on information secured through providers, waiver participants and their support systems. Targeted Case Managers monitor waiver participants' status as needed for changes in service need, referring participants for ~~re~~evaluation by the DHS ~~RN~~ PCSP/CC Nurse if necessary and reporting any participant complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant's legal representative, guardian or family member may participate on their behalf. This oversight ensures that participants are receiving the specified services to meet their needs and according to the person-centered service plan. DHS ~~RN~~ PCSP/CC Nurses and Targeted Case Managers must document all contacts (in person, telephone or correspondence) with or on behalf of the participant in the participant's case record. If a monitoring contact produces any information that warrants further action, DHS ~~RN~~PCSP/CC Nurses and Targeted Case Managers are responsible for following through and taking any action deemed appropriate.

Quality Improvement: Service Plan

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: Service Plan Assurance**

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

i. Sub-assurances:

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

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 participants reviewed who had service plans that addressed risk factors. Numerator: Number of service plans that address risk factors; Denominator: Number of records reviewed*~~ ***Number and percent of participant records reviewed which had PCSPs that address health and safety risk factors. Numerator: Number of participant records reviewed which had PCSPs that address health and safety risk factors; Denominator: Number of PCSPs 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 participants reviewed who had service plans that were adequate and appropriate to their needs as indicated by the assessment(s). Numerator: Number of participants with service plans that address needs; Denominator: Number of records reviewed*~~ *Number and percent of participants records reviewed which had PCSPs that were adequate and appropriate to their needs as indicated by the assessment(s). Numerator: Number of participants records reviewed which had PCSPs that were adequate and appropriate to address their needs as indicated by the assessment(s); 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 participants reviewed who had service plans that addressed personal goals. Numerator: Number of service plans that address personal goals; Denominator: Number of records reviewed*~~ *Number and percent of participants records reviewed which had PCSP that addressed personal goals. Numerator: Number of participant records reviewed which had PCSP that address personal goals; 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*

State:	
Effective Date	

☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

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

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 plan development procedures that are completed as described in the waiver application. Numerator: Number of participants' service plans completed according to waiver procedures; Denominator: Number of records reviewed*~~ **~~Number and percent of PCSPs that were updated when necessary to address a change in the participant's needs. Numerator: Number of PCSPs that were updated when necessary to address a change in the participant's needs. Denominator: Number of PCSPs 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*
[redacted]	■ *Operating Agency*	☐ *Monthly*	■ *Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*	[redacted] ■ *Representative Sample; Confidence Interval =*
[redacted]	☐ *Other Specify:*	☐ *Annually*	[redacted] ~~*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:*	☐ *Annualy*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

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 revised as warranted on or before waiver participants annual review date. Numerator: Number of participants' service plans that were*~~

	~~reviewed/revised before annual review date; Denominator: Number of records reviewed~~ **Number and percent of PCSPs that were updated when necessary to address a change in the participant's needs. Numerator: Number of PCSPs that were updated when necessary to address a change in the participant's needs. Denominator: Number of PCSPs 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 service plans reviewed that were updated at least every 12 months. Numerator: Number of service plans reviewed that were updated at least every 12 months; Denominator: Number service plans 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:*

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

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 participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan. ~~*Numerator: Number of participants' service plans who received services specified in service plan; Denominator: Number of records reviewed*~~ **Numerator: Number of participants records reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan; Denominator: Number of participants 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:*

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 an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with choice between institutional care waiver services and among waiver services; Denominator: Number of records reviewed*~~ **Number and percent of PCSP reviewed that indicated choice among waiver services was offered. Numerator: Number of PCSPs reviewed that indicated choice among waiver services was offered; Denominator: Number of PCSPs reviewed in which a change in participants needs was indicated.**

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 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*~~ **Number and percent of participant records reviewed that indicated choice of provider was offered as evidenced by an appropriately completed and signed freedom of choice form. Numerator: Number of participant records reviewed that indicated choice of provider was offered as evidenced by an appropriately completed and signed freedom of choice form; Denominator: Number of participant 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.

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

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

~~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~~ PCSP 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 present of justifi~~cion~~ying 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 wavier services and providers.~~

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

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

Record reviews of the overall program files are thorough and include a review of all required documentation regarding compliance with the PCSP ~~service plan~~ development assurance and ~~service plan~~ PCSP delivery. Reviews include, but are not limited to, completeness of the ~~service plan~~PCSP; timeliness of the ~~service plan~~ PCSP development process; appropriateness of all medical and non-medical services; consideration of participants in the ~~service plan~~ PCSP development process; clarity and consistency; compliance with program policy regarding all aspects of the ~~service plan~~ PCSP 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~~ PCSP development and delivery of services. Initial verification of service delivery is verified via the Start of ~~Care~~ Services (9510) form. This documentation is a part of every record review.

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

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

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 the Division of Medical Services (Medicaid agency) – 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~~ PCSPs, as well as problem correction and remediation. DAABHS, 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. Appropriate disciplinary action is taken when determined necessary per DHS policy.

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(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:

c. Timelines

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

●	**No**
○	**Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☐	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
☐	**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
☐	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	**Waiver is designed to support only individuals who want to direct their services.**
○	**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
○	**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.** *Specify the criteria*

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one)*:

○		**The state does not provide for the direction of waiver services by a representative.**
○		**The state provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:
	☐	**Waiver services may be directed by a legal representative of the participant.**
	☐	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

○	**Yes**. **Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ **Governmental entities**
	☐ **Private entities**
○	**No**. **Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service specified in Appendix C-1/C-3 **The waiver service entitled:**	
○	**FMS are provided as an administrative activity.** ***Provide the following information***	
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	

	Supports furnished when the participant is the employer of direct support workers:	
	☐	**Assists participant in verifying support worker citizenship status**
	☐	**Collects and processes timesheets of support workers**
	☐	**Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
	☐	**Other** *Specify:*
	Supports furnished when the participant exercises budget authority:	
	☐	**Maintains a separate account for each participant's participant-directed budget**
	☐	**Tracks and reports participant funds, disbursements and the balance of participant funds**
	☐	**Processes and pays invoices for goods and services approved in the service plan**
	☐	**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
	☐	**Other services and supports** *Specify*:
	Additional functions/activities:	
	☐	**Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
	☐	**Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
	☐	**Provides other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
	☐	**Other** *Specify:*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*	
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):	
	Participant-Directed Waiver Service	**Information and Assistance Provided through this Waiver Service Coverage**
	(list of services from Appendix C-1/C-3)	☐
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:*	

k. Independent Advocacy *(select one)*.

○	**No. Arrangements have not been made for independent advocacy.**
○	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		
Year 2		
Year 3		
Year 4 (only appears if applicable based on Item 1-C**)**		
Year 5 (only appears if applicable based on Item 1-C**)**		

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☐	**Recruit staff**
☐	**Refer staff to agency for hiring (co-employer)**
☐	**Select staff from worker registry**
☐	**Hire staff (common law employer)**
☐	**Verify staff qualifications**
☐	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
☐	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3. Specify the state's method to conduct background checks if it varies from Appendix C-2-a:**
☐	**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐	**Determine staff wages and benefits subject to applicable state limits**
☐	**Schedule staff**
☐	**Orient and instruct staff in duties**
☐	**Supervise staff**

☐	**Evaluate staff performance**
☐	**Verify time worked by staff and approve time sheets**
☐	**Discharge staff (common law employer)**
☐	**Discharge staff from providing services (co-employer)**
☐	**Other** Specify:

b. Participant – Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more***:**

☐	**Reallocate funds among services included in the budget**
☐	**Determine the amount paid for services within the state's established limits**
☐	**Substitute service providers**
☐	**Schedule the provision of services**
☐	**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
☐	**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
☐	**Identify service providers and refer for provider enrollment**
☐	**Authorize payment for waiver goods and services**
☐	**Review and approve provider invoices for services rendered**
☐	Other Specify:

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	**Modifications to the participant directed budget must be preceded by a change in the service plan.**
○	**The participant has the authority to modify the services included in the participant-directed budget without prior approval.** Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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 DCO-707 (Notice of Action form) or a system-generated Notice of Action created by the DHS County Office to provide notice to a participant when an adverse action is taken to deny, suspend or terminate eligibility for Living Choices. The DCO-707 or the system-generated Notice of Action is issued by the LTSS caseworker, and explains the action taken; the effective date of the action; and the reason(s) for the action.~~ 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 ARChoices. 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. ~~. DCO-707s and~~ Notices of Adverse 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 ~~DCO-707 or the system-generated~~ 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 ~~revising their service plan,~~ 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 ~~DCO-707 or on the system-generated~~ Notice of Action.

The ~~DCO-707 or the system-generated~~ Notice of Action is kept in the participant's ~~county office~~ electronic 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~~ The Notice of Action will be retained for five years from the date of last approval, closure, or denial.

~~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 RN 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 him or her, 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 RN. 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.~~

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 ~~DCO-707 or, when applicable, the system-generated~~ the Notice of Action. The form and the system-generated Notice of Action are available in Spanish and large print formats.

~~Living Choices~~ ARChoices participants' Medicaid eligibility and services will automatically continue during the appeal process when the administrative appeal is timely filed, unless the participant elects to have the benefits discontinue. The participants are informed of their option ~~by the DHS county office~~ 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 any 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.

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

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

Appendix F-2: Additional Dispute Resolution Process

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

●	**No. This Appendix does not apply**
○	**Yes. The state operates an additional dispute resolution process**

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

Appendix F-3: State Grievance/Complaint System

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

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

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

Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS)

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

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAABHS Central Office or their DHS ~~RN~~PCSP/CC Nurse~~. .~~ When ~~DAABHS~~ a PCSP/CC Nurse is contacted regarding a complaint or dissatisfaction, ~~DAABHS~~ the PCSP/CC Nurse explains the complaint process to the participant, and completes the HCBS Complaint Intake Report (AAS-9505). ~~electronically.~~ 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, ~~The HCBS Complaint database,~~ is used to track any dissatisfaction or complaint, including complaints against DAABHS staff and providers (including individual providers. ~~, provider organizations, and employees and contractors of provider organizations).~~ The record of complaint includes the date the complaint was filed.

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

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

Complaints concerning abuse, neglect and exploitation are routed to Adult Protective Services ~~immediately~~ for appropriate action. State law allows HCBS staff and APS staff to share information concerning clients on a need to know basis, but that information may not be re-disclosed to a third

party. A.C.A. 12-12-1717(a)(9) allows disclosure of reports to "the department" (DHS) for founded reports and A.C.A. 12-12-1718(a) and (b)(1)(A) allow disclosure of pending and screened out reports to "the department". ~~All APS reports involving waiver participants are reported on the monthly report and tracked by RN supervisory staff.~~

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

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

Complaints against DAABHS staff including DHSPCSP/CC nurses are referred to the DHS RN supervisor or the DAABHS Nurse Manager for investigation and resolution. If the complaint is not resolved at this level the complaint is referred to the appropriate internal agency depending on the nature of the complaint for investigation and appropriate action. Complaints may result in corrective action plan or appropriate personnel action.

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

●	**Yes**. **The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
○	**No**. **This Appendix does not apply** (*do not complete Items b through e).* *If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.*

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

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

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

~~Reporting requirements for DHS employees and contractors:~~

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

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

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

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

~~The DHS RN~~ The Division of Aging, Adult and Behavioral Health Services provides training and information to participants when initial contact is made and at a minimum of every 12 months with the update to the PCSP. DAABHS PCSP/CC Nurse 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 ~~RN~~ PCSP/CC Nurses 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.

Information is provided during the initial development of the PCSP, and at a minimum of every 12 months in conjunction with the update to the PCSP.

For incidents involving alleged abuse, neglect, and exploitation regarding adult clients, Adult Protective Services (APS) receives, investigates, evaluates, and resolves reports.

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 as required by state law. APS notifies the client and other relevant parties, including the offender, of the determination.

APS communicates with ~~Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency)~~ waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

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

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

Division of Provider Services and Quality Assurance (DPSQA) Responsibilities:

DPSQA ~~will~~ investigates those incidents that relate to allegations of failed provider practices.

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

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 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.~~

DAABHS as the operating agency for the waiver assumes responsibility for submitting critical incidents and events through the IRIS system. DPSQA is responsible for compiling all incidents into a single database for review and action. All incident reports for all sources are entered into the database. This database generates monthly, quarterly and annual reports to the DAABHS Program Administrator. The administrator reviews these reports to identify patterns and make systematic corrections when necessary.

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. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.~~ ~~DHS RNs reassess participants annually.~~ Division of Provider Services and Quality Assurance (DPSQA) is responsible for detecting unauthorized use of restraints. This oversight is conducted on an ongoing basis through incident reports received and investigated. Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to ~~immediately~~ contact ~~the DHS RN~~ DAABHS regarding any concerns for the participant's health and welfare.
○	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

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

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

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; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.~~ ~~DHS RNs reassess participants annually.~~ Division of Provider Services and Quality Assurance (DPSQA) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted on an ongoing basis through incident reports received and investigated. Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact ~~the DHS RN~~ DAABHS regarding any concerns for the participant's health and welfare.
○	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-b-ii.

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

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

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

●	**The state does not permit or prohibits the use of seclusion**

	Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
	~~The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.~~ ~~DHS RNs reassess participants annually.~~ ~~Division of Provider Services and Quality Assurance (DPSQA) is responsible for detecting unauthorized use of seclusion. This oversight is conducted on an ongoing basis through incident reports received and investigated.~~ Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact the DAABHS ~~DHS RN~~ regarding any concerns for the participant's health and welfare.
○	**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

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

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

Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

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

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

~~The DHS RN reviews the medication regimens at the time of evaluation and reevaluation. All medications are documented. Any potentially harmful practices the DHS RN discovers during the assessment or during a monitoring visit are documented in the participant record, addressed, and tracked for resolution.~~

c. Medication Administration by Waiver Providers

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

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

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

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

○	**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).** *Complete the following three items:*
	(a) Specify state agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the state:
○	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.** Specify the types of medication errors that providers are required to record:

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

Quality Improvement: Health and Welfare

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

i. Sub-assurances:

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

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 complaints addressed within required time frame. Numerator: Number of complaints addressed in required time frame; Denominator: Number of complaints*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Complaint Database	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *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 Aggregation and Analysis

Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

(check each that applies	(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 unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of unpreventable and preventable causes. Numerator: Number of deaths with unpreventable causes; Denominator: Number of deaths~~ **Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents**
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Unexpected Death 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
[redacted]	~~■~~ Operating Agency	☐ Monthly	☐ Less than 100% Review
	☐ Sub-State Entity	☐ Quarterly	[redacted] ☐ Representative Sample; Confidence Interval =
	☐ ■ Other Specify:	☐ Annually	[redacted]
	DPSQA	■ Continuously and Ongoing	[redacted] ☐ Stratified: Describe Group:
		☐ Other Specify:	[redacted]
			[redacted] ☐ Other Specify:
			[redacted]

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*
DPSQA	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	~~*Number of substantiated complaints. Numerator: Number of substantiated complaints; Denominator: Number of complaints*~~ **Number and percent of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of abuse. Numerator: Number of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of abuse. Denominator: Number of records reviewed.**
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Complaint Database	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐■ *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% ma				
		■ *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 critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents reviewed*~~ **Number and percent of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of neglect. Numerator: Number of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of neglect. 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 participant records reviewed where the participant and/or family or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents as specified in the waiver application. Numerator: Number of participants receiving information on abuse/neglect/exploitation/critical incidents; Denominator: Number of records reviewed*~~ **Number and percent of records reviewed that indicated the participant, guardian or family received information about how to ID and report critical incidents of exploitation Numerator: Number of records reviewed that indicated the participant, guardian or family received information about how to ID and report critical incidents of exploitation 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 incidents of abuse, neglect, exploitation, and unexplained death that are reviewed/investigated within the required timeframes. N: Number of incidents of abuse, neglect, exploitation, and unexplained death that are reviewed/investigated within the required timeframes. D: Number of Incidents of abuse, neglect, exploitation, and unexplained deaths.**
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*	
	☐■ *Other Specify:*	☐ *Annually*	
	Adult Protective Services (APS)	■ *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:Adult Protective Services*	☐ *Annually*
	■ *Continuously and Ongoing*
	☐ *Other Specify:*

b. Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

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

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

Performance Measure:	~~*Number and percent of critical incident reviews/investigations that were initiated and completed according to program policy and state law. Numerator: Number of critical incident investigations completed according to policy/law; Denominator: Number of critical incidents reviewed*~~ **Number and percent of critical incidents where the root cause was identified. Numerator: Number of critical incidents where the root cause was identified; Denominator: Number of critical incidents.**
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:DPSQA*	☐ *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:DPSQA*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	~~*Number and percent of critical incidents requiring reviews/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up; Denominator: Number of critical incidents reviewed.*~~ **Number and percent of critical incidents reviews/investigations that were initiated and completed according to program policy and state law. Numerator: Number of critical incident reviews/investigations initiated and completed according to program policy/law; Denominator: Number of critical incidents.**

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: DPSQA*	☐ *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: DPSQA	☐ ■ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of critical incidents requiring reviews/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up as specified; Denominator: Number of critical incidents. ~~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: DPSQA	☐ Annually	
		× 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:DPSQA*	■ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

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

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

Performance Measure:	~~*Number and percent of the use of restrictive interventions requiring investigations. Numerator is the number of investigations for the use of restrictive interventions. Denominator is the reported uses of restrictive interventions.*~~ **Number and percent of incident reports documenting intervention in which providers adhered to DHS policies for the use of restrictive interventions.** **Numerator: Number of incident reports documenting intervention in which providers adhered to DHS policies for the use of restrictive interventions;** **Denominator: Number of incident reports documenting intervention.**
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, on-site***	
If 'Other' is selected, specify:	

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

		☐ ■ *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: DPSQA*	■ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

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.

Performance Measure:	~~*Number and percent of changes in Level of Care Tier Levels and ISB Levels. Numerator - number of changes in Level of Care Tier Levels and ISB Levels. Denominator - Number of records reviewed.*~~ **Number and percent of waiver providers who meet and adhered to state health care standards established in licensure requirements upon review. Numerator: Number of waiver providers who meet and adhered to state health care standards established in licensure requirements upon review; Denominator: Number of waiver providers.**
Data Source *(Select one) (Several options are listed in the on-line application)**: Record reviews, on-site***	
If 'Other' is selected, specify:	

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

~~Arkansas addresses this assurance with a three step process that involves record review, ongoing communication with Adult Protective Services (APS), and Division of Medical Services (DMS) audits of waiver participants' records. Monthly record reviews are performed by DHS RN supervisors to assure that DHS RNs report incidences of abuse or neglect, and that safety and protection are addressed 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 DMS.~~

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

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

~~The process for reporting abuse as established in Arkansas Code Annotated 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult Maltreatment Hotline refers the matter immediately to the appropriate investigating agency. Under this statute, a resident of an assisted living facility is identified as a long-term care facility resident, and for the purposes of the statute is presumed to be an impaired person. A report for a long-term care facility resident is to be made immediately to the local law enforcement agency for the jurisdiction in which the long-term care facility is located, and to OLTC under the regulations of that office. DHS has jurisdiction to investigate all cases of suspected maltreatment of an endangered person or an impaired person. The APS unit of DHS shall investigate all cases of suspected adult maltreatment if the act or omission occurs in a place other than a long-term care facility; and all cases of suspected adult maltreatment if a family member of the adult person is named as the suspected offender, regardless of whether or not the adult is a long-term care facility resident. The OLTC unit of DHS shall investigate all cases of suspected maltreatment of a long-term care facility resident.~~

b. Methods for Remediation/Fixing Individual Problems

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

~~The Division of Aging, Adult, and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency)~~ DAABHS and the DMS 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 ~~RN~~PCSP/CC Nurses and considering this remediation as part of ~~RN~~PCSP/CC Nurses' performance evaluations.

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

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

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

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

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

ii. Remediation Data Aggregation

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

		☐ **Other** Specify:

c. **Timelines**

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

●	**No**
○	**Yes**

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

Appendix H: Quality Improvement Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

H.1 Systems Improvement

a. **System Improvements**

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

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

As a result of the discovery processes:

The interagency agreements were revised to provide a more visible product to clarify roles and responsibilities between DMS, ~~and~~DAABHS, and DPSQA.

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

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

ii. System Improvement Activities

Responsible Party *(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: DCO and Contracted Vendor	■ **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 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.~~

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, the Division of Medical Services (DMS) will meet with DAABHS to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue, etc.), complexity of the solution, and the financial impact. If it is determined that a system change is needed, a computer service request is submitted to the Arkansas Medicaid Enterprise (AME) unit within DMS and a priority status is assigned. DMS prioritizes system changes to MMIS and coordinates implementation with AME. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. AME and DMS monitor the system changes. If the system change is to the eligibility system, DAABHS will coordinate with the Division of County Operations (DCO) to implement and monitor the system change.

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
- o 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

APPENDIX I-1: Financial Integrity and Accountability

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

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

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

Pre-Payment Integrity ARChoices waiver providers submit ARChoices Waiver Service claims through the Medicaid Management Information System (MMIS). MMIS act as a pre-payment financial integrity check on all claims submitted. MMIS verifies a participant's ARChoices Waiver eligibility and a ARChoices Waiver service provider's active Medicaid enrollment for the date of service prior to paying a ARChoices Waiver claim. MMIS has the applicable per unit rate for the ARChoices Waiver service pre-loaded and has edits in place that will prevent the payment of claims exceeding any applicable daily, weekly, or annual benefit/service limits for the ARChoices Waiver service. MMIS only pays claims that clear all eligibility and financial edits.

The contracted fiscal agent also conducts random quality assurance checks of the above-listed edits to ensure they are functioning appropriately.

Post-Payment Integrity
Every month DAABHS conducts a random sample retrospective desk review of active and closed participant service records from the previous quarter. The participant service records are reviewed to determine if participants received, and ARChoices Waiver service providers were paid for, the ARChoices Waiver services in the type, scope, amount, frequency, and duration specified in the service plan, and if such services were paid at the correct rate. This is done by reviewing the POC in the participant service record in the ARChoices Database maintained by Vendor and comparing it to the ARChoices services billed and paid through MMIS. DAABHS uses the Raosoft Calculation System to determine a sample size that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.

DAABHS, the Operating Agency, communicates the results of the reviews to DMS. DMS as the State Medicaid Agency, communicates the with providers and creates Corrective Action Plans as necessary.

Additionally, DMS conducts its own retrospective desk review of active participant service records in the immediately preceding quarter to determine if participants received, and ARChoices Waiver service providers were paid for, the ARChopices Waiver services in the type, scope, amount, frequency, and duration specified in the service plan, and if such services were paid at the correct rate. DMS also uses the Raosoft Calculation System to determine a sample size that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.

The DMS financial team reports any recouped payments for ARChoices Waiver services as a prior period adjustment on the CMS-64 to remove the payments from claims for federal financial participation.

DMS notifies providers of patterns of non-compliance or irregularities and takes appropriate action including training to assist with appropriate claims submission. Continued patterns of non-compliance or irregularities resulting in over payment will be referred to the appropriate state agency for review and corrective action or penalties.

The Centers for Medicare and Medicaid Services ("CMS") conducts audits of Medicaid claims (including ARChoices Waiver service claims) in accordance with the Payment Error Rate Measurement ("PERM") regulations every three (3) years. CMS reviews the claims to ensure the services were medically appropriate, provided to an eligible participant, and paid at the correct amount. PERM reviews are intended to:

• identify those Medicaid programs that may be susceptible to significant improper payments;

• estimate the amount of improper payments;

• submit those estimates to Congress; and

• submit a report on actions the agency is taking to reduce improper payments.

Arkansas Legislative Audit is responsible for conducting the periodic independent audit of the ARChoices waiver program under the provisions of the Single Audit Act.

The Office of Medicaid Inspector General also conducts independent annual random reviews of all Medicaid programs, including the ARChoices Waiver. If a review finds errors in billing and fraud is not suspected, DMS recoups the payment(s) from the ARChoices Waiver provider. If fraud is suspected, then the provider is referred to the Medicaid Fraud Control Unit and Arkansas Attorney General's office for appropriate action including request for and monitoring of corrective action plan.

All ARChoices Waiver providers who are paid a total of $100,000 or more during a year by the State of Arkansas are required to submit an independent audit of its financial statements for that year in accordance with the Government Auditing Standards. ARChoices Waiver providers who are paid more than $750,000 in federal funds during a year must have an independent single audit conducted for that year in accordance with OMB Circular A-133. All required ARChoices Waiver service provider audits are submitted to and reviewed by the DHS Office of Payment Integrity and Audit (OPIA) for compliance with audit requirements. The purpose of the OPIA reviews of provider financial audits is to notify the Division of any deficiencies identified by that provider's CPA. DAABHS is notified of any deficiencies via e-mailed letter upon completion of the review. No CAPs are required and individual claims are not reviewed in the process. If during review of an audit issues are discovered, then OPIA is responsible for notifying DMS for recoupment or other appropriate action. Reviews are consistent across all providers and provider types.

Inappropriate claims are recouped and removed from the claims for FFP via the CMS-64 reporting system.

The state implemented a statewide EVV system for personal care, attendant care, and respite services in January 2021. The system is currently operating, and we are moving to cutting off direct billing access and requiring use of the EVV system. The state will implement EVV for home health and other home and community-based services in January 2023, as required by the 21st Century Cures Act. The EVV system captures the required data elements and submits those elements over to the MMIS billing system. The EVV

system will not submit a claim unless those data elements are present. The state staff can review data on critical exceptions to determine if a provider needs additional training or to be referred for further audit. The post-payment auditors can use EVV data to detect fraud, waste and abuse.

Quality Improvement: Financial Accountability

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: Financial Accountability Assurance**
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:	~~*Number and percent of reviewed claims with services specified in the participant's service plan. Numerator: Number of claims with services specified in service plan; Denominator: Number of claims*~~ ***Number and percent of claims reviewed that paid at the correct rate as specified in the waiver application. Numerator: Number of claims reviewed that paid at the correct rate as specified in the waiver application; Denominator: Number of claims reviewed.***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Recipient Profiles	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ *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 5% margin of error*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			■ *Other Specify:*
			~~*DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.*~~

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 of failed MMIS edit checks which are corrected to assure appropriate payment. Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks*~~ ***Number and percent of claims reviewed with services specified in the participant service plan. Numerator: Number of claims reviewed with services specified in the participant service plan; Denominator: Number of claims reviewed.***

Data Source *(Select one) (Several options are listed in the on-line application): Other*
If 'Other' is selected, specify:
Weekly Worksheets

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

Performance Measure:	~~*Number of failed MMIS edit checks which are corrected to assure appropriate payment. Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks*~~ ***Number and percent of claims reviewed that are coded and paid in accordance with the reimbursement methodology specified in the approved waiver and only for***

	services rendered. Numerator: Number of claims that are coded and paid in accordance with reimbursement methodology specified in the approved waiver and only for services rendered; Denominator: Number of claims reviewed.
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Daily LTC Update Error Report	

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

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

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

Performance Measure:	~~*Number and percent of waiver claims that were paid using the correct rate as specified in the waiver application. Numerator: Number of claims paid at correct rate; Denominator: Number of claims*~~ ***Number and percent of rates reviewed which remain consistent with the approved rate methodology throughout the five-year waiver cycle. Numerator: Number of rates reviewed which remain consistent with the approved rate methodology throughout the five-year waiver cycle. Denominator: Number of rates***
Data Source *(Select one) (Several options are listed in the on-line application): other*	
If 'Other' is selected, specify:	
Recipient Claims History Profile (Chart Reviews)	

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

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

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

DAABHS and DMS participate in monthly team meetings as needed to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to financial accountability for the waiver.

The MMIS system has audits and edits in place to ensure correct payment of claims. In the monthly case record review, all participant claims on selected cases records are reviewed against services authorized in the PCSP and claims are checked to see if payment was correct.

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

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

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

ii. Remediation Data Aggregation

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

c. Timelines

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

●	**No**
○	**Yes**

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

APPENDIX I-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).

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

Please reference Main Section 6-I for detailed information on the public comment process.

The fee schedule for the ARChoices program can be found on the DHS website: https://humanservices.arkansas.gov/wp-content/uploads/ARCHOICES-fees.pdf

~~DAABHS will review the rate methodologies no later than CY 2020.~~

DMS will review the rate methodologies per executive order on a three year cycle. If a methodology change is determined appropriate, it will be addressed in a subsequent waiver amendment or the waiver renewal application.

DMS conducted a review of the ARChoices rate in July 2021. The last rebasing of rates was conducted in January of 2019.

The rates for the ARChoices program are statewide and do not vary by geographic region. The actuarial calculation of rates assumed no geographic adjustment would be required in order to ensure access.

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

Attendant Care - Actuaries under contract with DMS developed a rate per 15 minutes for Attendant Care service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; annual number of hours practitioners are at work; and percentage of time an at-work practitioner is able to convert to billable units (productivity). Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Adult Day Health – Actuaries under contract with DMS developed a rate per 15 minutes for Adult Day Health service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; average number of beneficiaries and hours per beneficiary served each day; and annual number of days of operation. Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Respite (In-Home) - Actuaries under contract with DMS developed a rate per 15 minutes for in-home Respite service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; annual number of hours practitioners are at work; and percentage of time an at-work practitioner is able to convert to billable units (productivity). Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

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

Adult Day Services – Actuaries under contract with DMS developed a rate per 15 minutes for Adult Day Services using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; average number of beneficiaries and hours per beneficiary served each day; and annual number of days of operation. Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

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

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

Prevocational Services – Prevocational services is a fee-for-service rate established and approved by DMS and is equivalent to the rate established for state plan supportive employment services that are services similar to prevocational services. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

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

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver providers bill for the services and are reimbursed directly through the MMIS. *Attendant care and respite service claims must be verified using the Electronic Visit Verification (EVV) system.*

c. Certifying Public Expenditures *(select one)*:

●	**No. State or local government agencies do not certify expenditures for waiver services.**
○	**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

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

~~The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) staff verifies services were provided according to the person-centered service plan through an internal monthly monitoring system. Adjustments are made or referred to the Office of Medicaid Inspector General when claims are paid incorrectly.~~

All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable. *MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim.*

DAABHS and DMS verify services were provided according to the PCSP through an internal monthly case record review as described in Section I-1. Adjustments are made when claims are paid incorrectly and, when fraud, waste or abuse is suspected the case is referred to OMIG. As described in Section I-1, to remove the payments from claims for federal financial participation (FFP), DMS' financial team reports on the CMS-64 that a prior period adjustment is required.

MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DAABHS verifies services were provided according to the PCSP through an internal monthly case record review. Adjustments are made or referred to the OMIG when claims are paid incorrectly and fraud, waste or abuse is suspected. All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable.

All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable. MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DAABHS and DMS verify services were provided according to the PCSP through an internal monthly case record review as described in Section I-1. Adjustments are made when claims are paid incorrectly and, when fraud, waste or abuse is suspected the case is referred to OMIG. As described in Section I-1, to remove the payments from claims for federal financial participation (FFP), DMS' financial team reports on the CMS-64 that a prior period adjustment is required.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

●	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

■ ☐	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
■	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
☐	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.** Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

●	**No. The state does not make supplemental or enhanced payments for waiver services.**
○	**Yes. The state makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

●	**No. State or local government providers do not receive payment for waiver services.** *Do not complete Item I-3-e.*
○	**Yes. State or local government providers receive payment for waiver services.** *Complete item I-3-e.* Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish. *Complete item I-3-e.*

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	**The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**
○	**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○	**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

●	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
○	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

●	**No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
○	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

●	**No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
○	**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

●	**The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
○	**The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.
○	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
○	**This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. *Select at least one:*

■	**Appropriation of State Tax Revenues to the State Medicaid Agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

●	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
○	**Applicable** *Check each that applies:*

☐	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

●	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**
○	**The following source(s) are used.** *Check each that applies.*
	☐ **Health care-related taxes or fees**
	☐ **Provider-related donations**
	☐ **Federal funds**
	For each source of funds indicated above, describe the source of the funds in detail:

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

a. Services Furnished in Residential Settings. *Select one:*

○	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
●	**As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

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

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

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

●	**No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
○	**Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.** The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

●	**No. The state does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

i. Co-Pay Arrangement

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
☐	**Nominal deductible**
☐	**Coinsurance**
☐	**Co-Payment**
☐	**Other charge** *Specify*:

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
○	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

○ ●	**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
○	**Yes**. **The state imposes a premium, enrollment fee or similar cost-sharing arrangement.** Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded~~;~~ and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	11017.53 ~~8504.21~~	12160.00 ~~9666.00~~	23177.53 ~~18170.21~~	69191.00 ~~47580.00~~	2885.00 ~~2520.00~~	72076.00 ~~50100.00~~	48898.47 ~~31929.79~~
2	11056.16 ~~7726.79~~	12470.00 ~~9934.00~~	23526.16 ~~17660.73~~	70921.00 ~~48898.00~~	2959.00 ~~2590.00~~	73880.00 ~~51488.00~~	50353.00 ~~33827.27~~
3	11090.63 ~~8248.90~~	12772.00 ~~10209.00~~	23862.63 ~~18457.90~~	72694.00 ~~50252.00~~	3031.00 ~~2662.00~~	75725.00 ~~52914.00~~	51862.37 ~~34456.10~~
4	11126.47 ~~4704.78~~	13075.00 ~~10492.00~~	24201.47 ~~15196.78~~	74511.00 ~~51664.00~~	3103.00 ~~2735.00~~	77614.00 ~~54379.00~~	53412.53 ~~39182.22~~
5	11161.84 ~~5503.42~~	13386.00 ~~10782.00~~	24475.84 ~~16285.42~~	76374.00 ~~53075.00~~	3177.00 ~~2811.00~~	79551.00 ~~55886.00~~	55003.16 ~~39600.58~~

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:	Level of Care:
		Nursing Facility	
Year 1	11350	11350	
Year 2	11~~350~~425	11~~350~~425	
Year 3	11~~350~~500	11~~350~~500	
Year 4 (only appears if applicable based on Item 1-C)	11~~350~~575	11~~350~~575	
Year 5 (only appears if applicable based on Item 1-C)	11~~3~~650	11~~3~~650	

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

~~Data from the annual reports (CMS-372) for the 2013 reporting year for each of the two existing DAAS 1915(c) waivers which are being replaced with the new ARChoices in Homecare waiver were tabulated to estimate the average length of stay on the waiver.~~

~~A total of 9,374 unduplicated participants were served by the two waivers, with a total of 2,591,698 days of waiver coverage. The average length of stay on the waiver(s) is estimated at 276 days.~~

Data from the annual reports (CMS-372) was tabulated to estimate the average length of stay on the waiver.

The average length of stay was calculated utilizing data from 02/01/2016 through 01/31/2020.

A total of 9,021 unduplicated participants were served, with a total of 2,656,463 days of waiver coverage. The average length of stay on the waiver(s) is estimated at 295 days.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

~~For Waiver Years 1 through 3, historic utilization and cost data from SFYs 2011, 2012 and 2013 were used to derive utilization rates and cost for the elderly in home-based settings (ElderChoices waiver - EC), and adults with physical disabilities in home-based services~~

~~(Alternatives for Adults with Physical Disabilities waiver – AAPD). The utilization rates for the existing EC and AAPD were used to estimate the future utilization of these services for individuals, assuming that the elderly will have similar utilization rates to those found among adults with physical disabilities and vice versa.~~

~~For Waiver Years 4 and 5, the average costs/unit for Adult Day Health, Respite In-Home, Adult Day Services, Personal Emergency Response System (PERS) Unit Monitoring, and Attendant Care Services were modified to reflect the new payment rates to be effective January 1, 2019. The number of users for Adult Day Health was modified to reflect expected use based on experience to date, and the number of users for Attendant Care was modified to reflect changes expected due to the expected transition of service hours to state plan Personal Care services and modifications made to the Attendant Care service definitions. The number of users for the new service of Prevocational Services was projected as 1% of the unduplicated cap, and the average units/user was projected as the maximum number of units permitted for this service under the limits on amount, frequency, and duration identified in Appendix C-1/C-3 for this service.~~

Historical utilization of waiver services and the number of participants is based on data from CY 2019 historical 372 reports from waiver year 2019 and program managers insights. Data runs were conducted from the DSS for years 2019 and 2020. An emphasis was placed on 2019 data to avoid data skewing based on the public health emergency created by COVID-19. For this reason, 2019 was used as the starting point. Program management constructed the current forecast using the current waiver participation and utilization as a starting point. The waiver management team's experience enabled informed adjustments to be made that account for growth and development in the waiver. Given the uncertainly of the last 18 months, the State would like to monitor waiver utilization and propose changes should any adjustment be necessary. Reports are run using MMIS. MMIS provides more up to date data than 372 reports, can be run for time periods requested here, and uses the same data source relied upon by the 372. Cost per unit of services are current rates with any known changes with the exception of Attendant Care and In Home Respite. The cost per unit of these services is based on actuarially determined rate increase.

The State is aware there will be rate changes in the future but is not aware of what the new rates will be. Rates listed are current and will be amended when required.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

~~Weighted average of factor D from historic waivers, less current D, plus historic D prime.~~

Factor D' is based on SFY 2019 utilization and expenditures for Medicaid services outside the waiver utilized by ARChoices participants. ARChoices annual expenditure data was extracted from the decision support system (DSS) component of the MMIS. Quarter two 2021 to quarter one 2026 were taken into consideration when calculating the growth factor. Growth forecast is based on the CMS market basket index and financial leadership's input as discussed in prior correspondence. – a link to the web site where market basket data was accessed follows.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData
Note: Costs associated with ARChoices waiver services are displayed as "D" and not duplicated here.

iii. **Factor G Derivation**. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

~~Weighted average of historic waivers forward to forecast the combined waivers.~~

Factor G is computed based on the average annual expenditures for nursing home recipients with similar demographics and conditions of ARChoices participants. All data was extracted from the decision support system (DSS) component of the MMIS for SFY 2019.

Reports are run using DSS. DSS provides more up to date data than 372 reports, can be run for time periods requested here, and DSS uses the same data source relied upon by the 372. An inflationary factor based the State's anticipated cost in direct SNF care of 2.5% annually was applied.

Growth forecast is based on the CMS market Basket index forecasts Q2 2021 to Q12026. Medicaid economic index data pulled at the time of the original waiver submission. An adjustment was made after discussions with financial leadership. We feel growth in the 2.5% range each year is most likely.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

iv. **Factor G′ Derivation**. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

~~Weighted average of historic waivers forward to forecast the combined waivers.~~
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 with similar demographics of ARChoices recipients and reflects Medicaid services not associated with SNF care. Data was extracted from the decision support system (DSS) component of the MMIS. DSS reports were run for 2019 and 2020 (emphasis on 2019 to avoid data impacts due to the COVID19 driven public health emergency) for the population receiving services the waiver participants would be receiving if the waiver did not exist. Factor G services were identified and removed. With only G' services remaining calculations were done to determine the average per person cost. An inflationary factor based on the market basket forecast was applied. Note: Costs associated with SNF care are displayed in "G" and are not duplicated here. 2019 and 2020 data runs were conducted. An emphasis was placed on 2019 data to avoid data skewing based on the public health emergency created by COVID-19.

Growth forecast is based on the CMS market Basket index forecasts Q2 2021 to Q12026. Medicaid economic index data pulled at the time of the original waiver submission. An adjustment was made after discussions with financial leadership. We feel growth in the 2.5% range is most likely.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

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

Waiver Services	

Adult Day Health	manage components
Respite	manage components
Adult Day Services	manage components
Attendant Care Services	manage components
Environmental Accessibility Adaptations/Adaptive Equipment	manage components
Home-Delivered Meals	manage components
Personal Emergency Response System (PERS)	manage components
Prevocational 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**
Adult Day Health	15 minutes	65 ~~63~~	4713.00 ~~4068~~	$3.14 ~~$3.12~~	**$961923.30** **~~$799,606.08~~**
Respite Total:					**$20508139.68** **~~$6,441,773.60~~**
In Home	15 minutes	2541 ~~1147~~	1574 ~~1228~~	$5.12 ~~$4.50~~	$20477614.08 ~~$6,338,332.00~~
Short-Term Facility-Based	15 minutes	20 ~~75~~	~~890~~ ~~779~~	$1.68	$29904.00 ~~$98,154.00~~
Long-Term Facility-Based	15 minutes	5 ~~10~~	222.00 ~~946~~	$0.56	$621.60 ~~$5,297.60~~
Adult Day Services	15 minutes	234	3721	$2.50	**$1712698.00** **~~$2,176,785.00~~**
Attendant Care Services Total					**$92270100.48** **~~$77,957,590.50~~**
Attendant Care Services	15 minutes	6816 ~~6577~~	2644.00 ~~2291~~	$5.12 ~~$4.50~~	**$92270100.48** ~~$67,805,581.50~~
Environmental Accessibility Adaptations/Adaptive Equipment	Package	~~100~~ ~~172~~	1	$7500 ~~$4,162.00~~	**$750000.00** **~~$715,864.00~~**
Home Delivered Meals	One Meal	4997 ~~5422~~	~~246~~ ~~214~~	$5.97	$7338694.14 **~~$6,927,038.76~~**
Personal Emergency Response System (PERS) Total					$1,492,092.96
PERS Installation	One Installment	938	1	$29.90	$28,046.20
PERS Unit Monitoring	Day	5324	257	$1.07	$1,464,046.76
Prevocational Services Total					**$-**
Prevocational Services – Skill Development	15 minutes	10 ~~0~~	~~120~~ ~~0~~	$6.40	$7680.00~~-~~

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
Prevocational Services – Career Exploration	15 minutes	10 ~~0~~	120 ~~0~~	$6.40	$7680.00~~-~~
GRAND TOTAL:					**125049008.56** **~~$96,522,751.30~~**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					11350
FACTOR D (Divide grand total by number of participants)					$11017.53 ~~$8,504.21~~
AVERAGE LENGTH OF STAY ON THE WAIVER					295 ~~276~~

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
Adult Day Health	15 minutes	67 ~~63~~	4713 ~~4068~~	$3.12~~4~~	**$991520.94** **~~$799,606.08~~**
Respite Total:					**$20608085.28** **~~$6,574,397.60~~**
In Home	15 minutes	2553 ~~1171~~	1574 ~~1228~~	$5.12 ~~$4.50~~	$20574320.64 ~~$6,470,946.00~~
Short-Term Facility-Based	15 minutes	22 ~~75~~	890 ~~779~~	$1.68	$32894.40 ~~$98,154.00~~
Long-Term Facility-Based	15 minutes	7 ~~10~~	222 ~~946~~	$0.56	$870.24 ~~$5,297.60~~
Adult Day Services	15 minutes	202 ~~234~~	3467.00 ~~3721~~	$2.50	**$1750835.00** **~~$2,176,785.00~~**
Attendant Care Services Total					**$93285396.48** **~~$77,957,590.50~~**
Attendant Care Services	15 minutes	6891 ~~6679~~	2644.00 ~~2291~~	$5.12 ~~$4.50~~	**$93285396.48** ~~$68,857,150.50~~
Environmental Accessibility Adaptations/Adaptive Equipment	Package	105 ~~181~~	1	$7500.00 ~~$4,162.00~~	**$787500.00** **~~$753,322.00~~**
Home Delivered Meals	Meal	5022 ~~5505~~	~~246.00~~ ~~214~~	$5.97	**$7375409.64** **~~$7,033,077.90~~**

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**
Personal Emergency Response System (PERS) Total					**$1499452.00** ~~**$1,492,092.96**~~
PERS Installation	One Installment	945 ~~938~~	1	$29.90	$28255.50 ~~$28,046.20~~
PERS Unit Monitoring	Day	5350 ~~5324~~	257	$1.07	$1471196.50 ~~$1,464,046.76~~
Prevocational Services Total					**$18432.00**~~-~~
Prevocational Services – Skill Development	15 minutes	12 ~~0~~	120.00 ~~0~~	$6.40	$9216.00~~-~~
Prevocational Services – Career Exploration	15 minutes	~~12~~ ~~0~~	~~120.00~~ ~~0~~	$6.40	$9216.00~~-~~
GRAND TOTAL:					$126316631.34 ~~$87,698,432.44~~
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					11425 ~~11350~~
FACTOR D (Divide grand total by number of participants)					$11056.16 ~~$7,726.73~~
AVERAGE LENGTH OF STAY ON THE WAIVER					295 ~~276~~

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**
Adult Day Health	15 minutes	69 ~~68~~	4713 ~~4068~~	$3.124	**$1021118.58** **~~$8,630,666.88~~**
Respite Total:					**$20708030.88** **~~$6,707,021.60~~**
In Home	15 minutes	2565 ~~1195~~	1574.00 ~~1228~~	~~$5.12~~ ~~$4.50~~	$20671027.20 ~~$6,603,570.00~~
Short-Term Facility-Based	15 minutes	~~24~~ ~~75~~	890.00 ~~779~~	$1.68	-$35884.80 ~~$98,154.00~~
Long-Term Facility-Based	15 minutes	~~9~~ ~~10~~	~~222.00~~ ~~946~~	$0.56	$1118.88 ~~$5,297.60~~
Adult Day Services	15 minutes	204 ~~239~~	3467 ~~3721~~	$2.47 ~~$2.50~~	$1746951.96 **~~$2,223,297.50~~**
Attendant Care Services Total					-$94300692.48 **~~$74,331,495.00~~**
Attendant Care Services	15 minutes	6966 ~~7210~~	2644.00 ~~2291~~	$5.12 ~~$4.50~~	$94300692.48 ~~$74,331,495.00~~
Environmental Accessibility Adaptations/Adaptive Equipment	Package	~~110~~ ~~203~~	1	$7500.00 ~~$4,162.00~~	$825000.00 **~~$844,886.00~~**
Home Delivered Meals	Meal	5047 ~~5588~~	246 ~~214~~	$5.97	**$7412125.14** **~~$7,139,117.04~~**
Personal Emergency Response System (PERS) Total					$1506811.04 **~~$1,492,092.96~~**
PERS Installation	One Installment	952 ~~938~~	1	$29.90	$28,046.20
PERS Unit Monitoring	Day	5376 ~~5324~~	257	$1.07	$1478346.24 ~~$1,464,046.76~~
Prevocational Services Total					**$-21504.00**
Prevocational Services – Skill Development	15 minutes	14 ~~0~~	120.00 ~~0~~	$6.40 ~~$0.01~~	$-10752.00
Prevocational Services – Career Exploration	15 minutes	14 ~~0~~	120.00 ~~0~~	$6.40 ~~$0.01~~	$-10752.00
GRAND TOTAL:					**$127542234.08** **~~$93,624,997.78~~**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					11500 ~~11350~~

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**
FACTOR D (Divide grand total by number of participants)					$11090.63~~00~~ ~~$8,248.90~~
AVERAGE LENGTH OF STAY ON THE WAIVER					295 ~~276~~

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
Adult Day Health	15 minutes	~~71~~ 77	4713.00 ~~4068~~	$3.14	**$1050716.22** **~~$983,561.04~~**
Respite Total:					**$20807976.48** **~~$7,223,886.80~~**
In Home	15 minutes	2577 ~~1280~~	1574.00 ~~1228~~	$5.12 ~~$4.53~~	$20767733.76 ~~$7,120,435.20~~
Short-Term Facility-Based	15 minutes	26 ~~75~~	890.00 ~~779~~	$1.68	$38875.20 ~~$98,154.00~~
Long-Term Facility-Based	15 minutes	11 ~~10~~	222.00 ~~946~~	$0.56	$1367.52 ~~$5,297.60~~
Adult Day Services	15 minutes	206 ~~255~~	3467.00 ~~3721~~	$2.47	**$1764078.94** **~~$2,343,671.85~~**
Attendant Care Services Total					**$95315988.48** **~~$32,724,720.00~~**
Attendant Care Services	15 minutes	7041 ~~4200~~	2644.00 ~~1720~~	$5.12 ~~$4.53~~	~~$~~**$95315988.48** ~~$32,724,720.00~~
Environmental Accessibility Adaptations/Adaptive Equipment	Package	115 ~~220~~	1	$7500.00 ~~$4,162.00~~	**$862500.00** **~~$915,640.00~~**
Home Delivered Meals	Meal	5072 ~~5815~~	246.00 ~~214~~	$5.97	**$7448840.64** **~~$7,429,127.70~~**
Personal Emergency Response System (PERS) Total					**$1514170.08** **~~$1,495,548.24~~**
PERS Installation	One Installment	959 ~~938~~	1	$29.90	$28674.10 ~~$28,046.20~~
PERS Unit Monitoring	Day	5402 ~~5324~~	257.00 ~~8.45~~	$1.07 ~~$32.62~~	$1485495.98 ~~$1,467,502.04~~
Prevocational Services Total					~~$~~**$24576.00** **~~$283,084.80~~**
Prevocational Services – Skill Development	15 minutes	16 ~~114~~	120.00 ~~268~~	$6.40	$12288.00 ~~$195,532.80~~
Prevocational Services – Career Exploration	15 minutes	~~114~~	120.00 ~~120~~	$6.40	$12288.00 ~~$87,552.00~~
GRAND TOTAL:					$12878846.84 **~~$53,399,240.43~~**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					

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**
					11575 ~~11350~~
FACTOR D (Divide grand total by number of participants)					$11126.47 ~~$4,704.78~~
AVERAGE LENGTH OF STAY ON THE WAIVER					295 ~~276~~

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**
Adult Day Health	15 minutes	~~73~~ 78	~~4713.00~~ 4068	$3.14	**$1080313.86** **~~$996,334.56~~**
Respite Total:					**$20907922.08** **~~$8,030,498.60~~**
In Home	15 minutes	~~2589~~ 1425	1574.00 ~~1228~~	$5.12 ~~$4.53~~	$20864440.32 ~~$7,927,047.00~~
Short-Term Facility-Based	15 minutes	~~28~~ 75	890.00 ~~779~~	$1.68	$41865.60 ~~$98,154.00~~
Long-Term Facility-Based	15 minutes	~~13~~ 10	222.00 ~~946~~	$0.56	$1616.16 ~~$5,297.60~~
Adult Day Services	15 minutes	208 ~~272~~	3467.00 ~~3721~~	$2.47	**$1781205.92** **~~$2,499,916.64~~**
Attendant Care Services Total					**$96331284.48** **~~$40,516,320.00~~**
Attendant Care Services	15 minutes	7116 ~~5200~~	2644.00 ~~1720~~	$5.12 ~~$4.53~~	$40,516,320.00
Environmental Accessibility Adaptations/Adaptive Equipment	Package	120 ~~250~~	1	$7500.00 ~~$4,162.00~~	**$900000.00** **~~$1,040,500.00~~**
Home Delivered Meals	Meal	5097 ~~5950~~	~~246.00~~ ~~214~~	$5.97	**$7485556.14** **~~$7,601,601.00~~**
Personal Emergency Response System (PERS) Total					**$1521529.12** **~~$1,495,548.24~~**
PERS Installation	One Installment	966 ~~938~~	1	$29.90	$28883.40 ~~$28,046.20~~
PERS Unit Monitoring	Day	5428 ~~5324~~	257.00 ~~8.45~~	$1.07 ~~$32.62~~	$1492645.72 ~~$1,467,502.04~~
Prevocational Services Total					$27648.00 **~~$283,084.80~~**
Prevocational Services – Skill Development	15 minutes	18 ~~114~~	120 ~~268~~	$6.40	$13824.00 ~~$195,532.80~~
Prevocational Services – Career Exploration	15 minutes	18 ~~114~~	120	$6.40	$13824.00 ~~$87,552.00~~
GRAND TOTAL:					**$130035459.60** **~~$62,463,803.84~~**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					

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**
					11650 ~~11350~~
FACTOR D (Divide grand total by number of participants)					$11161.84 ~~$5,503.42~~
AVERAGE LENGTH OF STAY ON THE WAIVER					295 ~~276~~

TOC required

201.000 Arkansas Medicaid Certification Requirements for ARChoices HCBS Waiver Program

~~1-1-19~~10-1-~~21~~10-1-22

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

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

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

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

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

201.105 Provider Assurances

~~1-1-19~~10-1-~~21~~10-1-22

A. Agency Staffing

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

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Department of Human Services (DHS)~~, Division of Provider Services and Quality Assurance (DPSQA),~~ requires mandatory training. The provider must attend one of the two provider workshop trainings in the calendar year. “Provider” in this context means at least one provider representative who will be able to inform the rest of the provider staff of what was covered in training. Failure to attend one of these trainings could jeopardize the provider’s licensure and/or ~~/~~certification for the waiver. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to a~~n ARChoices~~ participant~~beneficiary~~.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the participant ~~beneficiary~~ he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:

a. Description of the purpose and philosophy of the ARChoices Waiver pProgram;

b. Discussion and distribution of the provider agency's written code of ethics;

c. Discussion of activities which shall and shall not be performed by the employee;

d. Discussion, including instructions, regarding ARChoices Waiver program record keeping requirements;

e. Discussion of the importance of the PCSP;

f. Discussion of the agency's procedure for reporting changes in the participant'beneficiary's condition;

g. Discussion, including potential legal ramifications, of the participantbeneficiary's right to confidentiality;

h. Discussion of the participantbeneficiary's rights regarding HCBS Settings as discussed in C of this section.

B. Code of Ethics

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

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

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

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

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

HCBS settings must have the following characteristics:

1. Chosen by the individual participant from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
   a. Choice must be identified and included in the PCSP.
   b. Choice must be based on the individual's participant's needs, preferences and, for residential settings, resources available for room and board.

2. Ensures a~~n individual's~~ participant's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, ~~individual~~ participant 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~~ participant choice regarding services and supports and who provides them.
5. The setting is integrated in and supports full access of ~~beneficiaries~~ participants receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.
6. In a provider-owned or controlled residential setting, 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~~ participant receiving services, and the ~~individual~~ participant 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~~ participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
    b. Each ~~individual~~ participant has privacy in their sleeping or living unit:
        i. Units have entrance doors lockable by the ~~individual~~participant, with only appropriate staff having keys to doors.
        ii. ~~Beneficiaries~~ Participants sharing units have a choice of roommates in that setting.
        iii. ~~Beneficiaries~~ Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
    c. ~~Beneficiaries~~ Participants have the freedom and support to control their own schedules and activities and have access to food at any time.
    d. ~~Beneficiaries~~ Participants are able to have visitors of their choosing at any time.
    e. The setting is physically accessible to the ~~individual~~participant.
    f. Any modification of the additional conditions specified in items 6.a. through 6.e. above must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:

        Identify a specific and individualized assessed need.

        i. Document the positive interventions and supports used prior to any modifications to the PCSP.
        ii. Document less intrusive methods of meeting the need that have been tried but did not work.
        iii. Include a clear description of the condition that is directly proportionate to the specific assessed need.
        iv. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
        v. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
        vi. Include the informed consent of the ~~individual~~participant.

vii. Include an assurance that interventions and supports will cause no harm to the ~~individual~~participant.

211.000 Scope

~~1-1-19~~10-1-~~21~~10-1-22

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

A. Attendant Care Services

B. Home-Delivered Meals

C. Personal Emergency Response System

D. Adult Day Services

E. Adult Day Health Services

F. Prevocational Services

G. Respite Care

H. Environmental Accessibility Adaptations/Adaptive Equipment

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

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

Participants who are determined to require skilled level of care as defined by State administrative rule are not eligible for this waiver program. Please see DHS Procedures for Determination of Medical Need for Nursing Home Services as established by the DHS Office of Long Term Care.

212.000 Eligibility for the ARChoices Program

10~~1~~-1-22~~1~~

A. To qualify for the ARChoices Program, a person must ~~be age twenty-one (21) through sixty-four (64) and have been determined to have a physical disability through the Social Security Administration or the Department of Human Services (DHS) Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or be sixty-five (65) years of age or older and require an intermediate level of care in a nursing facility. Persons determined to meet the skilled level of care, as determined by the Office of Long Term Care (OLTC), are not eligible for the ARChoices Program.~~meet the targeted population as described in section 211.000 in this manual and must be found to require an intermediate level of care in a nursing facility.

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

1. Determination of ~~categorical~~ financial eligibility;
2. Determination of ~~financial~~ medical eligibility;
3. Determination of nursing facility level of care;

4. Determination of a Service Budget Limit;

5~~4~~. Development of a person-centered service plan (PCSP);

6~~5~~. Development of an individual services budget (ISB);

7~~6~~. Notification to the ~~beneficiary~~ participant of his or her choice between home- and community-based services and institutional services; and,

8~~7~~. Choice by the ~~beneficiary~~ participant among certified providers.

B. Applicants for participation in the program (or their representatives) must make application for services at the Division of County Operations (DCO) ~~DHS~~ office in the county of their residence or on any electronic format provided by DHS for application through an interactive process. Medicaid eligibility is determined by the ~~DHS Division of County Operations~~DCO~~, the results of the independent assessment, and the Division of Provider Services and Quality Assurance (DPSQA) OLTC Eligibility Specialist and is~~ based on non-medical and medical criteria.~~non-functional and functional criteria. Income and resources comprise the non-functional criteria.~~ The ~~individual~~ participant must be a participant~~n~~ individual with a functional need.

C. Each waiver applicant to the ARChoices program will be assessed by the Independent Assessment Contractor. The independent assessment is performed utilizing the approved assessment instrument to assess functional need.

The approved assessment instrument will recommend tiers designed to help further differentiate participants by need. The tiers do not replace the Level of Care criteria, waiver eligibility determinations, or the PCSP process.

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

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

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

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

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

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

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

~~E. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the PCSP. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment. The tiers are intended to help inform waiver program oversight and administration and person-centered service planning. Tier levels are also a population-based factor used in determining participants' prospective individual services budgets. The tiers do not replace the Level of Care criteria described in Section C above, waiver eligibility determinations, or the person-centered service plan process.~~

1. Tier 0 (zero) and Tier 1 (one) indicate the ~~individual's~~ participant's assessed needs, if any, do not support the need for either ARChoices waiver services or nursing facility services.
2. Tier 2 (two) indicates the ~~individual's~~ participant's assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.
3. Tier 3 (three) indicates the ~~individual~~ participant needs skilled care available through a licensed nursing facility and therefore is not eligible for the ARChoices waiver program.

These indications notwithstanding, the final determination of Level of Care and ~~functional~~ medical eligibility is made by ~~the~~ DCO.~~OLTC.~~

This assessment of functional need is used as part of the process to determine if the person is medically and financially eligible as well in the development of a participant's PCSP. Medical eligibility is valid for twelve (12) months, unless a shorter period is specified.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where it is reported 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, and based on the review of the evaluation, a reassessment may be requested.

D. For more information please see the ARIA Manual.

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

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

G~~H~~. Eligibility for the ARChoices Waiver program begins the date ~~the DHS Division of County Operations~~DCO approves the application ~~unless there is a provisional plan of care~~. ~~(~~(If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.~~)~~) If a participant is moving from a Provider-Led Arkansas Shared Saving Entity (PASSE) to the ARChoices waiver program, the eligibility date will be no earlier than the first day following disenrollment from the PASSE.

H~~I~~. The ARChoices Waiver program provides for the entrance of all eligible persons on a first-come, first-served basis, once ~~beneficiaries~~ participants meet all ~~functional~~ medical and financial eligibility requirements.

~~However, the waiver dictates a maximum number of unduplicated, and active, beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated, or~~

~~active, beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:~~However, once all the waiver slots are filled, a waiting list will be implemented for this program and the following process will apply. Each ARChoices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of their eligibility for services; that all waiver slots are currently filled; and the applicants' ~~is~~ number ~~X~~ in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the ARChoices Waiver Program.

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

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

~~3.~~ Entry to the waiver will then be prioritized based on the following criteria and in the following order:

a. Waiver application determination date for ~~persons~~ participants 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);

d. Waiver application determination date for all other persons.

212.050 Definitions

10~~1~~-1-22~~1~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

M. PCSP means a person-centered service plan.

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

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

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

~~of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.~~

~~1. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.~~

~~2. Intravenous injections and hypodermoclysis or intravenous feedings.~~

~~3. Levin tubes and nasogastric tubes.~~

~~4. Nasopharyngeal and tracheostomy aspiration.~~

~~5. Application of dressings involving prescription medication and aseptic techniques.~~

~~6. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.~~

~~7. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.~~

~~8. Initial phases of a regimen involving administration of medical gases.~~

~~9. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.~~

~~10. Ventilator care and maintenance.~~

~~11. The insertion, removal and maintenance of gastrostomy feeding tubes.~~

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

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

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

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

A. MEDICAL ELIGIBILITY means the level of care needed to receive services through the waiver rather than in an institutional setting considering the participants functional needs. To be determined to meet medical eligibility, an applicant/participant must not require a skilled level of care.

B. APPROVED ASSESSMENT INSTRUMENT means DHS approved the instrument used by registered nurses employed by the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan (PCSP).

C. INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the approved assessment instrument for the purpose of collecting information used in determining level of care and developing the PCSP.

D. 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 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 in conjunction with the participant, at a minimum of every twelve (12) months, to determine continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility.— The evaluation may result in a reassessment being requested if there is evidence of a material change in the medical need of the participant.

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, based on evidence of a material change in medical eligibility documented at the evaluation. 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, is used in the development of the PCSP.

G. DHS ELIGIBILITY NURSE means a registered nurse authorized by DMS to perform reviews of all medical information available and, based on available information, to make a medical eligibility determination and then, if determined financially eligible the application will be approved for ARChoices, DHS eligibility nurses are also responsible for reviewing evaluation documentation for material changes to medical need and requesting a reassessment if warranted

H. DHS Person Centered Service Plan/Care Coordinator (PCSP/CC) NURSE means a registered nurse authorized by DMS to perform evaluations, develop person-centered service plans, and serve as the primary care coordinator and DHS contact for assigned participants.

I. SERVICE BUDGET LIMIT (SBL) means the limit on the maximum dollar amount of waiver services that may be authorized for and received by each specific participant.

J. PANEL means a team of three medical professionals comprising DAABHS nurse supervisory staff and a DHS Eligibility Nurse responsible for the determination of eligibility and LOC. Upon referral, the panel completes a review to determine a change in medical condition that may impact continued medical eligibility. The review may result in a temporary increase in the Service Budget Limit (SBL) for a period of 60 days and a reassessment utilizing the ARIA instrument if the panel determines that there is evidence of a material change in the functional or medical need of the participant which may require an increase in the SBL. Final determination of change in SBL is made by the DCO Eligibility Nurse

K. Temporary LEVEL OF CARE criteria means a temporary increase in SBL approved by the panel.– The PCSP, ISB, and SBL shall be adjusted to provide additional services on a temporary basis within and up to the participant's new SBL. The temporary PCSP, ISB, and SBL will remain in effect for up to 60 calendar days. Before the end of this 60 calendar days period, a reassessment must be completed using the approved assessment instrument and a new SBL determination must be made."

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

212.100 Service Budget Limit (SBL) ~~10-1-21~~**10-1-22**

Definition:

SERVICE BUDGET LIMIT (SBL) means the limit on the maximum dollar amount of waiver services that may be authorized for and received by each specific participant.

Methodology for Determining the SBL:

A. An Independent Assessment Contractor will perform independent assessments that gather functional information about each applicant using the approved instrument. This

assessment is used as part of the process to make a final determination of eligibility and, if the applicant is determined to be eligible, to be used to determine the SBL.

B. For participants, an evaluation is initiated at least every twelve (12) months. Based on the review of the evaluation, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment using the approved instrument. This information is used as part of the process to make a final determination of continued eligibility and, if the participant is determined to be eligible, to be used to determine the SBL.

C. The three SBLs are:

1. Intensive: The participant requires total dependence or extensive assistance from another person in all three (3) areas of mobility, feeding and toileting. The maximum SBL for services is $34,000 annually.
2. Intermediate: The participant requires total dependence or extensive assistance from another person in two (2) of the areas of mobility, feeding and toileting. The maximum SBL for services is $23,000 annually.
3. Preventative: The participant meets the functional need eligibility requirements for ARChoices but does not meet the criteria for the ISB Levels of Intensive or Intermediate. The maximum SBL for services is $6,000 annually.

If the projected cost of services identified in the PCSP is less than the applicable SBL amount, this shall not be construed to permit, suggest, or justify approval, coverage, or reimbursement of different or additional waiver services (including changes in amount, frequency, or duration); coverage and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or other actions to increase spending to use the remaining "unused" portion of the SBL amount.

DHS will monitor and take steps necessary to update these SBL amounts when waiver rates change.

212.200 ~~Prospective Individual Services Budget~~ Individual Services Budget (ISB) ~~10-1-21~~10-1-22

~~A. Individual Services Budget (ISB)~~

~~1. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.~~

~~2. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by the Department of Human Services Registered Nurse (DHS RN) for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.~~

~~3. Each participant's Individual Services Budget shall be explained when the DHS RN consults with the individual on the person-centered service plan. This may be done through written information.~~

~~4. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.~~

~~B. Adjustments, Considerations, and Safeguards Regarding Individual Services Budgets~~

~~1. During the development of each person-centered service plan, after considering the participant's assessed needs, priorities, preferences, goals, and risk factors, and to ensure that the cost of all ARChoices services for each participant does not exceed the applicable Individual Services Budget amount, the DHS RN shall, as necessary~~

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

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

~~2. Should the DHS RN determine that the ARChoices waiver services authorized for the participant within the limit of the applicable Individual Services Budget, other Medicaid or Medicare covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DHS RN shall counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The DHS RN may also order a re-assessment of the participant based upon a change of condition.~~

~~3. In the event that a participant's ISB requires changes or limitations to ARChoices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type, or amount of ARChoices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.) Any such participant-requested changes and substitutions are subject to the following:~~

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

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

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

~~d. The DHS RN determines the changes are reasonable and necessary for the individual and reflected in the approved person-centered service plan.~~

~~4. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. This exceptions process is intended as a safeguard to address exceptional circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated one-time temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:~~

~~a. In the professional opinion of the nurse panel, unique circumstances indicate that additional time is reasonably needed by the participant (or the participant's family on his or her behalf) to (1) adjust waiver service use costs to within the applicable Individual Services Budget (ISB) amount, (2) arrange for the start of or increase in non-Medicaid services (such as informal family~~

supports and Medicare-covered services), or (3) arrange for placement in an alternative residential or facility-based setting.

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

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

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

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

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

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

C. Transition Process

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

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

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

i. Waiver eligibility is re-evaluated;

ii. The Level of Care is reaffirmed or revised;

iii. A new independent assessment or re-assessment is performed;

iv. Expiration, renewal, extension, or revision of the participant's person-centered service plan occurs; or,

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

~~2. For all other ARChoices participants not otherwise identified above, the Individual Services Budget limit shall apply no later than sixty (60) days after the effective date of this waiver amendment.~~

~~3. For the following ARChoices participants, the DAABHS deputy director (or his/her designee) may on a case-by-case basis extend the effective date of the participant's first Individual Services Budget by a maximum of sixty (60) days per participant upon written request of the participant (or legal representative) or the participant's personal physician, if:~~

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

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

~~D. Methodology for Determining Individual Services Budgets~~

~~1. The Individual Services Budget amount for a participant is based upon that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The three (3) ISB Levels are:~~

~~a. Intensive: The participant requires total dependence or extensive assistance from another person in all three (3) areas of mobility, feeding and toileting.~~

~~b. Intermediate: The participant requires total dependence or extensive assistance from another person in two (2) of the area of mobility, feeding and toileting.~~

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

~~2. The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (3) below, is as follows:~~

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

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

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

~~3. For a participant with total waiver expenditures of more than $30,000 for calendar year 2018:~~

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

~~b. In the year following the Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures for calendar year 2019.~~

~~c. For purposes of this subsection (3), "total waiver expenditures" for a calendar year shall be calculated as the sum total of the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:~~

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

~~ii. Excluding amounts expended for environmental accessibility adaptations/adaptive equipment services.~~

~~4. For purposes of determining the projected cost of all waiver services in an individual's person-centered service plan, DAABHS shall assume that:~~

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

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

Individual Service Budget Limit (ISB):

A. Each PCSP shall include an Individual Service Budget (ISB) based upon the determination of Service Budget Limit (SBL) described above. The projected total cost of all authorized services in any PCSP shall not exceed the participant's SBL applicable to the time period covered by the PCSP.

B. For purposes of determining the projected cost of all waiver services in a PCSP, DAABHS shall assume that:

1. The participant will receive or otherwise use all services identified in the PCSP and in their respective maximum authorized amounts, frequencies, and durations; and

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

C. Each participant's ISB and PCSP shall be discussed with the participant.

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

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

F. Adjustments and Considerations Regarding Individual Services Budgets:

1. Process for a Change of Condition within the SBL Level with an increase in ISB: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, steps shall be taken to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition. A face-to-face visit and the task and hours guide shall be completed. If it is determined that the participant may require additional services within the current SBL, the results shall be reviewed with the program supervisor and the supervisor may approve the adjustment of the participant's PCSP and ISB to provide additional services up to the participant's current SBL. If the supervisor approves the additional services, the PCSP and ISB will remain in effect until the participant's next evaluation and determination of eligibility.

2. Process for a Change of Condition with an Increase of SBL Level: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, steps shall be taken to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition. An evaluation and task and hours guide is completed. If it is determined that the participant may be in need of additional services that may require an increase in the participant's SBL, the participant's case will be submitted to the panel for review and approval of temporary increase in SBL. The PCSP, ISB, and SBL will

be adjusted to provide additional services on a temporary basis within and up to the participant's new SBL. The temporary PCSP, ISB, and SBL will remain in effect no longer than 60 calendar days. Before the end of this 60 calendar days period, a reassessment must be completed using the ARIA instrument and a new SBL determination must be made.

3. Process for a Change in Condition with a Decrease in SBL, ISB or Change in Eligibility: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, and which may result in a decrease in the participant's SBL, ISB, or change in eligibility. An evaluation is initiated and provided 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 utilizing the ARIA Instrument. This information is used as part of the process to make a final determination of continued eligibility and, if the participant is determined to be eligible, to be used to determine the

4. Process for Granting an Exception to the $34,000 Maximum SBL: If a waiver participant, physician, family member, Targeted Case manager, or PCSP/CC Nurse requests an exception to the $34,000 maximum SBL due to additional medical or behavioral needs, without which the individual is likely to be institutionalized, steps will be taken to determine if the exception is to be granted. A participant will be granted an exception to the $34,000.00 maximum Service Budget Limit (SBL) if the participant, due to additional medical or behavioral needs, is likely to be institutionalized but for additional waiver services and the cost of the needed additional waiver services exceeds the $34,000 maximum SBL.

   a. The DHS PCSP/CC Nurse will exercise professional medical judgment to make an initial determination of whether the participant may qualify for an exception to the maximum SBL based on:

      i. The participant's evaluation utilizing the DHS-703 Form;

      ii. Other medical records or information pertinent to the participant's needs and documented in the participant's record;

      iii. The participant's physical, mental, or environmental needs observed by the DHS PCSP/CC Nurse and documented in the DHS-703 Form; and

      iv. The participant's preferences, risks, dangers, and supports as documented in the DHS-703 Form.

   b. If the DHS PCSP/CC Nurse makes an initial determination that the beneficiary may qualify for an exception, the DHS PCSP/CC Nurse will calculate the SBL as the sum of the SBL maximum above, plus the cost of the additional waiver services needed to prevent institutionalization. The participant's case will be submitted to the panel for review and approval of temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis for 60 calendar days. During the 60-calendar day temporary increase time period, a reassessment must be completed utilizing the ARIA Instrument and a final determination must be made by the panel based on all information available whether to grant the exception.

   c. The panel shall ensure that:

      i. Any temporary increase granted under this section meets the above criteria; and

      ii. Both temporary increase and exception amounts are determined in an equitable manner across the program, so that participants with comparable needs receive comparable exception amounts

   d. In no case may an exception increase the SBL above the cost of institutionalization as set form in Column 5 of Appendix J-1 Factor G of the CMS-approved ARChoices Waiver.

212.300 Person-Centered Service Plan (PCSP)

~~1-1-19~~10-1-~~21~~10-1-22

A. Each ~~beneficiary~~ participant in the ARChoices Program must have an individualized ~~ARChoices~~ PCSP. The authority to develop a~~n ARChoices~~ PC~~S~~PS is given to the Medicaid State agency's designee, the ~~Department of Human Services Registered Nurse (~~DHS PCPS/CC ~~RN~~Nurse). At the discretion of the ~~beneficiary~~participant, the ~~ARChoices~~ PCSP is developed with the ~~ARChoices beneficiary~~participant, representative, the ~~participant's~~ participant's family or anyone requested by the ~~participant~~participant, including the provider, if requested by the ~~beneficiary~~participant. At the request of the ~~beneficiary~~ participant or their representative, the ~~DHS RN~~ PCSP/CC Nurse can assist in coordinating and inviting any requested ~~beneficiaries~~parties.

B. When developing the waiver PCSP, the ~~beneficiary~~ participant may freely choose a family member or individual to appoint as a representative. The ~~beneficiary~~ participant and representative may participate in all decisions regarding the types, amount and frequency of services included in the PCSP. The representative may participate in choosing the provider(s) for the ~~beneficiary~~participant. If anyone other than the ~~beneficiary~~ participant chooses the provider, the ~~DHS RN~~ PCSP/CC Nurse will identify that individual on the PCSP. Should the self-directed service delivery model be selected by an individual other than the ~~beneficiary~~participant, that individual may not be the paid employee.

C. The ~~ARChoices~~ PCSP developed by the DHS PCPS/CC ~~RN~~ Nurse includes, but is not limited to:

1. ~~Beneficiary~~ Participant identification and contact information, including full name and address, phone number, date of birth, and Medicaid number~~ and the effective date of ARChoices Waiver eligibility~~;
2. Contact person;
3. Physician's name and address;
4. The amount, frequency and duration of authorized~~ARChoices~~ w~~W~~aiver services to be provided and the name of the service provider chosen by the ~~beneficiary~~ participant or representative to provide the services.

   ~~NOTE: Attendant Care, Respite Care and State Plan Personal Care hours are authorized based on the number of hours calculated by application of the Arkansas Medicaid Task and Hour Standards (THS) which is described below in Section D. Attendant Care, Respite Care and State Plan Personal Care hours are authorized in a monthly amount in the waiver PCSP. The beneficiary's chosen, Medicaid-certified provider is responsible for properly delivering Attendant Care, Respite Care and State Plan Personal Care services to support the needed activity of daily living (ADL) and instrumental activity of daily living (IADL) tasks, consistent with the approved PCSP, this manual and other applicable Arkansas Medicaid policy.~~
5. Other services outside the ~~ARChoices~~ waiver services, regardless of payment source, identified and/or ordered to meet the ~~beneficiary's~~ participant's needs including the option for the self-directed service delivery model;
6. The election of community services by the waiver ~~beneficiary~~ participant or representative;
7. The name and title of the DHS ~~RN~~ PCSP/CC Nurse responsible for the development of the ~~beneficiary's~~ participant's PCSP; and~~,~~
8. The individual services budget for the participant within the Service Budget Limit.

D. Task and Hour Standards (THS):

1. Background on THS

The Arkansas Medicaid Task and Hour Standards (THS) is the written methodology used by DHS ~~RNs~~ PCSP/CC ~~NURSEs~~Nurses as the basis for calculating the number of Attendant Care, Respite Care and State Plan Personal Care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks. The THS provides a standardized process for calculating the amount of reasonable, medically necessary Attendant Care, Respite Care, and State Plan Personal Care services hours, with the minute ranges and frequencies providing DHS nurses with the ability to adjust PCSPs based on unique factors related to a given participant's needs, preferences, and risks.

The current Division of Aging, Adult and Behavioral Health Services (DAABHS)-approved **THS** is located on the web. ~~at [insert website address]~~

The number of Attendant Care, Respite Care, and State Plan Personal Care hours/minutes that are authorized for each necessary task by week/month are calculated by the PCSP/CC Nurse consistent with the THS grid and based on:

a. Responses by the participant and their representatives to certain relevant questions in the approved assessment instrument or the annual evaluation conducted by the PCSP/CC Nurse, and

b. As appropriate, information obtained by the PCSP/CC Nurse during their PCSP meeting with the participant and participant's representatives or from participant's physician.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

The Arkansas THS is also used to calculate the reasonable quantity of hours to perform medically necessary tasks covered under Independent Choices self-directed personal assistance or State Plan personal care services for adults aged 21 or older.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the independent assessments; annual DHS nurse evaluations; electronic visit verification system; DMS audits of providers; and participant and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

2. The THS includes the following four components, described in a grid format:

a. The participant's Needs Intensity Score (0, 1, 2, or 3) for each task: ~~;~~

For each task, the DHS nurse will assign a Needs Intensity Score to the participant. The four Impairment Scores are defined as follows:

1. Needs Intensity Score 0 – The participant has no functional impairment with regard to the task and can perform it without assistance.
2. Needs Intensity Score 1 – (Mild): Minimal/mild functional impairment. The participant is able to conduct activities with minimal difficulty and need minimal assistance.
3. Needs Intensity Score 2 – (Severe): Extensive/severe functional impairment. The participant has extensive difficulty carrying out activities and needs extensive assistance.
4. Needs Intensity Score 3 – (Total): The participant is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the approved system.

b. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs

Intensity Score:

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The PCSP/CC Nurse preparing the PCSP will determine the number of minutes within the range that are appropriate for the participant based on conditions specific to the participant. For example, if a participant has cognitive or behavioral issues, the PCSP/CC Nurse may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a participant who is bald.

If the participant has extenuating circumstances and requires time outside the range (either more or less) for the task, the PCSP/CC Nurse must obtain supervisory approval. For supervisory approval, the PCSP/CC Nurse must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed medical needs and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the PCSP.

c. The frequency with which a task is necessary and reasonably performed:

The THS methodology considers the frequency with which each ADL and IADL is performed and reasonably necessary.

d. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

ARChoices does not cover assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then attendant care is not necessary and no time for that task is included in the PCSP. When another source is available to provide assistance with a needed ADL or IADL task, the time associated with the assistance from that other source is deducted from the total minutes per week.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task. For example, the participant's daughter may bathe her mother once a week and prepare all meals on weekends, eliminating the need for an attendant care aide to perform those tasks. For this participant, the total minutes per week for the tasks of bathing and meal preparation would be adjusted by the minutes associated with an aide assisting with one bath and six meals per week.

3. Calculation of total hours of attendant care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of attendant care hours approved for the participant for a month. The projected total cost of attendant care

plus all other authorized services in the PCSP shall not exceed the participant's Individual Services Budget applicable to the time period covered by the PCSP.

~~The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;~~

~~The frequency with which a task is necessary and reasonably performed; and,~~

~~The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.~~

~~The THS provides a standardized process for calculating the amount of reasonable, medically necessary Attendant Care, Respite Care and State Plan Personal Care services hours, with the minute ranges and frequencies providing DHS nurses with the ability to adjust PCSPs based on unique factors related to a given beneficiary's needs, preferences, and risks.~~

~~The number of Attendant Care, Respite Care and State Plan Personal Care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN consistent with the THS grid and based on:~~

~~Responses by the participant and their representatives to certain relevant questions in the ARIA assessment instrument, and~~

~~As appropriate, information obtained by the DHS RN during their PCSP meeting with the participant and participant's representatives or from participant's physician.~~

~~The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.~~

~~The Arkansas THS is also used to calculate the reasonable quantity of hours to perform medically necessary tasks covered under Independent Choices self-directed personal assistance or State Plan personal care services for adults aged 21 or older.~~

~~DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.~~

~~**2. Needs Intensity Score**~~

~~For each task, the DHS RN will assign a Needs Intensity Score to the participant based on the participant's and/or representative's responses to questions during the ARIA assessment and information collected by the DHS RN during the PCSP meeting with the participant. The four Impairment Scores are defined as follows:~~

~~Needs Intensity Score 0 – The participant has no functional impairment with regard to the task and can perform it without assistance.~~

~~Needs Intensity Score 1 – (Mild): Minimal/mild functional impairment. The participant is able to conduct activities with minimal difficulty and need minimal assistance.~~

~~Needs Intensity Score 2 – (Severe): Extensive/severe functional impairment. The participant has extensive difficulty carrying out activities and needs extensive assistance.~~

~~Needs Intensity Score 3 – (Total): The participant is completely unable to carry out any part of the activity.~~

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

3. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN preparing the PCSP will determine the number of minutes within the range that are appropriate for the participant based on conditions specific to the participant. For example, if a participant has cognitive or behavioral issues, the DHS RN may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a participant who is bald.

If the participant has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN must obtain supervisory approval. For supervisory approval, the DHS RN must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the PCSP.

4. The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information collected by the DHS RN during the PCSP meeting with the participant.

5. The amount of assistance with ADLs and IADLs provided by other sources

ARChoices does not cover assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then ARChoices attendant care is not necessary and no time for that task is included in the PCSP. When another source is available to provide assistance with a needed ADL or IADL task, the time associated with the assistance from that other source is deducted from the total minutes per week.

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information gathered by the DHS RN during the PCSP meeting with the participant.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task. For example, the participant's daughter may bathe her mother once a week and prepare all meals on weekends, eliminating the need for an attendant care aide to perform those tasks. For this participant, the total minutes per week for the tasks of bathing and meal preparation would be adjusted by the minutes associated with an aide assisting with one bath and six meals per week.

6. Calculation of total hours of attendant care per month

~~The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of attendant care hours approved for the participant for a month.~~ ~~**The projected total cost of attendant care plus all other authorized services in the PCSP (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.**~~

E. If waiver eligibility is approved by ~~the DHS Division of County Operations~~DCO after a review of financial documentation and either the independent assessment performed by the contractor or the annual evaluation as performed by the PCSP/CC Nurse, a copy of the PCSP signed by the DHS ~~RN~~ PCSP/CC Nurse and the waiver ~~beneficiary~~ participant or representative, will be forwarded to the ~~beneficiary~~ participant or representative and the Medicaid enrolled service provider(s) included in the PCSP. The service provider and the ~~ARChoices beneficiary~~ participant must review and follow the signed authorized PCSP. Services cannot begin until the Medicaid provider receives the authorized PCSP from the ~~DHS RN~~PCSP/CC Nurse. The original PCSP will be maintained by the DHS ~~RN~~PCSP/CC Nurse.

The implementation of the PCSP by a provider must ensure that services are:

1. Individualized to the ~~beneficiary's~~ participant'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~~ participant's welfare;
4. Monitored and adjusted as needed, based on changes authorized and reported by the DHS ~~RN~~ PCSP/CC Nurse regarding the waiver PCSP;
5. Provided within a system that safeguards the ~~beneficiary's~~ participant's rights to quality services as authorized on the waiver PCSP; and~~,~~
6. Documented carefully, with assurance that required information is recorded and maintained.

NOTE: Each service included on the ARChoices PCSP must be justified by the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse. This justification is based on medical necessity, the ~~beneficiary's~~ participant's physical, cognitive and functional status, other support services available to the ~~beneficiary~~ participant and other factors deemed appropriate by the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse.

Each ~~ARChoices~~ individual service must be provided according to the ~~beneficiary~~ participant's PCSP. For services included in the waiver PCSP, Medicaid reimbursement is limited to the amount and frequency that is authorized in the PCSP, subject to the ~~participant's~~ participant's individual services budget. As detailed in the Medicaid Program provider ~~contract~~agreement, providers may bill only after services are provided. Service are not compensable unless there is a valid and current PCSP in effect on the date of service.

~~NOTE: PCSPs are updated annually by the DHS RN and sent to the ARChoices provider prior to the expiration of the current PCSP. However, the provider has the responsibility for monitoring the PCSP expiration date and ensuring that services are delivered according to a valid PCSP. At least 30 and no more than 45 days before the expiration of each PCSP, the provider shall notify the DHS RN via email and copy the RN supervisor of the PCSP expiration date.~~

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

~~**REVISIONS TO A BENEFICIARY PCSP MAY ONLY BE MADE BY THE DHS RN.**~~

~~NOTE: All revisions to the waiver PCSP must be authorized by the DHS RN. A revised PCSP will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on an ARChoices PCSP, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the ARChoices PCSP are subject to recoupment.~~

~~All revisions to the PCSP must be consistent with and not exceed participant's updated individual services budget.~~

212.305 Targeted Case Management Services (Non-Waiver Service) ~~1-1-19~~10-1-~~2~~10-1-22

Each ~~ARChoices Person-Centered Service Plan (~~PCSP~~)~~ will include Targeted Case Management, unless refused by the waiver ~~beneficiary~~participant. The Targeted Case Manager is responsible for monitoring the ~~beneficiary's~~ participant's status on a regular basis for changes in their service need, referring the ~~beneficiary~~ participant for reassessment, if necessary, and reporting any ~~beneficiary~~ participant complaints and changes in status to the ~~Department of Human Services Registered Nurse(DHS RN~~PCSP/CC Nurse~~)~~ or ~~Nurse Manager~~DAABHS supervisory staff immediately upon learning of the change.

~~**NOTE: As stated in this manual, the service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Each service included on the ARChoices PCSP must be justified by the DHS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DHS RN.**~~

~~**For ARChoices beneficiaries whose waiver PCSP includes TCM at the time the DHS RN signs the PCSP, the ARChoices PCSP, signed by a DHS RN, will serve as the authorization for TCM services for one year from the date of the DHS RN's signature, as described above.**~~

~~212.310 Provisional Person-Centered Service Plan (PCSP)~~ ~~1-1-19~~

~~The ARChoices registered nurse (DHS RN) may develop a provisional PCSP prior to establishment of Medicaid eligibility, based on information obtained during the in-home functional assessments administered by the Independent Assessment Contractor and the DHS RN, when recommending functional approval based on the nursing home criteria. The DHS RN must discuss the provisional PCSP policy and have the approval of the applicant prior to completing and processing the provisional PCSP. The PCSP will be developed by the applicant and the DHS RN and signed by the applicant or the applicant's representative and the DHS RN.~~

~~The provisional PCSP will include all current PCSP information, except for the waiver eligibility date and the Medicaid beneficiary ID number.~~

~~The provisional PCSP will be mailed to the waiver applicant and each provider included on the PCSP. If the beneficiary and the provider accept the risk of ineligibility, the provider must begin services within an established time frame as determined by the Division of Aging, Adult and Behavioral Health Services (DAABHS) and notify the DHS RN, via Start Services form AAS-9510, that services have started. The DHS RN will track the start of care dates and give the applicant options when services are not started.~~

~~The provisional PCSP will expire 60 days from the date signed by the applicant and the DHS RN. A PCSP that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional PCSP.~~

~~A. A provisional PCSP may be developed and sent to providers only when the assessment outcome indicates functional eligibility and the DPSQA Office of Long Term Care determines based on the results of the ARIA assessment, that the applicant meets the level of care criteria for an adult with a functional need, as explained in Section 212.000, Eligibility for the ARChoices Program.~~

~~The waiver eligibility date will be established retroactively, effective on the day the provisional PCSP was signed by the applicant or applicant's representative and the DHS RN, if:~~

~~1. At least one waiver service begins within 30 days of the development of the provisional PCSP~~

~~AND~~

~~2. The waiver application is approved by the Division of County Operations.~~

~~B. If waiver services begin within 31 through 60 days of the development of the provisional PCSP, the retroactive eligibility date will be the effective date that a waiver service is started.~~

~~C. If waiver services do not begin within sixty (60) days from the date the provisional PCSP is signed by the DHS RN, the Division of County Operations will establish the waiver eligibility date as the date the application is entered into the system as an approved application. There will be no retroactive eligibility.~~

~~D. Provisional PCSPs are subject to the participant's individual services budget.~~

~~E. Provisional PCSPs may not include the non-waiver self-directed service delivery model~~

~~212.311 Denied Eligibility Application~~ ~~1-1-19~~

~~A. If the DHS Division of County Operations denies the Medicaid eligibility application for any reason, Medicaid and waiver services provided during a period of ineligibility will be the financial responsibility of the applicant. The DHS Division of County Operations will notify the DHS RN. The DHS RN will notify the providers via form AAS-9511 immediately upon learning of the denial. Reasons for denial include but are not limited to:~~

~~1. Failure to meet the nursing home admission criteria~~

~~2. Failure to meet financial eligibility criteria~~

~~3. Withdrawal of the application by the applicant~~

~~4. Death of the applicant when no waiver services were provided~~

~~NOTE: If waiver services were provided and the applicant dies prior to approval of the application, waiver eligibility will begin (if all other eligibility requirements are met) on the date waiver service(s) began and end on the date of death.~~

~~B. The applicant has the right to appeal by filing for a fair hearing. When an appeal ruling is made in favor of the applicant, the actions to be taken by the DHS Division of County Operations are as follows:~~

~~1. If the individual has no unpaid ARChoices Waiver charges, Medicaid coverage will begin on the date of the appeal decision. However, the waiver portion of the case will not be approved until the date the DHS Division of County Operations completes the case.~~

~~2. If the individual has unpaid waiver charges and services were authorized by the DHS RN, eligibility for both Medicaid and waiver services will begin on the date service began unless the hearing decision sets a begin date.~~

~~NOTE: Under no circumstances will waiver eligibility begin prior to the date of application or the date the provisional PCSP is signed by the DHS RN and the applicant or the applicant's representative, whichever is later.~~

212.312 Comprehensive Person-Centered Service Plan (PCSP)

~~10-1-2110-1-221-1-21~~

~~Prior to the expiration date of the provisional PCSP, the DHS RN~~ The comprehensive PCSP will ~~send the comprehensive PCSP to~~ be sent the waiver ~~beneficiary~~ participant to and all providers

included on the PCSP after completion thereof. ~~The comprehensive PCSP will replace the provisional PCSP. The comprehensive PCSP will include the Medicaid beneficiary ID number, the waiver eligibility date established according to policy and the comprehensive PCSP expiration date.~~

The comprehensive PCSP expiration date will be ~~three hundred sixty-five (365) days~~ twelve (12) months from the earliest date of approval by DCO of medical and/or financial ~~the DHS RN's signature on form AAS-9503, the ARChoices PCSP~~eligibility. ~~Once the renewal is either approved or denied by the DHS Division of County Operations the providers will be notified by the DHS RN. The notification for the approval will be in writing via a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.~~

Prior to the expiration of the ~~three hundred sixty-five (365) days~~twelve (12) months, financial and ~~functional~~ medical eligibility will be reviewed. ~~for renewal of the PCSP. Functional eligibility will be determined by an evaluation done by the DHS RN.~~

The DHS-703 form (Evaluation of Medical Need Criteria) is used at a minimum of every 12 months, or more frequently based on reported changes in medical condition, by registered nurses employed by the Division of Aging, Adult and Behavioral Health Services to determine continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility.

If there is evidence of a change in medical condition that may impact continued medical eligibility, based on the evaluation completed using the DHS-703 form, a referral may be made for an independent assessment utilizing the ARIA instrument. The information collected through the reassessment process, utilizing the ARIA instrument along with the tier determination, and any additional information are utilized by registered nurses within the Division of County Operations to evaluate whether the individual continues to meet the states level of care criteria and to determine any changes to the level of care. No change in level of care will occur without the use of the approved assessment instrument.

212.313 ARChoices Applicants Leaving an Institution

~~1-1-19~~10-1-~~2~~10-1-22

~~The policy regarding retroactive eligibility applies to applicants entering the waiver program from the community and to applicants entering the program from an institution. The same process and the same policy determining the waiver eligibility date will apply to applications of each type.~~

~~**EXCEPTION:**~~ No waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if ~~a provisional~~eligibility is determined and the PCSP is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest waiver eligibility date will be the day the applicant is discharged from the facility.

~~**NOTE: For inpatients, if a waiver application is filed at the local DHS Division of County Operations prior to discharge AND if a provisional PCSP is developed by the DHS RN prior to discharge, it may be possible to establish retroactive eligibility back to the date the applicant returned to his or her home if the applicant is ultimately found eligible for the program. (Note: Medicaid beneficiaries in nursing facilities do not have to complete a new application when applying for ARChoices. Their signature on the PCSP electing waiver services serves as the application.)**~~

~~**If no waiver application is filed and no functional assessment or provisional PCSP is completed by the Independent Assessment Contractor and DHS RN prior to an applicant's discharge from an institution, retroactive eligibility will not be possible back to the date the applicant returned to his home.**~~

~~**Functional assessments and PCSPs may be completed during a period of institutionalization; however, a discharge date must be scheduled. Since the purpose of the assessment and the PCSP is to depict the applicant's condition**~~

~~and needs in the home, premature assessments and PCSP development do not meet the intent of the program.~~

This policy applies to applicants leaving hospitals or nursing facilities.

~~212.314 Optional Participation~~ ~~1-1-16~~

~~Neither waiver providers nor waiver applicants are required to begin or receive services prior to an eligibility determination by the Division of County Operations. When services are started based on the receipt of a provisional PCSP, it is the responsibility of each provider to explain the process and financial liability to the applicant and/or representative **prior to beginning services**. The decision to begin services prior to an eligibility determination must be a joint decision between the provider and the applicant, both of whom must understand the financial liability of the applicant if eligibility is not established.~~

~~NOTE: Regardless of the reason for the denial and regardless of when a new waiver application may be filed, a provisional PCSP will only be utilized on a current waiver application. Once an application is denied, a new provisional PCSP must be developed if a subsequent waiver application is filed.~~

212.320 Authorization ~~o~~Of ~~The ARChoices~~the Person-Centered Service Plan (PCSP) with Personal Care Services ~~1-1-19~~10-1-~~21~~10-1-22

The following applies to ~~individuals~~ participants receiving both personal care services and ~~ARChoices~~ waiver services.

A. The DHS ~~RN~~ PCSP/CC Nurse is responsible for developing ~~an ARChoices~~a PCSP that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DHS ~~RN~~ PCSP/CC Nurse authorizing the services.

B. PCSP developed on or after the effective date of this Provider Manual may not include attendant care services unless the PCSP provides for at least 64 hours per month of personal care services. Attendant care services are intended to supplement personal care services available under the Medicaid state plan.

C. The ~~ARChoices~~ PCSP signed by the DHS ~~RN~~ PCSP/CC Nurse will suffice as the "Personal Care Authorization" for services required in the Personal Care Program~~. The PCSP developed by the personal care provider is still required.~~.

The responsibility of developing a personal care service plan is not placed with the PCSP/CC Nurse. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

D. ~~-~~ For ARChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the~~–~~ PCSP, signed by a~~–~~ PCSP/CC Nurse will serve as the authorization for personal care services for up to one year from the date of the PCSP/CC Nurse~~–~~ signature.

~~The responsibility of developing a personal care service plan is not placed with the DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.~~

~~NOTE: For ARChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a DHS RN, will serve as the authorization for personal care services for one year from the date of the DHS RN's signature, as described above.~~

~~D. The ARChoices PCSP is effective for one (1) year, once signed by the DHS RN.~~

212.323 Medicaid Audit Requirements 10-1-22

When the Medicaid Program, as authorized by the PCSP, reimburses for personal care services, all Medicaid audits will be performed based on that authorization. Therefore, all documentation by the personal care provider must tie services rendered to authorized services as reflected on the PCSP.

212.400 Temporary Absences from the Home ~~1-1-19~~10-1-~~21~~10-1-22

Once an ARChoices eligibility application has been approved, waiver services must be provided in a home and community-based services setting for eligibility to continue. Unless stated otherwise below, the ~~DHS Division of County Operations~~DCO must be notified immediately by the DHS ~~RN~~ PCSP/CC Nurse when waiver services are discontinued and action will be initiated by ~~the DHS Division of County Operations~~DCO to close the waiver case. Providers will be notified by the ~~DHS RN~~PCSP/CC Nurse.

A. Absence from the Home due to Institutionalization

A participant~~n individual~~ cannot receive ~~ARChoices W~~waiver services while in an institution. The following policy applies to any inpatient stay where Medicaid pays the facility for the date of admission, i.e., hospitals, nursing homes, rehab facilities, etc., for active waiver cases when the ~~beneficiary~~ participant is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver ~~beneficiary~~ participant is admitted to a hospital, ~~the DHS Division of County Operations~~DCO will not take action to close the waiver case unless the ~~beneficiary~~ participant does not return home within 30 days from the date of admission. If, after 30 days, the ~~beneficiary~~ participant has not returned home, the ~~DHS RN~~ PCSP/CC Nurse will notify ~~the DHS Division of County Operations~~DCO and action will be initiated to close the waiver case.
2. If ~~the DHS Division of County Operations~~DCO becomes aware that a ~~beneficiary~~ participant has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of the admission, but the Medicaid case will be left open. When the ~~beneficiary~~ participant returns home, the waiver case may be reopened effective the date the ~~beneficiary~~ participant returns home. A new assessment and medical eligibility determination will not be required unless a change of condition is determined requiring a change in SBL.

~~NOTE:~~ Nursing facility admissions, when referenced in this section, do not include ARChoices ~~beneficiaries~~ participants admitted to a nursing facility to receive facility-based respite services.

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

~~Payment for ARChoices services may be allowed for the date of a beneficiary's admission to an inpatient facility if the provider can provide verification that services were provided before the beneficiary was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:~~

- ~~Copies of claim forms or timesheets listing the times that services were provided~~
- ~~A statement from the inpatient facility showing the time that the beneficiary was admitted~~

- ~~This information must be submitted to DAABHS within 10 working days of receiving a request for verification.~~

~~If providers are unable to provide proof that ARChoices services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. ARChoices services provided on the same day the beneficiary is discharged from the inpatient facility are billable when provided according to policy and after the beneficiary was discharged.~~

B. Absence due to Reasons Other than Institutionalization

When a waiver ~~beneficiary~~ participant is absent from the home for reasons other than institutionalization, ~~the DHS Division of County Operations~~DCO will not be notified unless the ~~beneficiary~~ participant does not return home within 30 days. If, after 30 days, the ~~beneficiary~~ participant has not returned home and the providers can no longer deliver services as authorized on the ~~Person-Centered Service Plan (~~PCSP~~)~~ (e.g., the ~~beneficiary~~ participant has left the state and the return date is unknown), the ~~DHS RN~~ PCSP/CC Nurse will notify ~~the DHS Division of County Operations~~DCO. Action will be taken by the DHS Division of County Operations to close the waiver case.

NOTE: It is the responsibility of the provider to notify the ~~DHS RN~~ PCSP/CC Nurse immediately via form AAS-9511 upon learning of a change in the ~~beneficiary's~~ participant's status.

212.500 Reporting Changes in ~~Beneficiary's~~ Participant's Status

~~10-1-21~~10-1-22~~1-1-21~~

Because the provider has more frequent contact with the ~~beneficiary~~participant, many times the provider becomes aware of changes in the ~~beneficiary's~~ participant's status sooner than ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse or Targeted Case Manager. It is the provider's responsibility to report these changes immediately so proper action may be taken. Providers must complete the Waiver Provider Communication – Change of ~~Participant~~ Participant Status Form (AAS-9511) and send it to the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse. A copy must be retained in the provider's ~~beneficiary~~ participant case record. Regardless of whether the change may result in action by ~~the DHS Division of County Operations~~DCO, providers must immediately report all changes in the ~~beneficiary's~~ participant's status to the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse.

The Targeted Case Manager is responsible for monitoring the ~~beneficiary's~~ participant's status on a regular basis for changes in service need, referring the ~~beneficiary~~ participant for evaluation of any ~~beneficiary~~ participant complaints or change of condition to the ~~DHS RN~~PCSP/CC Nurse, or DHS ~~RN~~ Nurse Supervisor immediately upon learning of the change. The ~~DHS RN~~ PCSP/CC nurse will take steps to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition.~~a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RNs evaluation of the beneficiary.~~

212.600 Relatives Providing ARChoices Services

~~1-1-19~~10-1-~~21~~10-1-22

~~All~~ ARChoices services may be provided by a ~~beneficiary's~~ participant's relative, unless stated otherwise in this manual.

For the purposes of this section, a relative or family member shall be defined as all persons related to the ~~beneficiary~~ participant by virtue of blood, marriage, or adoption.

The following is applicable for all waiver services:

A. Under no circumstances may Medicaid payment be made for any waiver service rendered by the waiver ~~beneficiary's~~participant's:

1. Spouse

2. Legal guardian of the person

3. Attorney-in-fact granted authority to direct the ~~beneficiary's~~ participant's care

B. All providers, including relatives, are required to meet all ARChoices provider licensure and/or certification requirements, Arkansas Medicaid enrollment requirements and provide services according to the ~~beneficiary's~~ participant's PCSP and any established benefit limits for that specific service.

213.210 Attendant Care Services

~~1-1-19~~10-1-~~21~~10-1-22

Procedure Code	Modifier	Description
S5125	U2	Attendant Care Services
S5125		Attendant Care Self-Directed Model

Attendant Care services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible ~~beneficiary's~~ participant's functioning in his or her own home or elsewhere in the community where the ~~beneficiary~~ participant engages in activities, including work-related activities. Attendant Care services may be provided in a ~~beneficiary's~~ participant's home or while accompanying the ~~beneficiary~~ participant to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in section 213.220.

Attendant Care services consists of assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks through hands-on assistance, supervision and/ or cueing.

Hands-on assistance, supervision and/or cueing are defined as:

A. "Hands-on assistance" means a provider physically performs all or part of an activity because the ~~individual~~ participant is unable to do so.

B. "Set-up", a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an ~~individual~~ participant can perform an activity.

C. “Supervision” means a provider must be near the ~~individual~~ participant to observe how the ~~individual~~ participant is completing a task.

D. “Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the ~~individual~~ participant complete activities without hands-on assistance.

E. "Monitoring", ~~,~~ a form of supervision, means a provider must observe the ~~individual~~ participant to determine if intervention is needed.

F. “Stand-by", ~~,~~ a form of supervision, means a provider must be at the side of a~~n~~ ~~individual~~ participant ~~,~~ ready to step in and take over the task should the ~~individual~~ participant be unable to complete the task independently.

G. "Support", ~~,~~ a form of supervision, means to enhance the environment to enable the ~~individual~~ participant to be as independent as possible.

H. The following forms of assistance combine elements of Hands-on assistance, supervision and/or cueing:

I. "Redirection”, a form of supervision or cueing, means to divert the ~~individual~~ participant to another more appropriate activity.

J. "Memory care support", a blend of supervision, cueing and hands-on assistance. Includes services related to observing behaviors, supervision and intervening as appropriate in order to safeguard the service ~~beneficiary~~ participant against injury, hazard or accident. These specific supports are designed to support ~~beneficiaries~~ participants with cognitive impairments.

Activities of daily living include:

A. Eating

B. Bathing

C. Dressing

D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, menstrual hygiene, etc.)

E. Toileting

F. Mobility/ambulating, including functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

A. Meal planning and preparation consumed only by the ~~participant~~participant

B. Laundry for the ~~participant~~ participant or incidental to the ~~participant's~~ participant's care

C. Shopping for food, clothing and other essential items required specifically for the health and maintenance of the ~~participants~~participants

D. Housekeeping (cleaning of furniture, floors and areas directly used by the participant)

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

Health-related tasks are limited to the following activities:

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

B. Additional assistance with self-administration of prescribed medications, and/or

C. Emptying and replacing colostomy and ostomy bags.

Health-related tasks must be:

A. Consistent with all applicable State scope of practice laws and regulations;

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

C. For the care and safety of the ~~participant~~participant, do not require monitoring or supervision of the attendant by a licensed physician, nurse, or therapist;

D. Necessary to meet specific needs of the ~~participant~~ participant consistent with a written plan of care by a physician or registered nurse; and

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

The provision of assistance with ADLs, IADLs or health-related tasks does not entail nursing care.

Attendant care services tasks must be:

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

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

C. Expressly authorized in the ~~individual's~~ participant's person-centered service plan;

D. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services;

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

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

Attendant care services exclude all of the following:

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

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

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

D. Companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);

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

F. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

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

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

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

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

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

The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the ~~beneficiary~~ participant in accordance with the Arkansas Medicaid Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, month, and year. Any aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the ~~beneficiary~~ participant in accordance with the THS specifications are not covered.

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

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

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

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

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

D. When attendant care services delivered through a home health agency or private care agency are provided by the waiver ~~beneficiary's~~ participant's (i) spouse, (ii) legal guardian of the person; or (iii) attorney-in-fact granted authority to direct the ~~beneficiary's~~ participant's care;

E. On dates of service when the ~~participant~~participant:

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

2. Receives targeted or other supplemental benefits from a Medicare Advantage plan of any kind, where such supplemental services are reasonably comparable to or

duplicative of attendant care services, personal care services, or self-directed personal assistance;

3. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse;

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

5. Receives services from an inpatient hospital, nursing facility, assisted living facility, hospice facility, or residential care facility, unless approved in writing by a ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse as reasonable and necessary given the time of day of the facility admission or discharge, the need for transition assistance, or an inpatient hospital admission incident to an emergency department visit or direct inpatient admission by the attending physician.

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

G. For a task that was not actually performed.

~~Beneficiaries~~ Participants may choose to self-direct this service through Arkansas's IndependentChoices program under 1915(j) authority; or may receive services through an agency. The IndependentChoices Medicaid Provider Manual describes the self-directed service delivery model.

Attendant Care services must be provided according to the ~~beneficiary~~ participant's ~~ARChoices~~ written PCSP.

A brief description of the service(s) provided, including the signature and title of the individual rendering the service, must be documented in the ~~beneficiary's~~ participant's case record. See Section 214.000 for additional documentation requirements.

Benefit limits will be determined on a ~~client~~participant basis based on application of the Arkansas Medicaid Task and Hour Standards (THS) and the service limitations described in this manual.

DAABHS will update the Person-Centered Service Plan to take into the account any changes in the ~~participant's~~ participant's condition and/or living arrangements that would affect the number of hours of attendant care that could be approved under the Task and Hour Standards.

Fifteen (15) minutes of service equals one (1) unit.

An ARChoices ~~beneficiary~~ participant who spends more than five (5) hours (20 units) at an adult day services or adult day health services facility or who is receiving short-term, facility-based respite care will not be eligible for Attendant Care services on the same date of service unless authorized by the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse.

An ARChoices ~~beneficiary~~ participant receiving long-term, facility-based respite care is not eligible for Attendant Care services on the same date of service.

213.220 Travel Time of Attendant Accompanying ~~Participant~~Participant ~~1-1-19~~10-1-~~21~~10-1-22

A. The Attendant Care benefit only ~~comvers~~ covers attendant travel time when ~~all of~~all of the following appli~~esy~~:

1. The attendant accompanies the participant in the same vehicle as the participant travels to and returns from a community location for medical appointment or community activity;

2. The travel time billed is solely for necessary time in transit from the participant's home to the community location and the return travel from the community location to the participant's home;

3. The participant's participation in the local community activity is ~~the the~~for the benefit of the participant and to meet the participant's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the attendant, a family member, the driver, or other passengers);

4. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;

5. The participant's approved patient-centered service plan includes Attendant Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;

6. While in transit to and from the community location, the participant requires, or is likely to need given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility / ambulating; and,

7. The travel time is reasonable given driving distances, traffic conditions and weather with time and location documented.

B. Travel time is not ~~reimburseable~~reimbursable if any other adult person accompanying (or driving) the participant is a family member and is reasonably~~e~~ able to assist the participant in transit if needed.

C. Travel time accompanying a participant will count against the total number of Attendant Care hours per month authorized in the participant's person-centered service plan.

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

Participants vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of an attendant accompanying a participant is incident to but itself not the ADL task of toileting or the ADL task of mobility / ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Attendant Care hours, if any, associated solely with travel time of an attendant accompanying a participant to a medical visit or community activity. During the home visit to discuss the person-centered service plan, the participant (or their legal representative) should inform the DHS nurse of the ~~individual's~~ participant's community activities, need for an attendant to accompany them, and the distances and roundtrip travel times typically involved. Based on this information, consistent with the above requirements, and within the person's applicable Individual Services Budget, the DHS nurse may increase the number of Attendant Care hours per month covered in the PCSP to reasonably accommodate the travel time of an attendant accompanying the participant.

213.230 Attendant Care Services Certification Requirements ~~1-1-19~~10-1-~~21~~10-1-22

The following requirements must be met prior to certification by the Division of Provider Services and Quality Assurance (DPSQA) by providers of attendant care services. The provider must:

A. Hold a current Arkansas State Board of Health Class A and/or Class B license, Or Private Care Agency license.

B. All owners, principals, employees, and contract staff of an attendant care services provider must have national and state criminal background checks and central registry checks. 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 the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident

Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

C. Employ and supervise direct care staff who:

1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
2. Possess the necessary skills to perform the specific services required to meet the needs of the ~~beneficiary~~ participant the direct care staff member is to serve; and
3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and DPSQA certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DPSQA annually.

Providers are required to submit copy of renewed license to DPSQA.

213.240 Environmental Accessibility Adaptations/Adaptive Equipment

~~1-1-19~~10-1-~~21~~10-1-22

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

Excluded are adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the ~~individual~~participant, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes. All dwellings that receive adaptations must be in good repair and have the appearance of sound structure.

Permanent fixtures are not allowed on rented or leased properties.

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment services provided by a waiver ~~beneficiary's~~participant's:

A. Spouse;

B. Legal guardian of the person; or,

C. Attorney-in-fact granted authority to direct the ~~beneficiary's~~ participant's care.

213.250 Benefit Limit - Environmental Accessibility Adaptations/Adaptive Equipment

~~10-1-21~~10-1-22~~1-1-16~~

The overall cap for Environmental Accessibility Adaptations/Adaptive Equipment is $7,500 per the lifetime of the eligible waiver ~~beneficiary~~participant, including this service if received under the Alternatives for Adults with Physical Disabilities (AAPD) waiver. If a waiver ~~beneficiary~~ participant is receiving Environmental Accessibility Adaptations and Adaptive Equipment, the combined cost cannot exceed the $7,500 overall cap. A waiver ~~beneficiary~~ participant may

access through the waiver several occurrences of Environmental Accessibility Adaptations or for several items of Adaptive Equipment over a span of years, or he/she may access the whole $7,500 at one time. Once the $7,500 per eligible ~~beneficiary~~ participant is reached, no further Environmental Accessibility Adaptations/Adaptive Equipment can be accessed through the waiver by the eligible waiver ~~beneficiary~~ participant during his/her remaining lifetime.

213.260 Examples of Acceptable Environmental Accessibility Adaptations/Adaptive Equipment

~~10-1-21~~10-1-22~~1-1-16~~

Acceptable environmental accessibility adaptations/adaptive equipment must be necessary for the welfare of the ~~beneficiary~~ participant and may include, but are not limited to:

A. Installing and/or repairing ramps and grab-bars

B. Widening doorways

C. Modifying bathroom facilities

D. Installing specialized electronic and plumbing systems

E. Installing an electrical entry door to the home – if based on need and accessibility

F. Installing overhead tracks for transferring

G. Durable Medical Equipment not payable by Medicare/Medicaid

H. Generators for ventilator-dependent beneficiaries

213.270 Examples of Unacceptable Environmental Accessibility Adaptations/Adaptive Equipment

~~1-1-16~~10-1-20

Unacceptable environmental accessibility adaptations/adaptive equipment to the home include, but are not limited to:

A. Those that are of general utility

B. Those not of direct medical or remedial benefit to the ~~individual~~participant, such as carpeting, roof repair, central air conditioning, etc.

C. Those that add to the total square footage of the home

D. Purchase of any vehicle, such as automobile/van, regardless of previously installed modifications or adaptations

E. Vehicle modifications or purchase of a vehicle

F. Replacement of all carpeting when door widening is completed

G. Repairs or updates necessary in order to complete the environment accessibility adaptations/adaptive equipment

Examples:

1. In order to install a ramp, repairs to the porch or deck must be made to support the ramp. The ramp could be approved; the repairs to the existing porch or deck could not be approved.
2. Bathroom needs adaptation to install a new commode for disabled ~~individual~~participant. In order to replace the commode, the flooring must be replaced due to dry rot or decay. The new commode could be approved. The sub-flooring, etc., could not be approved.

H. Permanent fixtures to leased or rented homes.

213.290 Environmental Modifications/Adaptive Equipment

~~1-1-19~~10-1-~~2~~210-1-22

Prior to payment for this service, the waiver ~~beneficiary~~ participant is required to secure 3 separate itemized bids for the same service. Each bid must itemize the work to be done and must specifically identify any work that requires a plumbing or electrical license. The bids are reviewed by the ~~Division of Aging, Adult and Behavioral Health Services Registered Nurse (DHS RN)~~PCSP/CC ~~NURSE~~Nurse~~ ~~ or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided. All modification funds must be verified by the DAABHS prior to receiving services.

Each claim must be signed by the provider, the waiver ~~beneficiary~~ participant and ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse, or designee. A statement of satisfaction form must be signed by the waiver ~~beneficiary~~ participant prior to any claim being submitted. All claim forms, bids and ~~client~~participant satisfaction statement forms must be submitted to the DAABHS Unit prior to submission for payment.

NOTE: The Environmental Modification provider's Alternatives for Adults with Physical Disabilities (AAPD) certification will be valid as an ARChoices Environmental Modification provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under AAPD.

213.310 Hot Home-Delivered Meals

~~1-1-19~~10-1-~~2~~210-1-22

Hot Home-Delivered Meals provide one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with the Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible ~~beneficiaries~~ participants who are homebound. Homebound is defined as a person with normal inability to leave home without assistance (physical or mental) from another person; a person who is frail, homebound by reason of illness or incapacitating disability or otherwise isolated; or for whom leaving home requires considerable and taxing effort by the ~~individual~~ participant and absences from the home are infrequent, relatively short in duration or are attributable to the need to receive medical treatment.

Additionally, the ~~beneficiary~~ participant must:

A. Be unable to prepare some or all of his or her own meals;

B. Have no other individual to prepare his or her own meals; and

C. Have the provision of the Home-Delivered Meals included on his or her PCSP

The provision of a Home-Delivered Meal is the most cost-effective method of ensuring a nutritiously adequate meal.

The Home-Delivered Meals provider must maintain a log sheet signed by the ~~beneficiary~~ participant that includes date and time of delivery each time a meal is delivered to document receipt of the meal.

Hot Home-Delivered Meals must be provided according to the ~~beneficiary's~~ participant's written ARChoices PCSP.

Procedure Code	Required Modifier	Description
S5170	U2	Hot Home-Delivered Meal
S5170	—	Frozen Home-Delivered Meal
S5170	U1	Emergency Home-Delivered Meal

213.311 Hot Home-Delivered Meal Provider Certification Requirements

~~1-1-19~~10-1-~~2~~10-1-22

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of Hot Home-Delivered Meal services, a provider must:

A. Be a nutrition services provider whose kitchen is approved by the Arkansas Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, assure that the provider's intermediate source of delivery meets or exceeds federal, state and local laws regarding food transportation and delivery;*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law;*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

E. All owners, principals, employees, and contract staff of a hot, home-delivered meal services provider must have national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with Arkansas Code Annotated §§ 20-33-213 and 20-38-101 *et seq*. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry, the Adult and Long-Term Care Facility Resident Maltreatment Central Registry and the Certified Nursing Assistant/Employment Clearance Registry.

F. Notify the DHS ~~RN~~ PCSP/CC ~~NURSE~~Nurse immediately if:

1. There is a problem with delivery of service
2. The ~~beneficiary~~ participant is not consuming the meals
3. A change in the ~~individual's~~ participant's condition is noted

NOTE: Changes in service delivery must receive prior approval by the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse who is responsible for the ~~individual's~~ participant's Person-Centered Service Plan (PCSP). Requests must be submitted in writing to the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse. Any changes in the ~~individual's~~ participant's circumstances must be reported to the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse via form AAS-9511.

Home-Delivered Meals, hot or frozen, shall be included in the ~~beneficiary's~~ participant's PCSP only when they are necessary to prevent the institutionalization of a~~n individual~~participant.

Hot Home-Delivered Meals providers must recertify with DPSQA annually and the provider shall attach a copy of the agency's current Food Establishment Permit to the annual recertification.

213.320 Frozen Home-Delivered Meals ~~10-1-2110-1-221-1-16~~

Frozen Home-Delivered Meals service provides one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with DAAS Nutrition Services Program Policy Number 206.

The goal of the Frozen Home-Delivered Meals service is to supplement, not replace, the Hot Home-Delivered Meal service by providing one daily nutritious meal to homebound persons at risk of being institutionalized who:

A. Reside in remote areas where daily hot meals are not available;

B. Choose to receive a frozen meal rather than a hot meal; or

C. Are at nutritional risk and are certified to receive a meal for use on weekends or holidays when the hot meal provider is not in operation.

NOTE: While the ~~individual~~ participant has freedom of choice regarding this service, it is the responsibility of the DAAS RN developing the PCSP to ensure the appropriateness of the service. A hot meal delivered daily remains the food service of choice, when available. Therefore, a frozen meal must be approved by the DAAS RN. The service must be included on the PCSP. If the individual responsible for developing the PCSP does not think the frozen meals are appropriate for the ~~individual~~participant, other options will be considered. Those options include removing the Home-Delivered Meal service rather than authorizing a frozen meal.

It is the certified provider's responsibility to deliver the meals regardless if they are hot or frozen. Meals may not be left on the doorstep. The meals cannot be mailed to the ~~individual~~ participant via United States Postal Service or delivered by paid carrier such as Fed Ex or UPS.

213.321 ~~Beneficiary~~ Participant Requirements for Frozen Home-Delivered Meals ~~1-1-1910-1-2110-1-22~~

The ~~beneficiary~~ participant must:

A. Be homebound, which is defined by the following requirements:

1. The person is normally unable to leave home without assistance (physical or mental) from another person;
2. The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
3. Leaving home requires considerable and taxing effort by the ~~individual~~participant; and
4. Absences of the ~~individual~~ participant from home are infrequent, of relatively short duration or attributable to the need to receive medical treatment.

B. Be unable to prepare some or all of his or her meals or require a special diet and be unable to prepare it.

C. Have no other individual available to prepare his or her meals and the provision of a Frozen Home-Delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal.

D. Have adequate and appropriate storage and be able to perform the simple tasks associated with storing and heating a Frozen Home-Delivered Meal or have made other appropriate arrangements approved by DAABHS.

E. Have the provision of frozen meals included on his or her PCSP as developed by the appropriate ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse.

Frozen Home-Delivered Meals must be documented on the ~~ARChoices~~ PCSP by the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse and must be provided in accordance with the ~~beneficiary's~~ participant's written ~~ARChoices~~ PCSP.

213.323 Frozen Home-Delivered Meal Provider Certification Requirements ~~1-1-19~~10-1-~~2~~210-1-22

In order to become approved providers of frozen meals, providers must meet all applicable requirements of the Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.

To be certified by Division of Provider Services and Quality Assurance (DPSQA) as a provider of Home-Delivered Meal services, a meal provider must:

A. Be a nutrition services provider whose kitchen is approved by the Arkansas Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAABHS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, ensure that intermediate sources of delivery meet or exceed federal, state and local laws regarding food transportation and delivery*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law*

*NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.

E. All owners, principals, employees, and contract staff of a home-delivered meal services provider must have national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with Arkansas Code Annotated §§ 20-33-213 and 20-38-101 *et seq*. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

F. Provide frozen meals that:

1. Were prepared or purchased according to the Department of Health and DAABHS Nutrition Services Program Policy guidelines in freezer-safe containers that can be reheated in the oven or microwave.
2. Are kept frozen from the time of preparation through placement in the ~~individual's~~ participant's freezer.
3. Have a remaining freezer life of at least three months from the date of delivery to the home.
4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).
5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the ~~ARChoices beneficiary~~participant), menu analysis as required by DAABHS Nutrition Services Program Policy if other than DAABHS menus are used and both packaging and expiration dates.

NOTE: The milk must be delivered to the ~~beneficiary~~ participant at least seven (7) days prior to its expiration date.

G. Instruct each ~~individual~~participant, both verbally and in writing, in the handling and preparation required for frozen meals and provide written re-heating instructions with each meal, preferably in large print.

H. Ensure that meals that are not commercially prepared but produced on-site in the production kitchen:

1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;
2. Are prepared specifically to be frozen;
3. Are frozen as quickly as possible;
4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;
5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;
6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;
7. Are frozen in a manner that allows air circulation around each individual tray;
8. Are kept frozen throughout storage, transport and delivery to the ~~beneficiary~~participant; and
9. Are discarded after 30 days.

I. Verify quarterly that all ~~beneficiaries~~ participants receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks unless other appropriate arrangements have been made and approved by DAABHS. Any changes in the ~~individual's~~ participant's circumstances must be reported to the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse via form AAS-9511.

J. Notify the appropriate ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse immediately if:

1. There is a problem with delivery of service
2. The ~~individual~~ participant is not consuming the meals
3. A change in a~~n individual's~~ participant's condition is noted

NOTE: Changes in service delivery must receive prior approval by the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse who is responsible for the ~~individual's~~ participant's Person-Centered Services Plan (PCSP). Requests must be submitted in writing to the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse. Any changes in the ~~individual's~~ participant's circumstances must be reported to the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse via form AAS-9511.

K. Contact each ~~individual~~ participant daily Monday through Friday, either in person or by the phone, to ensure the ~~individual's~~ participant's safety and well-being. This is not required for:

1. ~~Individuals~~ Participants receiving Frozen Home-Delivered Meals only for weekends; or,
2. ~~Individuals~~ Participants who receive Attendant Care services or Personal Care services at least three (3) times per week.

Home-Delivered Meals, hot or frozen, shall be included in the ~~beneficiary's~~ participant's PCSP only when they are necessary to prevent the institutionalization of a~~n individual~~participant.

Frozen Home-Delivered Meals providers must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current Food Establishment Permit at all times.

213.330 Limitations on Home-Delivered Meals (HDMs)

~~1-1-19~~10-1-~~21~~10-1-22

One unit of service equals one meal. The maximum number of HDMs eligible for Medicaid reimbursement per month equals 31 meals. This includes hot, frozen or a combination of the two. There is no separate benefit limit for frozen meals.

The maximum number of emergency meals per State Fiscal Year is four (4).

Frozen HDMs may be provided daily to eligible beneficiaries. A maximum of seven (7) meals may be delivered at one time.

HDM providers may deliver more than seven meals at one time, if:

A. The waiver ~~beneficiary~~ participant receives Attendant Care services or Personal Care services at least three (3) times per week,

B. Frozen HDMs are ordered on the Person-Centered Services Plan (PCSP),

C. The waiver ~~beneficiary~~ participant has the means of storing 14 frozen meals (as verified by the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse).

HDM providers delivering frozen meals may deliver 14 at one time if ~~the DHS RN~~ PCSP/CC ~~NURSE~~Nurse enters 14 meals delivery approved in the comments section of the HDM entry on the PCSP. If this statement is not on the PCSP, or if any of the other factors above are not in place, the meal providers cannot deliver more than seven (7) meals at one time.

A~~n ARChoices beneficiary~~ participant may not be provided with a Hot or Frozen HDM on any day during which the ~~individual~~ participant receives more than five (5) hours of in-home or facility-based Respite care or more than five (5) hours of Adult Day Services or Adult Day Health Services. (Licensure mandates that providers of these services provide a meal or meals; therefore, a HDM on these dates is a duplicative service and prohibited under waiver guidelines.)

NOTE: Medicaid reimbursement for HDMs is not allowed on the same day to ~~beneficiaries~~ participants who are also attending Adult Day Services, Adult Day Health Services, or facility-based Respite care for more than five (5) hours. When applying this policy, the time of day the ~~beneficiary~~ participant

receives day services or respite services are also a factor. Whether there is duplication of services will be determined by comparing the time of day during which services occur.

When considering whether a HDM is billable for a~~n individual~~ participant receiving Adult Day Services, Adult Day Health Services or facility-based Respite services, on a specific date of service, the following must be applied:

If a ~~n ARChoices beneficiary~~ participant is receiving Adult Day Services, Adult Day Health Services or facility-based Respite at any time between the hours of 11:00 a.m. and 1:30 p.m. **and** the noon meal is routinely served to others at the facility during this timeframe, the noon meal must also be served to this ~~individual~~participant. A HDM is not allowable on the same date of service. This is true **regardless of the total number of Adult Day Services, Adult Day Health Services or Respite hours provided.**

213.340 Combination of Hot and Frozen Home-Delivered Meals

~~1-1-19~~10-1-~~21~~10-1-22

In instances where the ~~ARChoices beneficiary~~ participant wishes to receive a combination of hot and frozen meals, the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse shall evaluate the ~~beneficiary's~~ participant's situation based on the criteria set forth in Section 213.320, Frozen Home-Delivered Meals. If the criteria are met, the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse may prescribe on the PCSP a combination of hot and frozen meals to be delivered.

213.350 Emergency Meals

~~1-1-19~~10-1-~~21~~10-1-22

~~Beneficiaries~~ Participants may receive up to four (4) emergency meals per state fiscal year. The meals must:

A. Contain 33 1/3 percent of the Dietary Reference intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.

B. Be labeled "Emergency Meal" in large print, with instruction on use of the meal.

C. Be used within the limits of their shelf life, usually within six months.

213.400 Personal Emergency Response System

~~1-1-19~~10-1-~~21~~10-1-22

Procedure Code	Required Modifier	Description
S5161	UA	PERS Unit
S5160	—	PERS Installation

The Personal Emergency Response System (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. PERS enables an elderly, infirm or homebound ~~individual~~ participant to secure immediate help in the event of a physical, emotional or environmental emergency.

PERS is specifically designed for high-risk ~~beneficiaries~~ participants whose needs have been carefully determined based on their level of medical vulnerability, functional impairment and social isolation. PERS is not intended to be a universal benefit. The ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse must verify that the ~~individual~~ participant is capable, both physically and mentally, of operating the PERS unit.

PERS must be included in the ~~beneficiary's~~ participant's written ~~ARChoices~~ PCSP.

PERS providers must contact each ~~beneficiary~~ participant at least once per month to test the system's operation. The provider shall maintain a log of test calls that includes the date and time of the test, specific test results, corrective actions and outcomes.

A log of all ~~beneficiary~~ participant calls received must be maintained by the emergency response center. The log must reflect the date, time and nature of the call and the response initiated by the center. All calls must be documented in the ~~beneficiary's~~ participant's record. See Section 214.000 for other documentation requirements.

One (1) unit of service equals one (1) month. PERS is limited to a maximum of twelve (12) units per year.

The installation of PERS will be allowed once per lifetime or period of eligibility. Claims submitted for the installation of PERS should use procedure code **S5160**. Procedure code **S5160** may be billed for ~~ARChoices beneficiaries~~ participants who are accessing PERS services for their first time or for the current period of re-eligibility for ARChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging, Adult and Behavioral Health Services for extension of the benefit.

213.410 Personal Emergency Response System (PERS) Certification Requirements

~~1-1-19~~10-1-~~2~~10-1-22

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of personal emergency response services, a provider must:

A. Provide, install and maintain Federal Communications Commission (FCC) approved equipment which meets all Underwriter Laboratories Safety Standards;

B. Designate or operate an emergency response center to receive signals and respond according to specified operating protocol;

C. Establish a response system for each ~~beneficiary~~ participant and ensure responders receive necessary instruction and training; and

D. Ensure that equipment is installed by qualified providers who also provide instruction and training to ~~beneficiaries~~participants.

PERS providers must recertify annually with DPSQA.

213.500 Adult Day Services

~~1-1-19~~10-1-~~2~~10-1-22

Procedure Code	Required Modifier	Description
S5100	U1	Adult Day Services, 8-20 Units Per Date of Service
S5100	—	Adult Day Services, 21-40 Units Per Date of Service

Adult day services facilities are licensed by the Division of Provider Services and Quality Assurance (DPSQA) to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than 24 hours but more than two (2) hours per day, in a place other than the ~~beneficiaries'~~ participants' own homes.

When provided according to the ~~beneficiary's~~ participant's written ~~ARChoices Person-Centered Service Plan (~~PCSP~~)~~, ~~ARChoices beneficiaries~~participants may receive adult day services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day, according to

the ~~beneficiary's~~ participant's written PCSP. Adult day services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month. One (1) unit of service equals 15 minutes.

As required, ~~beneficiaries~~ participants who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, ~~ARChoices beneficiaries~~participants are not eligible to receive a home-delivered meal on the same day they receive more than 20 units (5 hours) of adult day services. Additionally, ~~beneficiaries~~ participants who attend an adult day service for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the ~~Department of Human Services Registered Nurse (DHS RN)~~DHS PCPS/CC Nurse.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for a~~n individual~~ participant who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the ~~beneficiary~~ participant is receiving day services, day health services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for ~~beneficiaries~~ participants participating in the ARChoices Waiver p~~P~~rogram.

Providers must consider the following to determine whether a home-delivered meal is billable for a~~n individual~~ participant receiving day services, day health services or facility-based respite services on a specific date of service.

If a~~n ARChoices beneficiary~~ participant is receiving day services, day health services or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to this ~~individual~~participant. A home-delivered meal is not allowable on the same date of service. This is true regardless of the total number of day services or respite units provided.

Adult day services and day health services providers are required to maintain a daily attendance log of ~~beneficiaries~~participants. Section 214.000 contains information regarding additional documentation requirements.

213.600 Adult Day Health Services (ADHS)

~~1-1-19~~10-1-~~21~~10-1-22

Procedure Code	Required Modifier	Description
S5100	TD, U1	Adult Day Health Services, 8-20 Units Per Date of Service
S5100	TD	Adult Day Health Services, 21-40 Units Per Date of Service

Adult day health services facilities are licensed to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to ~~beneficiaries~~ participants who are functionally impaired and who, due to the severity of their functional impairment, are not capable of fully independent living.

Adult day health services programs provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the ~~beneficiary~~ participant that cannot be provided by adult day care programs. Adult day health services are appropriate only for ~~beneficiaries~~ participants whose facility-developed care plans specify one or more of the following health services:

A. Rehabilitative therapies (e.g., physical therapy, occupational therapy),

B. Pharmaceutical supervision,

C. Diagnostic evaluation or

D. Health monitoring

~~ARChoices beneficiaries~~ Participants may receive adult day health services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day when the service is provided according to the ~~beneficiary's~~ participant's written ~~ARChoices Person-Centered Service Plan (~~PCSP~~)~~. Adult day health services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day health services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month.

~~Beneficiaries~~ Participants who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**, modifier **TD**) must be served a nutritious meal that equals one-third of the Recommended Daily Dietary Allowances. Therefore, ~~ARChoices beneficiaries~~ participants are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day health services. Additionally, ~~beneficiaries~~ participants who attend an adult day health services for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the ~~Department of Human Services Registered Nurse (DHS RN)~~PCSP/CC ~~NURSE~~Nurse.

Adult day health services providers are required by licensure to maintain a daily attendance log of ~~beneficiaries~~participants. See Section 214.000 for additional documentation requirements.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for a~~n individual~~ participant who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the ~~beneficiary~~ participant is receiving day services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse and/or DHS audit staff and considered when determining any duplication in services for ~~beneficiaries~~ participants participating in the ARChoices Waiver p~~P~~rogram.

Providers must consider the following to determine whether a home-delivered meal is billable for a~~n individual~~ participant receiving day services or facility-based respite services on a specific date of service.

If an ARChoices ~~beneficiary~~ participant is receiving day services or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to the ~~individual~~participant. A home-delivered meal is not allowable on the same date of service. This is true regardless of the total number of day services or respite units provided.

213.620 Prevocational Services

~~1-1-19~~10-1-~~2~~10-1-22

Procedure Code	Modifier	Description
T2015		Prevocational Services Skills Development
T2015	U3	Prevocational Services Career Exploration

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

Prevocational services are as follows:

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

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

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

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

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

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

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

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

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

Fifteen (15) minutes of services equals one (1) unit.

Providers of Prevocational Services under the ARChoices W~~w~~aiver program must be certified by the Division of Provider Services and Quality Assurance and must recertify annually.

Reimbursement is not permitted for prevocational services provided by a waiver ~~beneficiary's~~participant's:

A. Spouse;

B. Legal guardian of the person; or,

C. Attorney-in-fact granted authority to direct the ~~beneficiary's~~ participant's care.

213.700 Respite Care

~~1-1-19~~10-1-~~21~~10-1-22

Procedure Code	Description
T1005	Long-Term Facility-Based Respite Care
S5135	Short-Term Facility-Based Respite Care
S5150	In-Home Respite Care

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

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

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

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

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

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

E. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b) supervision necessary to maintain the health and safety of the participant, as supported by the independent assessment and determined medically necessary by the ~~Department of Human Services Registered Nurse (DHS RN)~~PCSP/CC Nurse; and

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

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

Respite Care is available in the following locations:

A. The Participant's home or place of residence;

B. Medicaid-certified hospital;

C. Medicaid-certified nursing facility;

D. Medicaid-certified adult day health facility; and

E. Medicaid-certified assisted living facility with a level II state license.

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

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

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

1. A short-term basis (eight (8) hours or less per date of service), or
2. A long-term (maximum of 24 hours per date of service and used most often when respite needed exceeds the short-term respite amount).

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

Respite care is subject to the following limitations:

C. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with the amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the ~~beneficiary~~ participant in the completed form of the Arkansas Task and Hour Standards (THS). Any amounts, frequencies, or durations in excess of the unpaid caregiver assistance amounts identified for the ~~beneficiary~~ participant in the THS are not covered.

D. Respite Care excludes:

1. Skilled health professional services, including physician, nursing, therapist, and pharmacist services.
2. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
3. Services provided for any other person other than the participant;
4. Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship; and
5. Habilitation services, including but not limited to, assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and,
6. Services provided for any tasks not included in a ~~beneficiary's~~ participant's service plans.

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

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

G. Reimbursement is not permitted for Respite Care services provided by a waiver ~~beneficiary's~~participant's:

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

In the event the in-home functional assessments performed by the Independent Assessment Contractor and the ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse substantiates a need for respite care services, the service will be authorized as needed, via the ~~beneficiary's~~ participant's PCSP, not to exceed an hourly maximum. The ~~DHS RN~~ PCSP/CC ~~NURSE~~Nurse will establish the service limitation based on the ~~beneficiary's~~ participant's medical need, other services included on the PCSP and support services available to the ~~beneficiary~~participant. Respite care services must be provided according to the ~~beneficiary's~~ participant's written PCSP subject to the ~~participant's~~ participant's Individual Services Budget.

An individual living in the home with the ~~beneficiary~~ participant is prohibited from serving as a Respite Services provider for the ~~beneficiary~~participant.

213.710 In-Home Respite Care

~~10-1-21~~10-1-22~~1-1-16~~

In-home respite care may be provided by licensed personal care or home health agencies. Reimbursement will be made for direct care rendered according to the ~~beneficiary's~~ participant's PCSP by trained respite workers employed and supervised by certified in-home respite providers.

Providers rendering respite care services in the ~~beneficiary's~~ participant's home must bill procedure code **S5150**. One (1) unit of service for procedure code **S5150** equals 15 minutes.

Eligible ~~beneficiaries~~ participants may receive up to 96 units of in-home respite care per date of service. For the state fiscal year (SFY), July 1 through June 30 each year, eligible ~~beneficiaries~~ participants may receive up to 4800 units (1200 hours) of In-Home Respite Care, or Facility-Based Respite Care or a combination of the two services.

When respite care is provided, the provision of or payment for other duplicate services under the waiver is prohibited. When a respite care provider is in the home to provide respite care services, the provider is responsible for all other in-home ARChoices services included on the ~~beneficiary's~~ participant's PCSP. For example, if attendant care services and/or home-delivered meals are included on the PCSP, the respite provider must provide these services while in the home. No other ARChoices service, other than PERS, may be reimbursed for the same time period.

213.711 Facility-Based Respite Care

~~1-1-19~~10-1-~~21~~10-1-22

Facility-based respite care may be provided outside the ~~beneficiary's~~ participant's home on a short- or long-term basis by residential care facilities, nursing facilities, adult day care facilities, adult day health care facilities, Level I and Level II Assisted Living Facilities and hospitals.

Facility-based providers rendering services for eight (8) hours or less per date of service must bill **S5135** for short-term, facility-based respite care. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible ~~beneficiaries~~ participants may receive up to 32 units (8 hours) of short-term, facility-based respite care per date of service.

Facility-based providers rendering services for more than 32 units (8 hours) per day must bill **T1005** for long-term, facility-based respite care. One (1) unit of service for procedure code **T1005** equals 15 minutes. A ~~beneficiary~~ participant may receive up to 96 units (24 hours) of service per date of service if the provider bills procedure code **T1005**.

Facility-based respite care services include short-term and long-term respite care services and can include any combination of billing codes **S5135** or **T1005**. A single provider may provide both long-term and short-term facility-based respite care services for a particular ~~beneficiary~~participant, but not on the same date of service.

Eligible ~~beneficiaries~~ participants may receive up to 4800 units (1200 hours) per State Fiscal Year of Facility-Based Respite Care- or In-Home Respite Care, or a combination of the two. ~~Beneficiaries~~ Participants receiving long-term, facility-based respite care services may receive only ARChoices Personal Emergency Response System (PERS) services concurrently.

Please refer to the NOTE found in Section 213.500 regarding Home-Delivered Meals and facility-based respite services.

214.000 Documentation

~~10-1-21~~10-1-22~~1-1-19~~

In addition to the service-specific documentation requirements previously listed, ARChoices providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the ~~beneficiary's~~ participant's PCSP

B. A brief description of the specific service(s) provided

C. The signature and title of the individual rendering the service(s)

   1. For records created through an electronic data system such as telephony, computer or other electronic devices, a unique identifier such as a PIN number assigned to and entered by the employee at the time of data input may suffice as an electronic signature and title, and

D. The date and actual time the service(s) was rendered. For Attendant Care or In-Home Respite Care, it is not necessary to itemize the time spent on each individual ADL or IADL task.

A provider's failure to maintain sufficient documentation to support his or her billing practices may result in recoupment of Medicaid payment.

No documentation for ARChoices services, as with all Medicaid services, may be made in pencil.

215.000 ARChoices Forms

~~1-1-19~~10-1-~~2~~10-1-22

ARChoices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging, Adult and Behavioral Health Services. These forms include but are not limited to:

A. Person Centered Service Plan — AAS–9503

B. Start Services — AAS–9510

C. ~~Beneficiary~~ Participant Change of Status — AAS–9511

Providers may request form AAS–9511 by writing to the Division of Aging, Adult and Behavioral Health Services.

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

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

240.000 PRIOR AUTHORIZATION

~~1-1-16~~10-1-~~21~~10-1-22

Attendant care, personal care and prevocational services provided under an authorized PCSP require prior authorization. Other services provided under the ARChoices Waiver p~~P~~rogram under an authorized PCSP do not require prior authorization. The PCSP signed by the DHS PCSP/CC Nurse serves as the authorization for ARChoices waiver services and Personal Care services.

261.000 Introduction to Billing

~~7-1-21~~0-1-~~21~~10-1-22~~0~~

ARChoices providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid ~~beneficiaries~~participants. Each claim may contain charges for only one (1) ~~beneficiary~~participant.

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

262.210 Place of Service Codes

~~1-1-19~~10-1-~~21~~10-1-22

The national place of service (POS) code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
~~Beneficiary's~~ Participant's Home	12
Day Care Facility	99
Nursing Facility	32
Provider's Office	11
Other Locations	99

262.300 Billing Instructions – Paper Only

~~11-1-17~~10-1-~~21~~10-1-22

Bill Medicaid for ARChoices services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

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.**

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

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

Payment for ARChoices services may be allowed for the date of a participant 's admission to an inpatient facility if the provider can provide verification that services were provided before the participant was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:

- Copies of claim forms or timesheets listing the times that services were provided
- A statement from the inpatient facility showing the time that the participant was admitted
- This information must be submitted to DAABHS within 10 working days of receiving a request for verification.

If providers are unable to provide proof that ARChoices services were provided before the participant was admitted to the inpatient facility, then payments will be subject to recoupment. ARChoices services provided on the same day the participant is discharged from the inpatient facility are billable when provided according to policy and after the participant was discharged.

262.310 Completion of CMS-1500 Claim Form

~~10-1-21~~10-1-22~~1-1-16~~

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	~~Beneficiary's~~ Participant's ~~or participant's~~ 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	~~Beneficiary's~~ Participant's ~~or participant's~~ last name and first name.
3.	PATIENT'S BIRTH DATE	~~Beneficiary's~~ Participant's ~~or participant's~~ date of birth as given on the ~~individual's~~ participant's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. ~~Beneficiary's~~ Participant's ~~or participant's~~ complete mailing address (street address or post office box).
	CITY	Name of the city in which the ~~beneficiary~~ participant ~~or participant~~ resides.
	STATE	Two-letter postal code for the state in which the ~~beneficiary~~ participant ~~or participant~~ resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.

Field Name and Number			Instructions for Completion
	TELEPHONE (Include Area Code)		The ~~beneficiary's~~ participant's ~~or participant's~~ telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED		If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)		Required if insured's address is different from the patient'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 patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
	a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured ~~individual~~participant.
	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)	Check YES or NO.
	b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
		PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d.	CLAIM CODES	The "Claim Codes" identify additional information about the ~~beneficiary's~~ participant'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.

Field Name and Number			Instructions for Completion
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.
15.	OTHER DATE		Enter another date related to the ~~beneficiary's~~ participant's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the ~~beneficiary's~~ participant'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

Field Name and Number		Instructions for Completion
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for ARChoices services. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a.	(blank)	Not required.
17b.	NPI	Enter NPI of the referring physician.
18.	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a ~~beneficiary's~~ participant's or ~~participant's~~ inpatient's hospitalization, enter the ~~individual's~~ participant's admission and discharge dates. Format: MM/DD/YY.
19.	ADDITIONAL CLAIM INFORMATION	Identifies additional information about the ~~beneficiary's~~ participant's~~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.
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.

Field Name and Number		Instructions for Completion
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. Some 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	Enter the appropriate place of service code. See Section 262.200 for codes.
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 usual charge to any ~~client~~participant, patient, or other ~~beneficiary~~ participant of the provider's services.
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 for ARChoices.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.

Field Name and Number		Instructions for Completion
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 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	If other than home or office, 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.

262.400 Special Billing Procedures – Environmental Modifications/Adaptive Equipment

~~1-1-19~~10-1-~~2~~210-1-22

Prior to payment for this service, the ~~ARChoices beneficiary~~participant is required to secure three separate itemized bids for the same service. The bids are reviewed by the ~~Department of Human Services Registered Nurse (DHS RN)~~PCSP/CC Nurse or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided.

Each claim must be signed by the provider, the ~~ARChoices beneficiary~~participant, and ~~DHS RN~~PCSP/CC ~~NURSE~~Nurse, or designee. A statement of satisfaction form must be signed by the ~~ARChoices beneficiary~~participant prior to any claim being submitted. Please refer to 213.290 for additional information.

TOC required

200.140 Assisted Living Facilities

~~1-1-19~~10-~~1-~~22

A. Only one type of assisted living facility, a Level 1 Assisted Living Facility (ALF), may enroll as a personal care provider.

B. The Division of Provider Services and Quality Assurance (DPSQA) ~~certifies,~~ licenses and regulates certain institutions, including ALFs.

C. Each ALF has a separate license, regardless of which type it is and regardless of its location or proprietorship.

D. Each ALF that provides personal care for Medicaid ~~beneficiaries~~clients and that desires Medicaid reimbursement for those services must enroll separately in the Arkansas Medicaid Personal Care Program, effective for dates of service on and after March 1, 2005.

1. Some providers operate multiple ALF facilities, sometimes on the same property or in the same complex and sometimes in multiple locations.
   a. Effective for dates of service before March 1, 2005, Medicaid covers personal care services provided by enrolled RCFs for residents of Level I ALFs under the same proprietorship as the enrolled RCF.
   b. Level I ALFs that are not under the same proprietorship as a Medicaid-enrolled RCF may not contract for Medicaid-covered personal care with an enrolled RCF owned by another entity.
   c. Except under the conditions described in part a above, personal care in any assisted living facility may be provided only by the facility itself, if it is enrolled in the Arkansas Medicaid Personal Care Program, or by
      ~~(1)~~i. A private care agency that is enrolled as a Personal Care provider or
      ~~(2)~~ii. A Class A or Class B home health agency that is enrolled as a Personal Care provider.
2. Several provider files may share the same Federal Employer Identification Number (FEIN). For example: A corporate entity that has one FEIN owns an RCF and a Level I ALF and enrolls them as Personal Care Program providers.
   a. Each facility is assigned a unique Arkansas Medicaid provider number.
   b. Each facility's Arkansas Medicaid Personal Care provider number is linked to its unique license number.
   c. Each facility's Arkansas Medicaid Personal Care provider number is linked to the corporate entity's single FEIN.

E. Sections 200.141 and 200.142outline Arkansas Medicaid Personal Care Program participation requirements for RCFs, and Level I ALFs.

F. Level II ALFs may participate in the Living Choices Assisted Living Program.

1. Living Choices is a home- and community-based program established for certain nursing home-eligible individuals who, without a program like Living Choices, would not be able to live in a dwelling of their own or would be able to do so only with great difficulty and with significant risk to their health and safety.
2. Providers may obtain Living Choices Program participation requirements by downloading the **Living Choices Assisted Living Provider Manual**. ~~from the Arkansas Medicaid website, https://medicaid.mmis.arkansas.gov.~~

3. Living Choices services are not covered for ~~beneficiaries~~clients receiving services through the Personal Care Program, and Personal Care Program services are not covered for ~~beneficiaries~~clients in the Living Choices Program.

200.142 Level I Assisted Living Facilities 10-1-~~22~~19

A Level I ALF applying for enrollment as a personal care provider must be licensed as a Level I ALF by the Division of Provider Services and Quality Assurance (DPSQA).~~.~~

202.210 Out-of-State Limited Services Personal Care Providers 10-1-~~22~~19

A. Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid eligible ~~beneficiary~~ client and they have a claim or claims to file with Arkansas Medicaid.

1. To enroll, providers must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet). View Medicaid Provider Enrollment Unit contact information.**
2. Out of sate providers must also be certified by DPSQA.
3. Enrollment as a limited services provider automatically expires after a year unless the provider provides and bills for subsequent services for Arkansas Medicaid ~~beneficiaries~~clients during the year. See part B below.

B. Out-of-state limited services providers remain enrolled for one year.

1. If an out-of-state limited services provider provides services to another Arkansas Medicaid ~~beneficiary~~ client during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

212.000 Program Purpose 10-1-~~18~~22

A. The purpose of Personal Care Program services is to supplement, not to supplant, other resources available to the ~~beneficiary~~client.

B. Personal care services are medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS and individually designed to assist ~~beneficiaries~~clients with their physical dependency needs as described in Section 213.200 and Sections 216.100 through 216.140.

213.000 Scope of the Program ~~1-1-19~~10-1-22

A. Personal care services are primarily based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Hands-on assistance in at least one of these areas, based on the ~~ARIA~~ assessment results~~,~~ is required. This type of assistance is provided by a personal care aide based on a ~~beneficiary~~client's physical dependency needs (as opposed to purely housekeeping services). An individualized plan

of care is developed based on the ~~ARIA~~ assessment results and information in the form designated by DHS that is submitted by the provider, and is based on a ~~beneficiary's~~ client's assessed dependency in at least one of the above-listed activities of daily living. While not a part of the eligibility criteria, the need for assistance with other tasks and IADLs (Instrumental Activities of Daily Living) are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized. Routines or IADLs include meal preparation, incidental housekeeping, laundry, medication assistance, etc. These tasks are also defined and described in this section of this provider manual and are defined in the Arkansas State Board of Nursing Position Statement 97-2.

B. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the ~~beneficiary~~client were in a hospital or nursing facility.

C. Personal care services may be similar to or overlap some services that home health aides furnish.

1. Home health aides may provide personal care services in the home under the home health benefit.
2. Skilled services that only a health professional may perform are not considered personal care services.

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

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State.~~, e.g., ARChoices, IndependentChoices;~~
2. Furnished in the ~~beneficiary~~client's home, and at the State's option, in another location.
3. Provided by an individual qualified to provide such services and who is not a member of the ~~beneficiary~~client's family. See Section 222.100, part A, for the definition of "a member of the ~~beneficiary~~client's family".

E. Personal care for Medicaid-eligible individuals requires prior authorization. See Sections 240.000 through 246.000.

F. Only Class-A Home Health agencies, Class-B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, and education service cooperatives may provide personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the ~~beneficiary~~client's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

213.110 Categorically Needy Medicaid Eligibility 10-1-~~223~~ ~~03~~

A. Only Categorically Needy Medicaid ~~beneficiaries~~ clients are eligible for personal care services. ~~Beneficiaries~~Clients in Medically Needy categories are not eligible for personal care services.

B. See Section I of this manual for the ~~Beneficiary~~ Client Aid Categories, including the category codes and abbreviated category descriptions. The suffix "MN" indicates a "Medically Needy" aid category.

1. An Eligibility Verification Transaction Response identifies an Aid Category Code and an Aid Category Description for each eligibility segment it lists.
2. The headings, "AID CATEGORY CODE" and "AID CAT DESCRIPTION," appear beneath each eligibility segment.
3. The Aid Category description of a Medically Needy category ends with "EC" (Exceptional Category) or "SD" (Spend Down), as it appears on the Eligibility Verification Transaction Response.

213.200 Physical Dependency Need Criteria for Service Eligibility 10-1-~~19~~22

A. The terms "routines," "activities of daily living" and "service" have particular definitions that apply to the Personal Care Program. See Sections 216.100 through 216.140 for definitions of these and other terms employed in this manual.

B. Personal care services, described in Sections 216.000 through 216.330, must be medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS.

C. Personal care services are individually designed to assist with a ~~beneficiary's~~ client's assessed physical dependency needs related to the following routine activities of daily living and instrumental activities of daily living:

1. Bathing
2. Bladder and bowel requirements
3. Dressing
4. Eating
5. Incidental housekeeping
6. Laundry
7. Personal hygiene
8. Shopping for personal maintenance items
9. Taking medications*
10. Mobility and Ambulation

* Assistance with medications is a personal care service only to the extent that it is permitted by the Arkansas Nurse Practice Act, implementing regulations permit a personal care aide to perform the service, and Arkansas State Board of Nursing Position Statement 97-2.

D. A number of conditions may cause "physical dependency needs."

1. Particular disabilities or conditions may or may not be pertinent to specific needs for individual assistance.
2. In assessing an individual's need for personal care, the question to pursue is whether the individual is unable to perform tasks covered by this program without assistance from someone else.
3. The need for individual assistance indicates whether to consider personal care.

213.300 ~~Beneficiary's~~ Client's Consent and Freedom of Choice 10-1~~3-03~~-22

A. A Medicaid ~~beneficiary~~ client has freedom of choice in selecting a personal care provider.

B. Provision of personal care services is contingent upon the written consent of the ~~beneficiary~~ client or the ~~beneficiary's~~ client's representative.

213.310 IndependentChoices Program, Title XIX State Plan Program ~~1-1-19~~10-1-22

IndependentChoices is operated by the Division of Provider Services and Quality Assurance (DPSQA) and operates under the authority of the Title XIX State Plan with the Division of Medical Services responsible for administrative and financial authority.

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly (age 65 and older) to direct their personal care. The ~~beneficiary~~client chooses a cash allowance in lieu of agency personal care services. IndependentChoices provides qualifying ~~beneficiaries~~clients with counseling and training to assist them with information to fulfill their role as an employer. The ~~beneficiary~~client as the employer will hire, train, supervise and, if necessary, terminate the services of their employee. In addition to hiring an employee, the ~~beneficiary~~client may use part of their budget to purchase goods and services that lessen their physical dependency needs. In addition to counseling support services, ~~beneficiaries~~clients may receive Financial Management Services (FMS) from a DMS contracted provider. The FMS provider will assist the ~~participant~~ client by processing timesheets, withholding and reporting State and Federal taxes, issuing a W-2 to all employees who meet the tax threshold and refunding taxes to the ~~participant~~ client and the employee when the threshold was not met. The FMS provider also coordinates the accuracy and coordination of the forms used to establish the Medicaid ~~beneficiary~~client as an employer and to employ a worker. The FMS provider representing the Medicaid ~~beneficiary~~client will obtain permissions and execute an IRS Form 2678 to act as the ~~beneficiary~~client's agent.

NOTE: The IndependentChoices Program is required to follow the rules and regulations of the State Plan approved Personal Care Program, unless stated otherwise in this manual.

213.320 ARChoices Home and Community-Based Waiver 10-1-22

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

A. Attendant Care Services

B. Home-Delivered Meals

C. Personal Emergency Response System

D. Adult Day Services

E. Adult Day Health Services

F. Prevocational Services

G. Respite Care

H. Environmental Accessibility Adaptations/Adaptive Equipment

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

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

NOTE: Individuals receiving State Plan personal care services through the ARChoices Home and Community Based Waiver are required to follows the rules and regulations of the State Plan approved Personal Care Program and the ARChoices Waiver Program.

213.500 Personal Care Service Locations 10-1-~~19~~22

A. Arkansas Medicaid covers personal care in a ~~beneficiary's~~ client's home and, at the state's option, in another location, for ~~beneficiaries~~clients of all ages.

1. A ~~beneficiary's~~ client's home is the ~~beneficiary's~~ client's residence, subject to the exclusions in part B, below.
2. Service locations outside the ~~beneficiary's~~ client's home must be included in the service plan. (If shopping or assistance with shopping is included in the service plan, it is understood that the actual activity occurs at a store. The place of service—for billing purposes—remains the ~~beneficiary's~~ client's home.)
3. The ~~beneficiary's~~ client's assessment and service plan must justify the medical necessity for personal care in a location other than the ~~beneficiary's~~ client's residence. For example: A ~~beneficiary's~~ client's service plan includes assistance with dressing. This particular ~~beneficiary~~ client regularly (by PCP referral or a physician's order) goes to a clinic or other site for a therapy, such as aqua therapy, that involves changing clothes. If, at the therapy site, assistance with dressing and/or changing is not included with the therapy service, the personal care service plan may include an aide's assistance. However, in such a situation, only the time the aide spends performing the service is covered.

B. Medicaid does not cover personal care services in the following locations:

1. A hospital,
2. A nursing facility,
3. A Level II assisted living facility,
4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or
5. An institution for mental diseases (IMD).

C. All individuals residing in locations listed above in part B are ineligible for Medicaid-covered personal care.

D. Individuals who are inpatients or residents of the facilities and institutions listed in part B are not eligible for Medicaid-covered personal care services in any location.

213.520 Personal Care in Public Schools- ~~Beneficiaries~~Clients under Age 21 ~~7-1-09~~10-1-22

A. Personal care in public schools is available to eligible ~~beneficiaries~~clients under the age of 21.

1. School may be an area on or off-site based on accessibility for the ~~beneficiary~~client.
2. When a ~~beneficiary~~client's education is the responsibility of the school district in which that individual resides, "public school" as a place of service for Medicaid-covered services is any location, on-site or away from the site of an actual school building or campus.
   a. When a ~~beneficiary~~client is attending school at a DDS community provider

facility because the school district has contracted with the facility to provide educational services, the place of service for Medicaid Program purposes is "public school."

b. When the home is the educational setting for a ~~beneficiary~~client who is enrolled in the public school system, "public school" is considered the place of service.

c. The ~~beneficiary~~client's home is not considered a "public school" place of service when a parent elects to home school a child.

B. Medicaid Program requirements are the same as for services delivered in the ~~beneficiary~~client's home.

C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the ~~beneficiary~~client receives services.

D. ~~Beneficiaries~~Clients receiving personal care in public schools may receive a number of services in accordance with an Individualized Education Program (IEP).

1. The IEP may not supersede or substitute for the personal care service plan.

2. The Personal Care Program requires a distinct and separate assessment and service plan.

E. Refer to Section 262.103 for billing instructions regarding personal care in public schools.

213.540 Employment-related Personal Care Outside the Home 10-1-~~19~~22

No condition of this section alters or adversely affects the status of individuals who are furnished personal care in sheltered workshops or similarly authorized habilitative environments. There may be a few ~~beneficiaries~~clients working in sheltered workshops solely or primarily because they have access to personal care in that setting. This expansion of personal care outside the home may enable some of those individuals to move or attempt to move into an integrated work setting.

A. Personal care may be provided outside the home when the requirements in subparts A1 through A5 are met and the services are necessary to assist an individual with a disability to obtain or retain employment.

1. The ~~beneficiary~~client must have an authorized, individualized personal care service plan that includes the covered personal care services necessary to and appropriate for an employed individual or for an individual seeking employment.

2. The ~~beneficiary~~client must be aged 16 or older.

3. The ~~beneficiary~~client's disability must meet the Social Security/SSI disability definition.

a. A ~~beneficiary~~client's disability may be confirmed by verifying his or her eligibility for SSI, Social Security disability benefits or a Medicaid disability aid category, such as Working Disabled or DDS Alternative Community Services waiver.

b. If uncertain whether a ~~beneficiary~~client qualifies under this disability provision, contact the Department of Human Services local office in the county in which the ~~beneficiary~~client resides.

4. One of the following two conditions must be met.

a. The ~~beneficiary~~client must work at least 40 hours per month in an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability).

b. Alternatively, the ~~beneficiary~~client must be actively seeking employment that requires a minimum of 40 hours of work per month in an integrated setting.

5. The ~~beneficiary~~client must earn at least minimum wage or be actively seeking employment that pays at least minimum wage.

B. Personal care aides may assist ~~beneficiaries~~clients with personal care needs in a ~~beneficiary~~client's workplace and at employment-related locations, such as human resource offices, employment agencies or job interview sites.

C. Employment-related personal care associated with transportation is covered as follows.

1. Aides may assist ~~beneficiaries~~clients with transportation to and from work or job-seeking and during transportation to and from work or for job-seeking.

2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; see Section 215.300, part F) in the service plan and all pertinent service documentation.

3. Medicaid does not cover mileage associated with any personal care service.

4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is included in the 64-hour per month personal care benefit limit for ~~beneficiaries~~clients aged 21 and older.

D. All personal care for ~~beneficiaries~~clients requires prior authorization.

E. Providers furnishing both employment-related personal care outside the home and non-employment related personal care at home or elsewhere for the same ~~beneficiary~~client must comply with the applicable rules at Sections 215.350 and~~,~~ 215.351~~ and 262.100~~.

213.600 In-State and Out-of-State Limited Services Secondary Personal Care Providers

10-1-~~19~~22

On rare occasions, a personal care ~~beneficiary~~client might have urgent cause to travel to a locality outside his or her personal care provider's service area. If DHS professional staff or contractor(s) designated by DHS authorizes personal care during the ~~beneficiary~~client's stay in that locality, the ~~beneficiary~~client may choose a personal care provider agency in the service area to which he or she is traveling.

A. In-State and Out-of-State Limited Services Secondary Personal Care Provider

If the selected provider is an in-state provider, the selected provider's services may be covered if all the following requirements are met:

1. The ~~beneficiary~~client's personal care provider (the "primary" provider) must request in writing that the selected provider (the "secondary" provider) assume the ~~beneficiary~~client's service for the specified duration of the ~~beneficiary~~client's stay.

2. The primary provider must forward to the secondary provider a copy of the ~~beneficiary~~client's current service plan and service documentation, including logs, for a minimum service period of sixty days prior to the request.

3. If the secondary provider requests additional information or documentation, the primary provider must forward the requested materials immediately.

4. The secondary provider must execute a written agreement to assume the ~~beneficiary~~client's care on behalf of the primary provider.

5. The secondary provider must submit its service documentation to the primary provider within ten working days of the ~~beneficiary~~client's departure from the temporary locality.

B. Out-of-State Limited Services Secondary Personal Care Provider

If the provider is an out-of-state provider, the provider must also download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application and contract to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).**

The selected provider must also submit to contractor designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff a written request for prior authorization accompanied with copies of the provider's license, Medicare certification, ~~beneficiary~~client's identifying information and the ~~beneficiary~~client's service plan.

C. All documentation exchanged between the primary and secondary providers must satisfy all Medicaid requirements.

213.610 Personal Care/Hospice Policy Clarification 10-1-~~19~~22

Medicaid ~~beneficiaries~~clients are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice and homemaker services.

A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with ~~beneficiaries~~clients or in home providers.

B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aid and homemaker services necessary for the treatment of the terminal condition.

C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the IndependentChoices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice-care in the home that provides the amount of services required to meet the needs of the ~~beneficiary~~client, the amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the

hospice and personal care records must explain the need for both and be supported by the policy in this section.

214.200 Service Plan Review and Renewal ~~7-1-2010~~-1-22

A. A personal care service plan is effective for up to one (1) year from the date of the ~~beneficiary~~client's last independent assessment.

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

214.300 Authorization of ARChoices Person Centered Service Plan and Personal Care Individual Service Plan 10-1-2~~21~~

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

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

This PCSP supersedes any other care plan that may have been previously developed by another Medicaid provider for the applicant. The ARChoices PCSP must include all appropriate ARChoices services and certain non-waiver services appropriate for the applicant, such as Personal Care.

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

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

~~The responsibility of developing a personal care individualized service plan is not placed with the DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.~~

The Arkansas Medicaid Program waives no other Personal Care Program requirements with regard to personal care individualized service plan authorizations ~~obtained by DHS RNs~~.

~~214.310 Development of ARChoices Person-Centered Service Plan~~ ~~1-1-19~~

~~If personal care services are not currently being provided when the DHS RN develops the ARChoices Person-Centered Service Plan (PCSP), the DHS RN will determine if personal care services are needed. If so, the service, amount, frequency, duration and the beneficiary's provider of choice will be included on the ARChoices PCSP. A copy of the ARChoices PCSP and a Start of Care form (AAS-9510) will be forwarded to the personal care provider, as is current practice for waiver services. The Start of Care form must be returned to the DHS RN within 10 working days from mailing or action may be taken by the DHS RN to secure another~~

~~personal care provider or modify the ARChoices PCSP. (The ARChoices PCSP is dated the date it is mailed.) Before taking action to secure another provider or modifying the PCSP, the applicant and/or family members will be contacted to discuss possible alternatives.~~

~~This PCSP supersedes any other care plan that may have been previously developed by another Medicaid provider for the applicant. The ARChoices PCSP must include all appropriate ARChoices services and certain non-waiver services appropriate for the applicant, such as Personal Care.~~

~~An agency providing services to an ARChoices beneficiary must report these services to the DHS RN. The services being provided to the ARChoices beneficiary must be included on the ARChoices PCSP. Prior to beginning services or revising services provided to an ARChoices beneficiary, contact the DHS RN so the PCSP is properly revised and approved. Please report all changes in services and changes in the ARChoices beneficiary's circumstances to the DHS RN immediately upon learning of the change. Certain services provided to an ARChoices beneficiary that are not included on the ARChoices PCSP may be subject to recoupment by the Medicaid Program.~~

~~**NOTE: It is the IndependentChoices employer or personal care provider's responsibility to place information regarding their presence in the home in a prominent location so that the DHS RN will be aware that they are serving the beneficiary. Preferably, the provider will place the information on the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will place the information in a location satisfactory to the applicant, as long as it is readily available and easily accessible by the DHS RN.**~~

~~The personal care individualized service plan developed by the personal care provider must meet all requirements as detailed in the personal care provider manual. This includes, but is not limited to, the amount of personal care services, personal care tasks, frequency and duration. The ARChoices PCSP and the required justification for each service remains the responsibility of the DHS RN. Therefore, final decisions regarding services included on the ARChoices PCSP rest with the DHS RN.~~

~~**NOTE: For ARChoices waiver beneficiaries participating in the IndependentChoices program, services are effective on the date of the DHS RN's signature on the ARChoices waiver PCSP.**~~

214.330 Medicaid Audit Requirements for the ARChoices ~~-~~Person-Centered Service Plan

10-1-~~19~~22

When the Medicaid Program, as authorized by the ARChoices Person-Centered Service Plan (PCSP), reimburses for Personal Care services, all Medicaid audits will be performed based on that authorization. Therefore, all documentation by the Personal Care provider must tie services rendered to services authorized as reflected on the ARChoices PCSP.

~~215.100 IndependentChoices Assessment and Service Plan Formats~~

~~1-1-19~~

~~A.~~

~~For IndependentChoices beneficiaries who are also active waiver beneficiaries in the ARChoices Program, the assessment tool used for waiver level of care determination and the waiver Person-Centered Service Plan (PCSP) will suffice to support authorization for personal care services, if signed by theDHS RN. Eligibility for personal care services is based on the same criteria as state plan personal care services. Services are effective on the date of the waiver PCSP. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver PCSP must include, at least, the information designated by DHS that is utilized to support the medical necessity, eligibility and amount of personal care services provided through~~

~~IndependentChoices or agency personal care services. This information is required in documentation for each beneficiary. As with all required documentation, this information must be available in the participant's chart or electronic record and available for audit and Quality Management Strategy reviews.~~

215.200 Personal Care Provider's Prior Authorization Request ~~7-1-20~~10-1-22

A. As part of each prior authorization request, each provider shall submit a complete and accurate form designated by DHS. The provider is not required to submit a proposed Individualized Service Plan to DHS.

B. The completed form designed by DHS shall include all information applicable to the individual ~~beneficiary~~client, including:

1. ~~Beneficiary~~Client and provider information;
2. Certification that the ~~beneficiary~~client's service plan will not duplicate any other in-home services of which the provider is aware;
3. The total number of hours per month the provider seeks to offer the ~~beneficiary~~client;
4. Detailed information on all personal assistance available to the ~~beneficiary~~client through other sources, including informal caregivers (e.g., family, friends), community organizations (e.g., Meals on Wheels), Medicare (e.g., Medicare home health aide services), or the ~~beneficiary~~client's Medicare Advantage health plan;
5. The frequency of in-person supervisory visits to be made by an agency supervisor based on the specific needs of the ~~beneficiary~~client and the recommendations of an agency-designated registered nurse; and,
6. The signed approval of the ~~beneficiary~~client or the ~~beneficiary~~client's legal representative.

C. When a ~~beneficiary~~client has two or more personal care providers, the providers should cooperate in the required nursing evaluation and the preparation and submission of the prior authorization request and completed form designated by DHS on behalf of the ~~beneficiary~~client.

D. When an individual will receive some or all of his or her services in a congregate setting, the assessment must reflect the RN's determination that the individual is an appropriate candidate for services delivered in that setting. See Section 216.201 and Sections 220.110 through 220.112.

E. Before furnishing any personal care services to an individual, the provider must prepare a complete and accurate Individualized Service Plan with proposed hours/minutes and frequency of needed tasks consistent with the aggregate number of hours authorized under the Task and Hour Standards (as described in Section 240.100). The service plan must be prepared, certified, and signed by a supervisor or registered nurse. The service plan and all subsequent revisions must be kept by the personal care provider as Documentation under Section 221.000.

215.210 Alternative Resources for Assistance 10-1-~~19~~22

A. The following requirements regarding alternative resources for assistance do not apply, or apply only insofar as they are legal, practical and practicable when the identifiable resources are prohibited from assisting the ~~beneficiary~~client by law or by a facility's or organization's rules or bylaws. For example, a relative of the ~~beneficiary~~client is an alternative resource in the ~~beneficiary~~client's home or the relative's home but not in the public school.

B. The form designated by DHS that is submitted by the provider to DHS or the contractor designated by DHS must include written evidence that the ~~beneficiary~~client or the ~~beneficiary~~client's representative and the provider have considered alternative resources available to assist or partially assist the ~~beneficiary~~client with physical dependency needs identified in the assessment.

1. The provider must determine whether voluntary third-party resources are available and if so, the extent of the third party's willingness to devote time to the benefit of the ~~beneficiary~~client. The provider must:
   a. Consider other members of the ~~beneficiary~~client's household as well as nearby relatives and friends,
   b. Indicate the usual times of their availability to assist the ~~beneficiary~~client and the frequency and duration of their assistance, and
   c. Explain the circumstances of any individual household member's inability to provide any assistance or to provide less than complete assistance with the ~~beneficiary~~client's physical dependency needs.
2. The provider must also consider such alternative community resources as public and private community agencies and organizations, whether secular or religious, paid or volunteer.
   a. Consider entities that provide not only in-home services, but also such services as adult day care or caregiver respite.
   b. List the approximate number of hours per week the ~~beneficiary~~client receives (or will receive) services from each such community resource.

C. The provider must make reasonable efforts to determine the nature, scope, frequency and duration of other services the individual receives, particularly in-home services.

D. The provider's case record documentation must include the certification that the ~~beneficiary~~client's individualized service plan does not duplicate any other in-home services of which the provider is aware.

215.300 Individualized Service Plan 10-1-2219

A ~~beneficiary~~client must receive services in accordance with an individualized service plan.

A. The plan must be acceptable to the ~~beneficiary~~client or the ~~beneficiary~~client's representative.

B. A registered nurse and other appropriate personnel of the personal care provider agency, in concert with the ~~beneficiary~~client or the ~~beneficiary~~client's representative, must design the individualized service plan to correlate with the physical dependency needs identified in the assessment.

C. The individualized service plan must be limited to assistance with the ~~beneficiary~~client's individual physical dependency needs.

D. The service plan must clearly identify which of the ~~beneficiary~~client's physical dependency needs will be met by each task performed by a personal care aide.

1. This requirement does not necessarily mandate writing a unique statement for each task or task component. Indexing the assessment may expedite documentation by permitting one to reference the relevant section of the assessment for the explanatory detail. For example:
   a. "Task 1 (corresponds to) Physical Dependency 2."
   b. "Task 6 (corresponds to) Physical Dependency 3."

2. In addition to establishing its correspondence to the assessment (e.g., designing individualized services for a ~~beneficiary~~client's physical dependency needs); the service plan must describe for each routine or activity listed:
    a. The individual tasks the aide is to perform for the ~~beneficiary~~client,
    b. The individual tasks with which the aide is to assist the ~~beneficiary~~client and
    c. The frequency and duration of service of each routine and activity, including:
        ~~(1)~~i. The number of days per week each routine or activity will be accomplished and
        ~~(2)~~ii. The maximum and minimum estimated aggregate minutes the aide should spend on all authorized tasks each service day.

E. The service plan must include written instructions for the personal care aide specifying how and when to execute or assist with the ~~beneficiary~~client's routines or activities including:
    1. The number of days per week to accomplish each routine or activity (as well as which days when relevant) and
    2. The time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.

F. The service plan must include written instructions describing whether and to what extent the aide's function in individual task components of each routine or activity is:
    1. To assist the ~~beneficiary~~client to perform the task,
    2. To perform the task for the ~~beneficiary~~client or
    3. To observe the ~~beneficiary~~client perform the task.

G. The service plan must require the ~~beneficiary~~client to perform all tasks within the ~~beneficiary~~client's capability. Medicaid does not cover assistance with any task a ~~beneficiary~~client can perform unless DHS professional staff or contractor(s) designated by DHS have authorized the assistance. For example:
    1. A ~~beneficiary~~client can manage his own laundry but he cannot extract wet items from the washer while leaning over the machine.
        a. The assessment notes that he needs assistance with the task of removing wet items from the washing machine.
        b. The service plan describes the assistance designed for his individual physical dependency need with his laundry.
        c. The registered nurse instructs the aide to perform the task(s) constituting the service.
    2. Loading the washer, emptying the dryer, folding and ironing clothing and linens are not covered tasks for this particular ~~beneficiary~~client.
    3. Removing laundry from the washer and loading it in the dryer are covered tasks for this ~~beneficiary~~client if those tasks are described in his service plan and authorized by DHS professional staff or contractor(s) designated by DHS.

H. The form designated by DHS that is submitted by the provider must support the service plan and the provider's RN's instructions to the aide(s) regarding the delivery of services. The plan must reflect whether the individual is receiving services in more than one setting. If a ~~beneficiary~~client is receiving services in more than one setting, it must be clear in which setting a ~~beneficiary~~client receives a particular service or assistance. See part G of Section 215.200, Section 216.201 and Sections 220.110 through 220.112.

See Section 215.330 for information about service plan revision requirements.

215.310 Identifying Individual Physical Dependency Needs 10-1-2219

A. A personal care provider must identify and describe (*assess*) a ~~beneficiary~~client's need for assistance (*physical dependency need*) with individual task components of routines and activities of daily living in the form designated by DHS.

B. The provider must describe the type, amount, frequency and duration of assistance required for each task thus identified (*individualized service plan*) in the form designated by DHS.

C. A personal care aide furnishes assistance (*service*) with the individual task components of routines and activities of daily living, in accordance with the individualized service plan authorized by DHS professional staff or contractor(s) designated by DHS.

D. The following examples illustrate how to facilitate service plan development and service documentation by assessing the ~~beneficiary~~client at the level of individual task performance:

E. A ~~beneficiary~~client is unable to pick up slender items, such as spoons and toothbrushes, and sometimes loses his grip on those objects.

1. This condition causes similar physical dependency needs in different routines.

Sample Assessment Entry	
Eating:	The ~~beneficiary~~client needs someone to place eating utensils in his grasp and to retrieve them when he drops them.
Oral hygiene:	The ~~beneficiary~~client needs someone to place his toothbrush in his grasp and to retrieve it when he drops it.

2. The service plan will contain instructions to the aide similar to this Sample Service Plan Entry.

Sample Service Plan Entry	
Eating:	Place the (*object*) in (*~~beneficiary~~client's name*)'s grasp.
Oral hygiene:	Retrieve the (*object*) when (*~~beneficiary~~client's name*) drops it and replace the (*object*) in his grasp.

F. Medicaid Program staff reviewing a personal care provider's records must be able to readily observe that the service plan logically follows the assessment, which is possible only if the provider assesses the ~~beneficiary~~client at the individual task performance level.

1. Additionally, the aide's daily service documentation and the registered nurse's case notes must address the requirements and objectives of the service plan.

2. There must be a clear and logical relationship of each component of this documentation to each other component and to the service continuum.

215.320 Identifying Frequency of In-Person Supervisory Visits 10~~7~~-1-220

A. A registered nurse designated by the personal care provider must identify and recommend the frequency for in-person visits to be made by the supervisor of the personal care aide, based on the specific needs of the ~~beneficiary~~client.

B. The frequency of in-person visits shall be at least every 365 days and shall be determined jointly by the personal care provider and the ~~beneficiary~~client or the ~~beneficiary~~client's legal representative, based on the recommendations of the registered nurse.

C. The individualized service plan must identify the agreed frequency, the risk factors that are specific to that ~~beneficiary~~client, and a justification for the agreed frequency. The risk factors identified by the service plan must include without limitation any relevant medical diagnoses; the ~~beneficiary~~client's mental status; the presence of family or other residents in the ~~beneficiary~~client's home, and the frequency of their presence; and the ~~beneficiary~~client's physical dependency needs, including the activities of daily living (ADL) with which the ~~beneficiary~~client needs assistance.

D. If the frequency identified in the service plan is less than the frequency recommended by the registered nurse, the service plan shall identify the medical justification for the reduced frequency.

E. If the ~~beneficiary~~client has a significant change of condition affecting a risk factor, the registered nurse shall review the frequency of in-person visits and recommend changes as appropriate.

215.330 Service Plan Revisions ~~7~~10-1-2~~20~~

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

A. A personal care provider must amend a ~~beneficiary~~client's individualized service plan to document any permanent service plan changes before the provider amends service delivery.

1. For purposes of this requirement, a **permanent** service plan change is one expected to last thirty (30) days or more.
2. Service plan revisions must be made if a ~~beneficiary~~client's condition changes to the extent that the personal care provider must modify, add or delete tasks.
3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.
   a. Changes in the amount, frequency or duration of a service must be documented in the medical record,
   b. The reasons for the service variances must be written daily in the service documentation.
4. A service plan revision must be authorized by DHS professional staff or contractor(s) designated by DHS only if the provider requests to increase or decrease the total monthly hours. DHS professional staff or the DHS contractor will review the request and determine, based on application of the Task and Hour Standards described in Section 240.100, the amount of adjustment to make in prior authorized minutes. DHS professional staff or the DHS contractor will revise the number of minutes in Interchange.

B. Providers may not reduce a ~~beneficiary~~client's services without prior authorization by DHS professional staff or contractor(s) designated by DHS

C. The personal care provider must document medical reasons for service plan revisions.

D. The new beginning date of service is the date authorized by DHS professional staff or contractor(s) designated by DHS.

E. Service plan revisions and updates since the previous assessment must remain with the service plan. Updates since the previous assessment must include documentation of when and why the change occurred.

215.350 Service Plan Requirements for a Single Provider and a Single ~~Beneficiary~~Client at Multiple Service Locations

10-1-22~~07~~

A. Only one service plan for personal care services is necessary when a single provider is delivering services to a ~~beneficiary~~client in more than one authorized location.

B. The service plan must identify which tasks the aide performs at each location.

1. When the aide performs the same or similar tasks at each location, the service plan must separately identify the tasks at each location in accordance with the criteria in Sections 215.300 and 215.310.

2. The aide's service documentation must reflect the service location distinctions.

215.351 Service Plan Requirements for Multiple Providers

~~7~~10-1-22~~0~~

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

A. Each provider must create an individualized service plan and collaborate with the ~~beneficiary~~client's other personal care provider(s) to create a comprehensive service plan.

1. Each comprehensive service plan must clearly state which provider provides which services, where and on which day(s) they do so, which time(s) of day they furnish services and the maximum and minimum amount of time per day and per week that the provider will take to perform those services.

2. Each comprehensive service plan must be authorized, signed and dated by the provider.

B. Each time a personal care provider intends to revise or renew a comprehensive service plan, that provider must notify the ~~beneficiary~~client's other personal care provider(s) to agree on the revision or renewal.

C. If the providers cannot agree on a comprehensive service plan, plan revision or plan renewal, the providers shall submit the various alternatives to DHS professional staff or contractor(s) designated by DHS, who shall determine the terms of the final comprehensive service plan.

D. Any Medicaid provider having knowledge that another Medicaid provider has failed to comply with a service plan, including a comprehensive service plan, shall notify the DMS Director of such failure within ten (10) business days of the occurrence, or sooner if the ~~beneficiary~~client's life or health is threatened.

215.360 Changes of Condition

10~~7~~-1-22~~0~~

A. The individualized service plan must identify individualized, ~~beneficiary~~client-specific standards, based on the identified risk factors, for when a caregiver or supervisor must document and report any significant change in the ~~beneficiary~~client's condition. A significant change is one that exhibits a major decline or improvement in the physical or mental health status of the ~~beneficiary~~client.

B. If a caregiver or supervisor observes a significant change of condition, the caregiver or supervisor must document and report the change of condition as required by the change-reporting standards contained in the ~~beneficiary~~client's individualized service plan. Documentation must include the time and date the change was identified by the caregiver and a full description of the change.

C. Within twenty-four (24) hours of a significant change of condition being reported, a registered nurse must evaluate and document an assessment of the ~~beneficiary~~client, including without limitation the reported change of condition.

D. A change of condition under this section may result in a change to the service plan or to the frequency of supervisory visits, but it does not automatically result in a new Independent Assessment by the DHS Independent Assessment Contractor. Independent Assessments or Reassessments are governed by the provisions of the Arkansas Independent Assessment Medicaid Provider Manual.

216.000 Coverage ~~7~~10-1-2~~20~~

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

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State
2. Provided by an individual qualified to provide such services and who is not a member of the ~~beneficiary~~client's family. See Section 222.100, part A, for the definition of "a member of the ~~beneficiary~~client's family"
3. Prior authorized by DHS professional staff or contractor(s) designated by DHS
4. Provided by an individual who is
   a. Qualified to provide the services;
   b. Supervised by an individual meeting the qualification set forth in Section 220.100; and,
   c. Not a member of the ~~beneficiary~~client's family; ~~OR~~or
   d. Qualified to provide the service according to approved policy in the Independent Choices Program.
5. Furnished in the ~~beneficiary~~client's home or, at the State's option, in another location

B. Medicaid restricts coverage of personal care to services directly helping a ~~beneficiary~~client with certain specified routines and activities, regardless of the ~~beneficiary~~client's ability or inability to execute other non-covered routines and activities. Personal care services may be provided in a ~~beneficiary~~client's home or while accompanying the ~~beneficiary~~client to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in this section.

C. Travel Time of Personal Care Aide Accompanying ~~Beneficiary~~Client:

1. Personal care only covers personal care aide travel time when all of the following apply:
   a. The personal care aide accompanies the ~~beneficiary~~client in the same vehicle as the ~~beneficiary~~client travels to and returns from a community location for medical appointment or community activity;
   b. The travel time billed is solely for necessary time in transit from the ~~beneficiary~~client's home to the community location and the return travel from the community location to the ~~beneficiary~~client's home;
   c. The ~~beneficiary~~client's participation in the local community activity is for the benefit of the ~~beneficiary~~client and to meet the ~~beneficiary~~client's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the personal care aide, a family member, the driver, or other passengers);

d. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;

e. The ~~beneficiary~~client's Individualized Service Plan includes Personal Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;

f. While in transit to and from the community location, the ~~beneficiary~~client requires, or is likely to need given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility/ambulating; and

g. The travel time is reasonable given driving distances, traffic conditions, and weather, with time and locations documented.

2. Travel time is not reimbursable if any other adult person accompanying (or driving) the ~~beneficiary~~client is a family member and is reasonably able to assist the ~~beneficiary~~client in transit if needed.

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

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

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

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

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

216.130 Tasks

~~7-22-10~~10-1-22

A. "Tasks" are components of routines and instrumental activities of daily living. For example:

1. Meal preparation is a routine that involves a number of tasks: removing food from the refrigerator or pantry, opening food containers and packages, processing meats or vegetables, mixing ingredients, setting oven temperatures and adjusting stovetop settings; setting out, using, washing and putting away cooking and eating utensils, etc.

2. Laundry is an activity of daily living. Some tasks associated with the laundry activity are: sorting items to be washed, measuring detergent and additives, adjusting

machine settings, extracting wet items from the washer and dry items from a dryer, hanging wet items on a line to dry, etc.

B. "Individual task component" and "task component" have the same meaning as "task." The words "routine," "activity" and "task," retain their meaning regardless of whether the person performing them is the ~~beneficiary~~client, the aide or any other person.

216.140 Service 10-1-~~22~~9

A. A “personal care service" is a covered task or a related group of covered tasks.

B. A "personal care aide service" is a personal care service.

1. "Personal care services" and "personal care aide services" are interchangeable expressions that mean "covered tasks."
2. Only a certified personal care aide, or an individual who meets or exceeds the qualifications of a personal care aide, as defined in Section 222.100, who is also in the employ of a Medicaid-enrolled personal care provider, may provide covered personal care services or personal care aide services as defined in this manual.

C. As a condition of coverage and reimbursement, all personal care services must be:

1. Reasonable and medically necessary, supported by the individual’s latest nursing evaluation, and consistent with the individual’s service plan;
2. Expressly authorized in the individual’s approved personal care services prior authorization;
3. Not available from another source (including, but not limited to, family members, a member of the ~~beneficiary~~client’s household, or other unpaid caregivers; another Medicaid State Plan covered service; the Medicare program; the ~~beneficiary~~client’s Medicare Advantage plan or Medicare prescription drug plan; or the ~~beneficiary~~client’s private long-term care, disability, or supplemental insurance coverage);
4. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services, including without limitation the aggregate weekly or monthly limits calculated by DHS for the ~~beneficiary~~client in accordance with the Arkansas Medicaid Task and Hours Standards;
5. Provided by qualified, Medicaid-enrolled, DPSQA-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and
6. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

D. Personal care services exclude all of the following:

1. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including, but not limited to, aseptic or sterile procedures, application of dressings, medications administration, injections, observation and assessment of health conditions, insertion, removal, or irrigation of catheters, tube or other enteral feedings, tracheostomy care, oxygen administration, ventilator care, drawing blood, and care and maintenance of any medical equipment;
2. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
3. Services provided for a person other than the ~~beneficiary~~client, including but limited to a provider, family member, household resident, or neighbor;

4. Companion, socialization, entertainment, or recreational services or activities of any kind (including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);
5. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and
6. Mental health counseling or services.

216.201 Simultaneous Services and Congregate Settings 10-1-~~3-03~~22

Simultaneous services to two (2) ~~beneficiaries~~clients or to more than two (2) ~~beneficiaries~~clients in a congregate setting may be covered provided the service plan and the scope, duration and frequency of each individual's services are directly related to the needs of the individual as reflected in the RN's assessment of the individual's physical dependency needs. Part H of Section 215.300, Sections 216.211 and Sections 220.110 through 220.112 provide additional information and include instructions for determining the relative amount of coverage available per ~~beneficiary~~client for tasks performed for multiple ~~beneficiaries~~clients.

216.211 Meal Preparation 10-1-22~~3-03~~

A. Meal preparation is a covered personal care service if the aide's logged service time meets certain conditions:

1. The aide must make reasonable efforts to prepare servings of a size or an amount commensurate with the ~~beneficiary~~client's nutritional needs and normal appetite. For the purpose of these rules a provider will be presumed to have made a reasonable effort unless the quantity of food prepared exceeds by more than 100% the ~~beneficiary~~client's need for a meal or meals. An example follows.
   a. An aide prepares soup for a ~~beneficiary~~client.
   b. The ~~beneficiary~~client typically consumes 8 oz. of soup per meal.
   c. If the aide prepares 16 oz. or less per meal, the provider will be presumed to have made reasonable efforts to limit the service to the ~~beneficiary~~client's needs.
   d. However, if the aide prepares 3 quarts of soup per meal, the time required is presumed unreasonable and the provider is not entitled to reimbursement. Refer to part E of this section for rules regarding simultaneous services for two or more ~~beneficiaries~~clients.
2. Medicaid does not cover an aide's time at meal preparation tasks or assisting at meal preparation tasks for individuals who are not personal care ~~beneficiaries~~clients or whose personal care service plans do not include meal preparation tasks or assistance with meal preparation tasks.
   a. The aide must document the meal preparation tasks in the ~~beneficiary~~client's personal care service record.
   b. Refer to part E of this section for rules regarding simultaneous services for two or more ~~beneficiaries~~clients.

B. This routine includes the tasks involved in:

1. Preparing and serving a meal and
2. Cleaning articles and utensils used in the preparation of the meal.

C. To be eligible to receive personal care assistance with meal preparation, a ~~beneficiary~~client's physical dependency needs must prevent or substantially impair his or her ability to perform meal-preparation tasks or to clean up the utensils and preparation area.

D. The aide's service in the ~~beneficiary~~client's meal preparation routine is hands-on assistance with meal preparation tasks the ~~beneficiary~~client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

E. Simultaneous services to two ~~beneficiaries~~clients or to more than two ~~beneficiaries~~clients in a congregate setting may be covered if the rules below and the regulations stated at Section 216.201 and Sections 220.110 through 220.112 are followed.

1. Medicaid will cover the actual time attributable to the individual ~~beneficiary~~client when services, such as meal preparation, are delivered simultaneously.

2. Refer to Section 220.111 for the methodologies required to determine the amount of time attributable to the individual ~~beneficiary~~client.

F. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following example.

1. A ~~beneficiary~~client is able to remove items from the refrigerator and pantry and to perform most tasks related to meal preparation.

2. The assessment states, "~~Beneficiary~~Client's arthritic condition prevents him from opening bottles and jars with small tops and from gripping eating utensils."

3. A related entry in the service plan would be similar to:

   Meal preparation:

   a. The aide will open bottles and jars with lids too small for the ~~beneficiary~~client to negotiate.

   b. The aide will operate cooking and serving utensils the ~~beneficiary~~client cannot grip or pick up.

G. The complete meal-preparation routine might include additional instructions. These examples are simply to illustrate that instructions at the task level facilitate correlation of physical dependency needs with individualized services.

216.212 Consuming Meals 10-1-~~22~~9

A. The service related to this routine includes the tasks involved in giving the ~~beneficiary~~client hands-on assistance to consume a meal and fluids. It does not include meal preparation.

B. To receive personal care assistance with this routine, a ~~beneficiary~~client's physical dependency needs must prevent or substantially impair his or her ability to execute tasks such as cutting food in bite-size pieces or negotiating food from plate to mouth.

C. The related service is hands-on assistance with the ~~beneficiary~~client's physical dependency needs to accomplish eating. The aide may only assist with or perform functional tasks the ~~beneficiary~~client cannot physically perform, in accordance with the ~~beneficiary~~client's physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following examples.

1. An assessment states, "~~Beneficiary~~Client's arthritis prevents him from gripping slender objects such as eating utensils with either hand." The related task in the service plan is for the aide to "cut items into bite-size pieces and deliver them from plate to mouth for the ~~beneficiary~~client."

2. The same assessment also states, "Effects of a recent stroke cause the ~~beneficiary~~client to choke or to risk choking unless food is pureed."

   a. The related task in the service plan is for the aide to "puree food items for the ~~beneficiary~~client."

b. A separate statement, "The aide will deliver spoonfuls from plate to mouth for the ~~beneficiary~~client," addresses the arthritic condition.

E. Observing a ~~beneficiary~~client eat is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the ~~beneficiary~~client's eating places the ~~beneficiary~~client at risk of injury or harm.

216.240 Personal Hygiene 10-1-22~~19~~

A. The tasks constituting this service are those involved in hands-on assistance with the ~~beneficiary~~client's personal hygiene. "Personal hygiene" means grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene.

1. An aide's time spent reminding a ~~beneficiary~~client to perform personal hygiene tasks is not a covered service unless the ~~beneficiary~~client's service plan includes hands-on assistance with personal hygiene.

2. An aide's time spent observing a ~~beneficiary~~client perform personal hygiene tasks is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the activity places the ~~beneficiary~~client at risk of injury or harm.

B. ~~Beneficiaries~~Clients eligible for this service must have a physical dependency preventing or substantially impairing their ability to perform hair and skin care and grooming, oral hygiene, shaving and nail care.

C. The aide's service in regard to this routine is hands-on assistance with personal hygiene tasks the ~~beneficiary~~client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.250 Bladder and Bowel Requirements 10-1-22~~13-03~~

A. The tasks constituting this service are those involved in hands-on assistance with the ~~beneficiary~~client's elimination routines.

B. ~~Beneficiaries~~Clients eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To safely enter and exit the bathroom, or

2. To properly complete elimination routines without assistance.

C. The aide's service in this routine is hands-on assistance with bladder-and-bowel-voiding tasks the ~~beneficiary~~client cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.260 Medication 10-1-22~~19~~

A. Personal care aide services regarding medication routines are covered only to the extent that they are permitted by the Arkansas Nurse Practice Act and implementing rules and regulations.

B. The tasks constituting this service are those involved in hands-on assistance with the ~~beneficiary~~client's medications.

C. ~~Beneficiaries~~Clients eligible for this service must have a physical dependency need preventing or substantially impairing their ability to safely and correctly dispense and ingest orally administered prescription medications.

D. The aide's service in regard to the ~~beneficiary~~client's medication routines is hands-on assistance with tasks the ~~beneficiary~~client cannot physically perform, according to the detailed physical dependency needs described in the assessment, as described in the Arkansas State Board of Nursing Position Statement 97.2.

E. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.270 Mobility and Ambulation 10-1-22~~19~~

A. The tasks constituting this service are those involved in hands-on assistance with the ~~beneficiary~~client's mobility and ambulation. "Mobility and ambulation" mean functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive equipment.

B. ~~Beneficiaries~~Clients eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To turn themselves in bed,
2. To move from bed to chair (including wheelchair or motorized chair),
3. To walk (alone or with a device) or
4. To operate a push wheelchair or a motorized chair.

C. The aide's service in this routine is hands-on assistance with ambulation and mobility tasks the ~~beneficiary~~client cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.300 Tasks Associated with Covered Activities of Daily Living 10-1-22~~13-03~~

A. The tasks constituting this group of services are those involved in hands-on assistance with the ~~beneficiary~~client's incidental housekeeping, laundry and shopping. Tasks associated with activities of daily living are not covered if the aide is also performing the tasks for other individuals of the same household, home or facility

1. Who are not Personal Care Program ~~beneficiaries~~clients, or
2. Who are Personal Care Program ~~beneficiaries~~clients whose service plans do not require the identical tasks.

B. To be eligible for services associated with activities of daily living:

1. A ~~beneficiary~~client must exhibit one or more physical dependency need(s) related to his or her impaired ambulation, mobility or functional capability within the service delivery location;
2. The personal care assessment must describe the impairments that prevent or impede the ~~beneficiary~~client's ability to move freely and safely about the living area and to perform necessary tasks and
3. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.310 Incidental Housekeeping

10-1-2219

A. "Incidental housekeeping" means cleaning of the floor, furniture, and areas that are directly used by the ~~beneficiary~~client.

B. The aide's service in regard to incidental housekeeping is hands-on assistance with covered tasks the ~~beneficiary~~client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

C. The assessment must describe the impairments that prevent or impede the ~~beneficiary~~client's ability to move freely and safely about their living area and clean the floor and furniture in the area they occupy.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.320 Laundry

10-1-2213-03

A. "Laundry" means laundering only items incidental to the care of the ~~beneficiary~~client. Laundry is not a covered service if it includes laundry services for the convenience of non-Medicaid eligible individuals residing in the same service delivery location. For example,

1. A spouse requires assistance with laundry. The remaining cohabiting spouse is not a Medicaid ~~beneficiary~~client.
    a. The cohabiting spouse is usually considered an alternative resource.
    b. It is presumed that the cohabiting spouse will perform routine laundry services for the household.
2. If, however, the Medicaid-eligible spouse is incontinent of bowel or bladder:
    a. Laundry may be a covered service to the extent that it is a service designed to address the ~~beneficiary~~client's immediate needs, e.g., cleaning soiled bedding or clothing.
    b. If the laundry service is designed to address the ~~beneficiary~~client's immediate needs, the aide may top up an incomplete washer-load by including items used by the remaining cohabiting spouse and the service will still be covered.

B. The aide's service in regard to laundry is hands-on assistance with covered laundry tasks the ~~beneficiary~~client cannot physically perform, according to the ~~beneficiary~~client's physical dependency needs detailed in the assessment.

C. The assessment must also describe the impairment(s) that prevent or impede the ~~beneficiary~~client's ability to move freely and safely about his or her living area and to perform some or all of the laundry tasks involved in maintaining his or her own clothing and bed and bath linens.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.330 Shopping

10-1-2219

"Shopping" means services to address the ~~beneficiary~~client's physical dependency need by assisting the ~~beneficiary~~client with shopping or by shopping for the ~~beneficiary~~client.

A. Assisting a ~~beneficiary~~client with shopping is a covered service only when the ~~beneficiary~~client is purchasing items that are necessary for the ~~beneficiary~~client's health and maintenance in the home (such as food, clothing, and other essential items) and that are used primarily by the ~~beneficiary~~client or, are used primarily by the ~~beneficiary~~client

and other Personal Care Program ~~beneficiaries~~clients who reside in the same service delivery location, and whose service plans include assistance with shopping.

1. The aide's service in regard to shopping is hands-on assistance with covered shopping tasks the ~~beneficiary~~client cannot physically perform, according to the ~~beneficiary~~client's physical dependency needs detailed in the assessment.
2. The assessment must describe the impairment(s) that prevent or impede the ~~beneficiary~~client's ability to move freely and safely in stores and perform some or all of the shopping tasks necessary to maintain his or her health and comfort.
3. The service plan must correlate each required task with the ~~beneficiary~~client's corresponding physical dependency need. See Sections 215.300 and 215.310.

B. If the service plan requires the aide to shop for the ~~beneficiary~~client:

1. The ~~beneficiary~~client, or the ~~beneficiary~~client's representative, has freedom of choice to describe the items to be purchased (within the constraints stated herein) for the ~~beneficiary~~client's maintenance in the home.
2. The ~~beneficiary~~client has freedom of choice to designate the individual stores at which to purchase the items.
   a. If the designated stores are within the ~~beneficiary~~client's normal retail service area the service plan need not identify the specific stores.
   b. If the designated stores are outside the normal retail service area for residents of the ~~beneficiary~~client's locale, the service plan must include the stores' names and locations.

C. If there are other members of the ~~beneficiary~~client's household, the service plan must not include shopping, or assistance with shopping, unless the assessment fully documents all reasons each household member can neither:

1. Assist with or do the ~~beneficiary~~client's shopping, nor
2. Arrange for someone else to assist with or to do the ~~beneficiary~~client's shopping.

D. Medicaid provides no additional coverage for an aide's mileage incurred performing shopping tasks.

216.400 Personal Care Aide Service and Documentation Responsibility 10-1-~~22~~19

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

It is the responsibility of the personal care aide to accomplish the following:

A. Perform authorized tasks as instructed by the supervising RN or QIDP.

B. Maintain a service log.

1. The service log must be completed at the time services are delivered. In the service log, it is not necessary to itemize the time spent on each individual ADL or IADL task for a given ~~beneficiary~~client, provided these tasks were performed by the same personal care aide in the same visit on the same day and at the same location.
2. If the service log is not completed concurrently with service delivery, coverage may be denied.
3. Refer to Sections 220.110 through 220.112 for service log requirements.

C. Provide necessary documentation showing the date, time, location, nature and scope of authorized services delivered.

D. Provide necessary documentation showing the date, time, location, nature and scope of emergency services delivered.

1. If an emergency requires the personal care aide to perform a personal care service task not included on the personal care service plan, the personal care aide must receive when possible, prior approval from the supervising registered nurse or QIDP to perform the task.

2. When prior approval is not possible, the personal care aide may perform the emergency service task, but she or he must receive post-service approval from the supervising registered nurse or QIDP.

3. Document the circumstances in detail, describing:

a. The nature of the emergency,

b. The action or task required to resolve the emergency and

c. The justification for the unscheduled service.

E. If a personal care aide does not perform a particular task scheduled on the service plan, the personal care aide must document why she or he did not perform the task that day.

217.000 Benefit Limits 10-1-2219

A. Medicaid imposes a 64-hour benefit limit, per month, per ~~beneficiary~~client, on personal care aide services for ~~beneficiaries~~clients aged 21 and older.

B. The 64-hour limitation applies to the monthly aggregated hours of personal care aide services.

C. This 64 - hour limit on personal care services for ~~beneficiaries~~clients aged 21 and older is a firm cap for which there will be no extensions or exceptions.

D. The hour limit does not apply to ~~beneficiaries~~clients under age 21.

220.100 Service Supervision ~~7-1-20~~10-1-221

A. The provider must assure that the delivery of personal care services by personal care aides is supervised.

1. A supervisor must be a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.

2. Alternatively, a Qualified Intellectual Disabilities Professional (QIDP) may fulfill the supervision requirement for personal care services to ~~beneficiaries~~clients residing in alternative living situations or alternative family homes, licensed and certified by DPSQA as personal care providers.

3. An individual who personally provides personal care services to a ~~beneficiary~~client may not supervise another personal care aide providing personal care services to that same ~~beneficiary~~client.

B. The supervisor has the following responsibilities.

1. The supervisor must instruct the personal care aide in

a. Which routines, activities and tasks to perform in executing a ~~beneficiary~~client's service plan;

b. The minimum frequency of each routine or activity; and

c. The maximum number of hours per month of personal care service delivery, as authorized in the service plan.

2. At least once a month, the supervisor must

a. Review the aide's records;

b. Document the record review; and

c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

3. At least annually, the supervisor must visit the ~~beneficiary~~client at the service delivery location to conduct on-site evaluation.

a. Medicaid requires that at least one of these supervisory visits annually must be when the aide is not present.

b. If the frequency of in-home supervisory visits for a ~~beneficiary~~client is greater than one annually, at least one visit must be while the aide is present and furnishing services.

4. When the aide is present during the visit the supervising RN or QIDP must

a. Observe and document;

~~(1)~~i. The condition of the ~~beneficiary~~client;

~~(2)~~ii. The type and quality of the personal care aide's service provision;

~~(3)~~iii. The interaction and relationship between the ~~beneficiary~~client and the aide; and

~~(4)~~iv. Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.

b. Consult with the agency-designated registered nurse regarding modifications to the service plan, if necessary, based on the observations and findings from the visit and document the consultation in the ~~beneficiary~~client's records; and,

c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

5. When the aide is not present during the visit, the supervisor must

a. Observe and document the condition of the ~~beneficiary~~client;

b. Observe and document, from available evidence, the type and quality of the personal care aide's service provision;

c. Observe, document, and report any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits;

d. Query the ~~beneficiary~~client or the ~~beneficiary~~client's representative and document pertinent information regarding the ~~beneficiary~~client's opinion of:

~~(1)~~i. The type and quality of the aide's service;

~~(2)~~ii. The aide's conduct; and

~~(3)~~iii. The adequacy of the working relationship of the ~~beneficiary~~client and the aide.

e. Consult with the agency-designated registered nurse regarding modifications to the service plan, if necessary, based on observations and findings from the visit and document the consultation in the ~~beneficiary~~client's records; and

f. Further instruct the aide, if necessary, and document the nature of and the reasons for further instructions.

C. The provider must review the service plan and the aide's records as necessary. The review will ensure that the daily aggregate time estimate in the service plan accurately reflects the actual average time the aide spends delivering personal care aide services to a ~~beneficiary~~client.

220.110 Service Log 10-1-2213

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

Instructions in this section apply to all ~~beneficiaries~~clients' service logs, with one exception. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers maintain their service logs by means of the format and instructions of form DMS-873, *"Arkansas Department of Human Services Division of Medical Services Instructions for completing the Service Log & Aide Notes For Personal Care Services in a Residential Care Facility"*. Effective for dates of service on and after March 1, 2008, form DMS-873 is found in Section V of this manual and DMS requires that RCF Personal Care providers use it exclusively for its designated purposes. See Section 220.111 for special documentation requirements regarding multiple ~~beneficiaries~~clients who are attended by one aide. Those instructions at Section 220.111 do not apply to RCF Personal Care providers, effective for dates of service on and after March 1, 2008. See Section 220.112 for special documentation requirements regarding multiple aides attending one ~~beneficiary~~client. Those instructions at Section 220.112 do not apply to RCF Personal Care providers, effective for dates of service on and after March 1, 2008. The examples in these sections and in Section 220.110 are related to food preparation, but personal care ~~beneficiaries~~clients may receive other services in congregate settings if their individual assessments support their receiving assistance in that fashion.

A. Medicaid covers only service time that is supported by an aide's service log.

B. Service time in excess of the maximum service time estimates in the authorized service plan is covered only when the provider complies with the rules in Sections 215.330 and 220.110 through 220.112.

C. The time estimate in the service plan is not service documentation. It is an estimate of the anticipated minimum and maximum daily duration of medically necessary personal care aide service for an individual ~~beneficiary~~client.

D. For each service date, for each ~~beneficiary~~client, the personal care aide must record the following:

1. The time of day the aide begins the ~~beneficiary~~client's services.
2. The time of day the aide ends a ~~beneficiary~~client's services. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the ~~beneficiary~~client's service delivery location.
3. Notes regarding the ~~beneficiary~~client's condition as instructed by the service supervisor.
4. Task performance difficulties.
5. The justification for any emergency unscheduled tasks and documentation of the prior-approval or post-approval of the unscheduled tasks.
6. The justification for not performing any scheduled service plan required tasks.
7. Any other observations the aide believes are of note or that should be reported to the supervisor.

E. If the aide discontinues performing service-plan-required tasks at any time before completing all of the required tasks for the day, the aide will record:

1. The beginning time of the non-service-plan-required activities,
2. The ending time of the non-service-plan-required activities,
3. The beginning time of the aide's resumption of service-plan-required activities and
4. The beginning and ending times of any subsequent breaks in service-plan-required aide activities.

5. If the aide discontinues or interrupts the ~~beneficiary~~client's service-plan-required activities at one location to begin service-plan-required activities at another location, the aide must record the beginning and ending times of service at each location.

220.111 Service Log for Multiple ~~Beneficiaries~~Clients 10-1-22~~19~~

Effective for dates of service on and after March 1, 2008, the rules in this section do not apply to RCF and ALF Personal Care providers.

An aide delivering services to two or more ~~beneficiaries~~clients at the same service location, during the same period (discontinuing or interrupting a ~~beneficiary~~client's service plan required tasks to begin or resume service plan required tasks for another ~~beneficiary~~client, or performing an authorized service simultaneously for two or more ~~beneficiaries~~clients. For example, cleaning a living space used by more than one ~~beneficiary~~client or preparing a meal that will be eaten by more than one ~~beneficiary~~client), must comply with the applicable instructions in parts A or B below:

A. If providing services for only two ~~beneficiaries~~clients, the aide must record in each ~~beneficiary~~client's service log

1. The name of each individual for whom they are simultaneously performing personal care service;
2. The beginning and ending times of service for each ~~beneficiary~~client and the beginning and ending times of each interruption and of each resumption of service; and
3. Which services or services were performed simultaneously for more than one ~~beneficiary~~client.

B. If services are performed in a congregate setting (more than two ~~beneficiaries~~clients) the service log must state

1. The actual time of day (clock-time) that the congregate services begin and end;
2. The number of individuals, and the name of each individual, both Medicaid-eligible and non-Medicaid eligible, who received the documented congregate services during that period; and.
3. Which services or services were performed simultaneously for more than one ~~beneficiary~~client.

C. For services performed simultaneously for more than one ~~beneficiary~~client, the provider must split the time among the ~~beneficiaries~~clients (for example, if the aide cleaned a bathroom shared by two ~~beneficiaries~~clients and it took 20 minutes, the aide would document only half of that time - 10 minutes - for each ~~beneficiary~~client for the task).

D. If the ~~beneficiaries~~clients have different providers and different aides, both providers may not bill for cleaning a shared living space (e.g., a bathroom) or performing another task that benefits both ~~beneficiaries~~clients (e.g., preparing a meal for both). The providers must determine which of their aides will be responsible for performing the task. The provider whose aide did not perform the task may not bill for it.

E. A provider who knowingly bills twice for the same service or for a service that has been billed by another provider is committing a fraudulent act and may be referred by DHS to the Medicaid Fraud Control Unit.

220.112 Service Log for Multiple Aides with One ~~Beneficiary~~Client 10-1-22~~12~~

Effective for dates of service on and after March 1, 2008, the rules in this section do not apply to RCF and ALF Personal Care providers.

When two or more aides attend a single ~~beneficiary~~client, each aide must record the beginning and ending times of each service plan required routine or activity of daily living that she or he performs for the ~~beneficiary~~client, regardless of whether another aide is performing a service plan required routine or activity of daily living at the same time.

222.100 Personal Care Aide Selection, Training and Continuing Education 10-1-~~2213~~

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

A. The ~~beneficiary~~client must receive Medicaid Personal Care services from a certified personal care aide who is not a member of the ~~beneficiary~~client's family. The Medicaid agency defines, "a member of the ~~beneficiary~~client's family" as:

1. A spouse.
2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent.
3. Legal guardian of the person.
4. Attorney-in-fact granted authority to direct the ~~beneficiary~~client's care.

B. Personal care aides must be selected on the basis of such factors as:

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

C. The personal care provider is responsible for ensuring that personal care aides in its employ are:

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

D. DMS will deem valid the Certified Personal Care Aide status of an individual with

1. Personal Care Aide Certification conferred before April 1, 1998, and
2. Documentation of ongoing compliance with Personal Care Program policies in effect before April 1, 1998, regarding continuing education and competency requirements.
3. The deemed status will be effective for dates of service on and after April 1, 1998, conditional upon the certified aide's continuing compliance with program policies.

E. A qualified training program (see Section 222.110) may waive the training component of personal care aide certification requirements for individuals who can document previous experience as personal care aides, nurse's aides or similar occupations requiring the same skills needed by personal care aides.

1. The qualified training program must verify the individual's previous experience.
2. The individual must pass the personal care aide examinations and skills tests.

F. Certified Nursing Assistants with current valid credentials are deemed qualified personal care aides.

G. Certified Home Health Aides with current valid credentials are deemed qualified personal care aides.

222.110 Conduct of Training ~~7-1-2010-1-221~~

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

A. A personal care aide training program may be offered by any organization meeting the standards in this section for:

1. Instructor qualifications;
2. Content and duration of personal care aide training; and,
3. Documentation of personal care aide training and certification.

B. Personal Care provider agencies conducting personal care aide training must maintain their training program documentation.

C. Personal Care providers hiring or contracting with individuals or organizations to conduct personal care aide training must maintain the individual's or organization's training program documentation. The provider is responsible for maintaining the training program documentation file.

D. Required training program documentation includes:

1. The number of hours each of classroom instruction and supervised practical training;
2. Names and qualifications of instructors and copies of licenses of supervising registered nurses;
3. Street addresses and physical locations of training sites, including facility names when applicable;
4. Maintaining samples of the forms used to document the ~~beneficiary~~client's consent to the training in their home, if the training includes supervised practical training in the home;
5. The course outline;
6. Lesson plans;
7. The instructor's methods of supervising trainees during practical training;
8. The training program's methods and standards for, determining whether a trainee can read and write well enough to perform satisfactorily the duties of a personal care aide;
9. The training program's method of evaluating written tests, oral exams (if any) and skills tests, including the relative weights of each in the minimum standard for successful completion of the course;
10. The training program's minimum standard for successful completion of the course; and
11. Evidence and documentation of successful completions (Certificates supported by internal records).

E. Personal Care providers are responsible for the upkeep of all required training program documentation.

F. A qualified personal care aide training and certification program must include instruction in each of the subject areas listed in Section 222.120.

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

1. Minimum classroom training time is twenty-four (24) hours.
2. Minimum time for supervised practical training is sixteen (16) hours.
   a. "Supervised practical training" means training in a laboratory or other setting in which:

~~(1)~~i. The trainee demonstrates knowledge by performing tasks on an individual while

~~(2)~~ii. The trainee is under supervision as defined in Section 220.100.

b. Trainees must complete at least sixteen (16) hours of classroom training before beginning any supervised practical training.

3. Supervised practical training may occur at locations other than the site of the classroom training.

a. However, trainees must complete at least twenty-four (24) hours of classroom training before undertaking any supervised practical training at an actual service delivery site.

b. The training program must have the written consent of the ~~beneficiary~~client or the ~~beneficiary~~client's representative if aide trainees furnish any of the ~~beneficiary~~client's services at the ~~beneficiary~~client's service delivery location.

~~(1)~~i. A copy of the ~~beneficiary~~client's consent must be maintained in the file of each aide trainee receiving supervised practical training at the ~~beneficiary~~client's service delivery location.

~~(2)~~ii. The ~~beneficiary~~client's daily service documentation must include the names of the supervisor or QIDP and the personal care aide trainees.

4. The training of personal care aides and the supervision of personal care aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse whose current credentials are on file with the provider.

a. The qualified registered nurse must possess a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of in-home health care.

b. Other individuals may provide instruction under the supervision of the qualified registered nurse.

c. Supervised practical training with a consenting personal care ~~beneficiary~~client for a subject must be personally supervised by:

~~(1)~~i. The qualified registered nurse; or

~~(2)~~ii. By a licensed practical nurse under the general supervision of the qualified registered nurse.

H. Providers must maintain documentation demonstrating that aide training meets the requirements set forth herein.

222.120 Personal Care Aide Training Subject Areas

~~7-1-20~~10-1-~~22~~4

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

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

B. Understanding and following spoken and written instructions.

C. Communications skills, especially the skills needed to:

1. Interact with ~~beneficiaries~~clients;

2. Report relevant and required information to supervisors; and,

3. Report events accurately to public safety personnel and to emergency and medical personnel.

D. Record-keeping, including:

1. The role and importance of record keeping and documentation;
2. Service documentation requirements and procedures, especially all documentation Medicaid requires of personal care aides, as described in Medicaid Personal Care Program policy statements current at the time of the aide's training;
3. Reporting and documenting non-medical observations of ~~beneficiary~~client status; and
4. Reporting and documenting, when pertinent, the ~~beneficiary~~client's observations regarding their own status.

E. Recognizing and reporting, to the supervisor or Qualified Intellectual Disabilities Professional (QIDP), when changes in the ~~beneficiary~~client's condition or status require the aide to perform tasks differently than instructed.

F. State law regarding delegation of nursing tasks to unlicensed personnel as designated by the Arkansas State Board of Nursing.

G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.

H. Safe transfer techniques and ambulation.

I. Normal range of motion and positioning.

J. Recognizing emergencies and knowledge of emergency procedures.

K. Basic household safety and fire prevention.

L. Maintaining a clean, safe and healthy environment.

M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the ~~beneficiary~~client with:

1. Bed bath;
2. Sponge, tub or shower bath;
3. Shampoo; sink, tub or bed;
4. Nail and skin care;
5. Oral hygiene;
6. Toileting and elimination;
7. Shaving;
8. Assistance with eating;
9. Assistance with dressing;
10. Efficient, safe and sanitary meal preparation;
11. Dishwashing;
12. Basic housekeeping procedures; and
13. Laundry skills.

N. Early recognition and reporting of changes in client condition.

222.140 In-Service Training 10-1-2213

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

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

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

1. When appropriate, in-service training may occur at a personal care service delivery location when the aide is furnishing personal care services.

2. In-service training at a service delivery site may occur only if the ~~beneficiary~~client or the ~~beneficiary~~client's representative has given prior written consent for training activities to occur concurrently with the ~~beneficiary~~client's care.

B. The Personal Care Program provider agency and the personal care aide must maintain documentation that they are meeting the in-service training requirement.

240.000 PRIOR AUTHORIZATION ~~1-1-19~~10-1-~~22~~4

A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all ~~beneficiaries~~clients, including ~~beneficiaries~~ clients participating in the IndependentChoices Program.

B. Prior authorization does not guarantee payment for the service.

1. The ~~beneficiary~~ client must be Medicaid-eligible on the dates of service and must have available benefits.

2. The provider must follow the billing procedures in this manual.

C. The ~~Arkansas Independent Assessment (ARIA) is the~~approved assessment instrument used by registered nurses of the DHS Independent Assessment Contractor to collect information used in determining the ~~beneficiary's~~ client's physical dependency needs for "hands-on" services with activities of daily living (ADL), and in calculating the number of personal care hours that can be authorized for the ~~beneficiary~~client. The ~~ARIA~~approved assessment instrument system assigns tiers designed to help further differentiate individuals by need. Each ~~beneficiary~~ client is assigned a tier level (0, 1, 2, or 3) following each assessment ~~or re-assessment~~annual evaluation by the DHS nurse.

1. Tier 0 (zero) indicates the individual's assessed needs, if any, do not support the need for personal care services.

2. Tiers 1 (one), 2 (two), or 3 (three) indicate the individual's assessed needs do support the need for personal care services.

D. The Task and Hour Standards will be used ~~by DHS RNs and DHS contractors~~ to calculate the number of personal care hours that can be authorized for the ~~beneficiary~~client.

240.100 Task and Hour Standards (THS) ~~1-1-19~~10-~~1-22~~4

A. Background on THS

The Arkansas Medicaid Task and Hour Standards (THS) is the written methodology used by the ~~DHS RNs and~~ DHS contractor RNs to calculate the number of personal care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

~~The~~ **View the current DAABHS approved THS**. ~~is located on the web at~~ **~~https://medicaid.mmis.arkansas.gov/Download/provider/provdocs/Manuals/ARCHOICES/THS.doc~~**

The THS includes the following four components, described in a grid format:

1. The ~~beneficiary~~client's Needs Intensity Score (0, 1, 2, or 3) for each task;

2. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;
3. The frequency with which a task is necessary and reasonably performed; and
4. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary personal care services hours, with the minute ranges and frequencies, providing the ability to adjust service plans based on unique factors related to a given ~~beneficiary~~client's needs, preferences, and risks.

The number of personal care hours/minutes that are authorized for each necessary task by week/month are calculated ~~by the DHS or by the contractor(s) designated by DHS~~ consistent with the THS grid and based on:

1. Responses by the ~~beneficiary~~client and their representatives to certain relevant questions in the ~~ARIA~~ approved assessment instrument, and
2. As appropriate, information obtained by the provider RN during their individualized service plan meeting with the ~~beneficiary~~client and ~~beneficiary~~client's representatives or from the ~~beneficiary~~client's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ~~ARIA~~ assessments and electronic visit verification system; DPSQA audits of providers; and ~~beneficiary~~client and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

B. Needs Intensity Score:

For each task, ~~the DHS RN or the contractor(s) designated by DHS will assign~~ a Needs Intensity Score is assigned to the ~~beneficiary~~client based on the ~~beneficiary~~client's and/or representative's responses to questions during the ~~ARIA~~ assessment and information obtained by the provider ~~RN~~ nurses during their individualized service plan meeting with the ~~beneficiary~~client and ~~beneficiary~~client's representative or from the ~~beneficiary~~client's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS. The four Needs Intensity Scores are defined as follows:

Impairment Score 0 – The ~~beneficiary~~client has no functional impairment with regard to the task and can perform it without assistance.

Impairment Score 1 (Mild): Minimal/mild functional impairment. The ~~beneficiary~~client is able to conduct activities with minimal difficulty and needs minimal assistance.

Impairment Score 2 (Severe): Extensive/severe functional impairment. The ~~beneficiary~~client has extensive difficulty carrying out activities and needs extensive assistance.

Impairment Score 3 (Total): The ~~beneficiary~~client is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ~~ARIA~~ approved assessment system.

C. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. ~~The DHS RN or contractor(s) designated by DHS will determine t~~The number of minutes within the range that are appropriate for the ~~beneficiary~~client based on conditions specific to the ~~beneficiary~~client will be determined. For example, if a ~~beneficiary~~client has cognitive or behavioral issues, the maximum number of minutes in the range for bathing may be warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a ~~beneficiary~~client who is bald.

If the ~~beneficiary~~client has extenuating circumstances and requires time outside the range (either more or less) for the task~~, the DHS RN or~~ designated contractor RN must obtain supervisory approval. For supervisory approval, the RN must document the ~~participant~~client's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the ~~participant~~client's assessed or observed medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the personal care prior authorization ~~or ARChoices PCSP~~ must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the personal care provider prior authorization ~~or PCSP~~.

D. The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a ~~beneficiary~~client will be determined based on the ~~ARIA~~ approved assessment instrument results and information obtained by the provider RN during their individualized service plan meeting with the ~~beneficiary~~client and ~~beneficiary~~client's representative or from the ~~beneficiary~~client's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

E. The amount of assistance with ADLs and IADLs provided by other sources

Personal care services are not available for assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then personal care services are not necessary and no time for that task is included. When another source is available to provide some instances of a needed ADL or IADL task, the frequency and time associated with these other sources are adjusted to correspond with the remaining assessed needs.

The amount of support with ADLs and IADLs provided by other sources is informed by the ~~ARIA~~ assessment results and information obtained by the provider RN during their individualized service plan meeting with the ~~beneficiary~~client and ~~beneficiary~~client's representative or from the ~~beneficiary~~client's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g.,

supplemental services). Other support is calculated for each task based on how much support is provided with the task (e.g., the ~~beneficiary~~client's daughter bathes her mother once a week and prepares all meals on weekends). For example, where a needed meal is supplied by Meals on Wheels, minutes for meal preparation may not be necessary and should be adjusted.

F. Calculation of total hours of personal care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of personal care hours approved for the ~~beneficiary~~client for a month.

241.000 Personal Care Program Prior Authorization (PA) Responsibility ~~1-1-19~~10-1-22~~1~~

A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization of personal care services for ~~beneficiaries~~clients.

B. DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's completed form designated by DHS and submitted documentation for personal care services. Based on the information in the ~~ARIA~~ assessment and the form designated by DHS, they authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.

C. DHS professional staff or contractor(s) designated by DHS have a right to review the ~~beneficiary~~client's medical information.

242.000 Personal Care PA Request Procedure 10-1-22~~1~~9

A. Providers must use the form designated by DHS to request PA. **View or print the form designated by DHS (English).** **View or print the form designated by DHS (Spanish).**

B. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals for ~~beneficiaries~~clients who are assessed at Tier 1, 2, or 3 will be retroactive to the beginning date of service if the request is received within the 30-day time frame. There will be no prior authorization, including any retroactive prior authorization, if the ~~beneficiary~~client is assessed at Tier 0.

C. Providers should submit prior authorization forms to the contractor(s) designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff

243.000 Provider Notification Procedure 10-1-21~~9~~

Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

A. For approved cases, an approval letter will be mailed to the requesting provider, detailing the procedure codes approved, total number of service time increments, beginning and ending dates and the authorization number.

B. For denied or partially denied cases, a denial letter with reason for denial will be mailed to the ~~beneficiary~~client and the requesting provider. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation. The letter shall specify why the prior authorization request was denied or partially denied and shall give the ~~beneficiary~~client notice of the right to file a request for a fair hearing and where to file the

request. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation.

244.000 Duration of PA ~~7~~10-1-2~~210~~

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

245.000 Provider Process for Reconsideration of PA Determination 10-1-2~~219~~

Reconsideration of a denial may be requested within thirty calendar days of the denial date. Reconsideration requests must be made in writing to DHS professional staff or the contractor(s) designated by DHS and must include additional documentation to substantiate the medical necessity of the requested services.

If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, the DHS professional staff or the contractor(s) designated by DHS issues a written notification of the decision to the ~~beneficiary~~client and provider. **View or print AFMC contact information.**

246.000 ~~Beneficiary~~Client Process for Appeal of PA Determination 10-1-2~~108~~

When the ~~beneficiary~~client receives an adverse decision concerning a request for PA determination, the ~~beneficiary~~client may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter from the DHS professional staff or contractor(s) designated by DHS explaining the denial. Appeal requests must be submitted to the Department of Human Services, Appeals and Hearings Section. **View or print the Department of Human Services, Appeals and Hearings Section contact information**.

250.210 Payment Level 10-1-2~~219~~

There are 10 Payment Levels, each based on the average number of 15-minute units of service per month required to fulfill a ~~beneficiary~~client's service plan.

A. Level 1 includes RCF and ALF Personal Care ~~beneficiaries~~clients whose service plans comprise 100 units or less per month of medically necessary personal care.

B. Level 10 includes RCF and ALF Personal Care ~~beneficiaries~~clients whose service plans comprise 256 or more units per month of medically necessary personal care.

C. Level 2 through Level 9 were established in equal increments between 101 and 255 units per month.

250.211 Payment Level Determination 10-1-2~~219~~

A. The average of a service plan's monthly units of service is used to determine each ~~beneficiary~~client's Payment Level.

B. Calculate a ~~beneficiary~~client's average number of monthly units of personal care as follows.

1. Add the Weekly Minute Totals from the prior authorization approved by DHS using the Task and Hour Standards.

2. Divide the minutes by **15** (*15 minutes equals one unit of service*) to calculate weekly average units of service.
3. Multiply the weekly average units from step 2 by **52** (*Weeks in a year*) and divide the product by **12** (*Months in a year*) to calculate monthly average units of service.
4. Consult the "RCF and ALF Personal Care Service Rate Schedule" on the Arkansas Medicaid Personal Care Fee Schedule to find the applicable Daily Multi-Hour Service Rate for each Payment Level. Procedure code T1020 is the applicable code for RCF and ALF Personal Care providers.

251.100 Individuals with Disabilities Education Act (IDEA) and ~~Beneficiary~~Client Free Choice

251.120 IDEA Responsibilities of School Districts and Education Service Cooperatives ~~8-1-04~~10-1-~~22~~1

Arkansas public school districts and education service cooperatives (ESCs), when enrolled as Arkansas Medicaid Personal Care providers, are deemed the provider of service.

A. As such, the school districts and ESCs must provide services, under the guidelines of the Arkansas Medicaid Personal Care Provider Manual, to the following groups of children.
   1. Medicaid-eligible school-aged children with disabilities, whose Individualized Education Programs (IEPs) call for personal care as a "Related Service" in accordance with the Individuals with Disabilities Education Act (IDEA).
   2. Medicaid-eligible preschool children (aged 3 through 4 years) with disabilities, who are enrolled in special education programs, and whose IEPs include personal care.

B. Under the IDEA, the student's parent or guardian may independently select an enrolled Medicaid provider, ("other provider") other than the school district or ESC. This exception requires the existence of each of the following conditions:
   1. Neither the school district or ESC nor anyone acting on behalf of the school district or ESC may refer the ~~beneficiary~~client, or the ~~beneficiary~~client's parent or guardian, to the other provider.
   2. There is no arrangement by the school district or ESC, or persons or entities in privity with the school district or ESC, for the other provider to furnish the services.
   3. The other provider does not, either directly or through another person or entity, have a contract with the school district or ESC or with persons or entities in privity with the school district or ESC, for referrals, consulting or the provision of Medicaid-covered services.
   4. The other provider is not under control or supervision of the school district or ESC or persons or entities in privity with the school district or ESC.

C. For purposes of this rule, "privity" means a derivative interest growing out of a contract, mutuality of interest, or common ownership or control.

261.000 Introduction to Billing ~~7-1-20~~10-1-~~22~~1

A. Personal Care providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to Medicaid ~~beneficiaries~~clients.

B. Providers submitting claims electronically through the provider portal use the Professional claim format.

C. A claim may contain charges for only one (1) ~~beneficiary~~client.

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

262.101 Personal Care for a ~~Beneficiary~~Client Aged 21 or Older (Non-RCF) 10-1-2219

Procedure Code	Modifier	Service Description
T1019	U3	Personal Care for a non-RCF ~~Beneficiary~~Client Aged 21 or Older, per 15 minutes (requires prior authorization)

262.102 Personal Care for a ~~Beneficiary~~Client Under 21 (Non-RCF) ~~3-1-08~~10-1-221

Procedure Code	Modifier	Service Description
T1019		Personal Care for a (non-RCF) ~~Beneficiary~~Client Under 21, per 15 minutes (requires prior authorization)

262.103 Personal Care in a Public School ~~8-1-04~~10-1-221

Procedure Code	Modifier	Service Description
T1019	U4	Personal Care for a ~~Beneficiary~~Client Under 21, provided by a school district or education service cooperative, per 15 minutes (requires prior authorization).

262.104 Personal Care in an RCF or ALF 10-1-22119

A. To bill for RCF or ALF Personal Care, use HCPCS procedure code **T1020** and the modifier corresponding to the ~~beneficiary~~client's Payment Level in effect for the date(s) of service being billed.

B. The Payment Level that a provider bills must be consistent with the ~~beneficiary~~client's service plan in effect on the day that the provider furnished the personal care services billed.

Payment Level Specifications and Modifiers for Procedure Code T1020

Payment Levels	Minimum Service Units	Maximum Service Units	Modifier
Level 1	Less than 100	100	U1
Level 2	101	119	U2
Level 3	120	139	U3
Level 4	140	158	U4
Level 5	159	177	U5
Level 6	178	196	U6
Level 7	197	216	U7
Level 8	217	235	U8
Level 9	236	255	U9

Payment Level Specifications and Modifiers for Procedure Code T1020

Payment Levels	Minimum Service Units	Maximum Service Units	Modifier
Level 10	256	256	UA

262.105 Employment-Related Personal Care Outside the Home 10-1-2219

Procedure Code	Modifier	Service Description
T1019	U5	Employment-related personal care outside the home, ~~beneficiary~~client aged 16 or older, per 15 minutes. All personal care services require prior authorization.

262.106 Billing RCF and ALF Personal Care Services 10-1-1221

A. RCF and ALF Personal Care providers may not bill for days during which a ~~beneficiary~~client received no personal care services (for instance, he or she was away for a day or more); therefore, do not include in the billed dates of service any days the ~~beneficiary~~client was absent.

B. For each unbroken span of days of service, multiply the days of service by the applicable Daily Service Rate and bill that amount on the corresponding claim detail.

C. Documentation requirements outlined in the Medicaid Personal Care Policy Section 216.400 (Personal Care Aide Service and Documentation Responsibility) must be adhered to when providing Personal Care services at all ALF facilities.

262.110 Coding Home and DDS Facility Places of Service ~~3-1-08~~10-1-221

A. The ~~beneficiary~~client's home is the ~~beneficiary~~client's residence, subject to the exclusions in Section 213.500, part B. For example, if a ~~beneficiary~~client lives in a residential care facility (RCF) or an assisted living facility (ALF), then the RCF or ALF is the ~~beneficiary~~client's home and is so indicated on a claim by place of service code **12**.

B. Section 213.520, part A, explains and describes special circumstances under which the place of service is deemed "public school."

1. The Arkansas Department of Education (ADE) sometimes deems a student's home a "public school," coded **03.**
2. Under certain circumstances, the ADE deems a Division of Developmental Disabilities Services community provider facility ("DDS facility") a "public school," also coded **03**.

C. When ~~beneficiaries~~clients receiving personal care in a DDS facility are not in the charge of their school district, the place of service code is **99,** "Other Place of Service," because there is no national code for a DDS clinic or facility.

262.300 Calculating Individual Service Times for Services Delivered in a Congregate Setting ~~3-1-08~~10-1-221

Rules in this section and its subsections regard calculation and determination of service-time to convert into billing units (Fifteen-minute units). Effective for dates of service on and after March 1, 2008, those rules do not apply to RCF Personal Care providers' billing.

Rules in this section and its subsections that are applicable to assessments and service plan development continue to apply to RCFs.

If services, such as meal preparation in a congregate setting, are delivered simultaneously, only the actual proportionate service time attributable to each individual ~~beneficiary~~client is covered.

A. The provider shall compute the covered time by dividing the actual aide clock-hours, attributing a proportionate share to each individual and multiplying each individual's proportionate share by a percentage arrived at from the individual's assessment. For example:

1. If an individual is totally dependent and cannot prepare a meal, the provider would be eligible for 100 percent of the ~~beneficiary~~client's proportionate share.
2. If a resident is totally capable of preparing a meal, the provider is not eligible for any reimbursement for any of the ~~beneficiary~~client's proportionate share.
3. If the ~~beneficiary~~client has an impairment that limits but does not totally prevent meal preparation the provider will be eligible for reimbursement of 50 percent of the individual's proportionate share of the aide's time.

B. The ~~beneficiary~~client's assessment must describe, in narrative form, his or her level of impairment with respect to each physical dependency with which the ~~beneficiary~~client receives assistance in a congregate setting.

262.310 Unit Billing

~~7-1-04~~10-1-~~22~~4

A. Fifteen minutes of authorized, documented and logged personal care equals one unit of personal care aide service.

B. Providers may not bill for less than fifteen minutes of service; however personal care aides' time spent providing services for a single ~~beneficiary~~client may be accumulated during a single, 24-hour calendar day, and the sum—in minutes—divided by 15 to calculate the number of units of service provided during that day.

C. The estimated daily maximum service time in the ~~beneficiary~~client's service plan is the upper limit for daily billing.

D. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single ~~beneficiary~~client.

E. There is no "carryover" of time from one day to another or from one ~~beneficiary~~client to another.

F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

262.311 Calculating Units

~~07-01-04~~10-1-~~22~~4

A. Personal Care providers must bill Medicaid by 15-minute units.

B. Total the daily personal care service-time for a single ~~beneficiary~~client in minutes, using the beginning and ending service times from the service logs.

C. Set your calculator to compute to three decimal places.

D. Divide the total time (expressed in minutes) by fifteen and

E. Bill for the lesser of:

1. The rounded, whole-number quotient of the division or
2. The maximum time estimate in the service plan.

262.400 Billing Instructions—Paper Only

10~~1~~-1-22~~17~~

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

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**

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

262.410 Completing a CMS-1500 Claim Form for Personal Care

10-1-22~~19~~

When a provider must bill on a paper claim, the fiscal agent accepts only red-lined, sensor-coded CMS-1500 claim forms. Claim photocopies and claim forms that are not sensor-coded cannot be processed.

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	~~Beneficiary~~Client's 10-digit Medicaid or ARKids First-A identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	~~Beneficiary~~Client's last name and first name.
3.	PATIENT'S BIRTH DATE	~~Beneficiary~~Client's date of birth as given on the individual's Medicaid or ARKids First-A identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. ~~Beneficiary~~Client's complete mailing address (street address or post office box).
	CITY	Name of the city in which the ~~beneficiary~~client resides.
	STATE	Two-letter postal code for the state in which the ~~beneficiary~~client resides.
	ZIP CODE	Five-digit ZIP code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The ~~beneficiary~~client's telephone number or the number of a reliable message/contact/ emergency telephone
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.

Field Name and Number		Instructions for Completion
7.	INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Required if the insured's address is different from the patient's address.
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9a and d are required. Name of the insured individual's employer and/or school.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d. CLAIM CODES	The "Claim Codes" identify additional information about the ~~beneficiary~~client'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.

Field Name and Number	Instructions for Completion
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, 9c and 9d.Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: 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.
15. OTHER DATE	Enter another date related to the ~~beneficiary~~client's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the ~~beneficiary~~client's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of the referral source.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.

Field Name and Number	Instructions for Completion
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not applicable.
19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER	Insert LEA number.
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.
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 number.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. A provider may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the date sequence. 3. RCFs may bill for a date span of any length within the same calendar month, provided the ~~beneficiary~~client was present every day of the date span and all services provided within the date span were at the same Payment Level.
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.

Field Name and Number		Instructions for Completion
D.	PROCEDURES, SERVICES, OR SUPPLIES	
	CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
	MODIFIER	Modifier(s) when 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 services totaled in the detail. This charge must be the usual charge to any ~~beneficiary~~client patient, or other recipient of the provider's services.
		RCFs' charges should equal no less than the product of the number of units (days) times the ~~beneficiary~~client's Daily Service Rate. If the charge is less, Medicaid will pay the billed charge.
G.	DAYS OR UNITS	The units (in whole numbers) of service provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening and referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, advise Provider Enrollment so that the year-end 1099 will be correct and reported correctly.
26.	PATIENT'S ACCOUNT NO.	Optional entry for providers' accounting and account-retrieval purposes. Enter up to 16 numeric, alphabetic or alpha-numeric characters. This character set appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum of all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments received from other sources on this claim. Do not include amounts previously paid by Medicaid.

Field Name and Number	Instructions for Completion
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PROVIDER	The performing provider or an individual authorized by the performing provider or by an institutional, corporate, business or other provider organization, must sign and date the claim, certifying that the services were furnished by the provider, under (when applicable) the direction of the individual provider or other qualified individual, and in strict and verifiable accordance with all applicable rules of the Medicaid program in which the provider participates. A "provider's signature" is the provider's or authorized individual's personally written signature, a rubber stamp of the signature, an automated signature or a typed signature. The name of a group practice, a facility or institution, a corporation, a business or any other organization will prevent the claim from being processed.
32. SERVICE FACILITY LOCATION INFORMATION	If services were not performed at the ~~beneficiary~~client's home or at the provider's facility (*e.g.*, school, etc.) enter the name, street address, city, state and zip code of the facility, workplace etc. where services were performed. If services were furnished at multiple sites (for instance, when job-seeking), indicate "multiple locations" or leave blank.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.