EXHIBIT P

DEPARTMENT OF HUMAN SERVICES, AGING & ADULT SERVICES

SUBJECT: Attendant Care for a Beneficiary of the Alternatives for Adults with Physical Disabilities Medicaid Waiver Program

DESCRIPTION: Pursuant to Medicaid Regulations, the Department of Human Services, Division of Aging and Adult Services is proposing a new Certification and Medicaid Provider Application for Attendant Care for a Participant of the Alternatives for Adults with Physical Disabilities Medicaid Waiver Program and Agreement Between Attendant Care Provider and Beneficiary.

Attendant Care providers must be certified by the Division of Aging and Adult Services. To be certified, providers must meet all requirements to provide attendant care to AAPD clients and complete the Certification and Medicaid Provider Application, which collects all necessary information from potential providers to ensure that they meet these requirements and that the health, safety, and well-being of clients is protected. This packet includes the following: an explanation of the Alternatives for Adults with Physical Disabilities (AAPD) waiver program and the purpose of the application; an Employer Information form, which details information regarding who holds authority to manage the participant's healthcare and decisions; the Application for AAPD Certification/Medicaid Provider; the Provider Eligibility Requirements form; and an explanation of DHS Policy 1088 (Participant Exclusion Rule), which must be signed by the applicant.

The AAPD Waiver Program Agreement between Attendant Care Provider and Beneficiary must be signed by the attendant care provider and the AAPD participant. The Agreement Between Attendant Care Provider and Beneficiary ensures that both parties understand and accept the responsibilities of self-direction and their specific roles in the process.

PUBLIC COMMENT: No public hearing was held. The comment period expired on October 13, 2012. No public comments were submitted. The proposed effective date is January 1, 2013.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Arkansas Code § 20-76-201 authorizes the Department of Human Services to administer programs for the indigent and to "make rules and regulations" pertaining to the administration of those programs. Arkansas Code § 20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Arkansas Department of Human Services
DIVISION Division of Aging and Adult Services
DIVISION DIRECTOR Krista Hughes
CONTACT PERSON Erica Sweeney
ADDRESS PO Box 1437, Slot S530, Little Rock, AR 72203
PHONE NUMBER 501-320-6555 **FAX NUMBER** 501-682-8155 **E-MAIL** erica.sweeney@arkansas.gov

INSTRUCTIONS

A. **Please make copies of this form for future use.**
B. **Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
C. **If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
D. **Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:**

Donna K. Davis
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?
Certification and Medicaid Provider Application for Attendant Care for a Participant of the Alternatives for Adults with Physical Disabilities Medicaid Waiver Program and Agreement Between Attendant Care Provider and Beneficiary

2. What is the subject of the proposed rule?
Attendant Care Providers must be certified by the Division of Aging and Adult Services. The Certification and Medicaid Provider Application is a packet of forms that must be completed in order for providers to be certified. This packet includes the following: an explanation of the Alternatives for Adults with Physical Disabilities (AAPD) waiver program and the purpose of the application; an Employer Information form, which details information regarding who holds authority to manage the participant's healtcare and decisions; the Application for AAPD Certification/Medicaid Provider; the Provider Eligibility Requirements form; and, an explanation of DHS Policy 1088 (Participant Exclusion Rule), which must be signed by the applicant.

The AAPD Waiver Program Agreement between Attendant Care Provider and Beneficiary must be signed by the attendant care provider and the AAPD participant.

3. Is this rule required to comply with federal statute or regulations? Yes ☐ No ☒

11. Do you expect this rule to be controversial? Yes ☐ No ☒
If yes, please explain.

12. Please give the names of persons, groups, or organizations that you expect to comment on these rules. Please provide their position (for or against) if known.

Names	Category	For	Against
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Summary of Policy

Pursuant to Medicaid Regulations, the Arkansas Department of Human Services, Division of Aging and Adult Services is proposing a new Certification and Medicaid Provider Application for Attendant Care for a Participant of the Alternatives for Adults with Physical Disabilities Medicaid Waiver Program and Agreement Between Attendant Care Provider and Beneficiary.

Attendant Care Providers must be certified by the Division of Aging and Adult Services. In order to be certified, providers must meet all requirements to provide attendant care to AAPD clients and complete the Certification and Medicaid Provider Application, which collects all necessary information from potential providers to ensure that they meet these requirements and that the health, safety and well-being of clients is protected. This packet includes the following: an explanation of the Alternatives for Adults with Physical Disabilities (AAPD) waiver program and the purpose of the application; an Employer Information form, which details information regarding who holds authority to manage the participant's healthcare and decisions; the Application for AAPD Certification/Medicaid Provider; the Provider Eligibility Requirements form; and, an explanation of DHS Policy 1088 (Participant Exclusion Rule), which must be signed by the applicant.

The AAPD Waiver Program Agreement between Attendant Care Provider and Beneficiary must be signed by the attendant care provider and the AAPD participant. The Agreement Between Attendant Care Provider and Beneficiary ensures that both parties understand and accept the responsibilities of self-direction and their specific roles in the process.

The revised policy will be effective January 1, 2013.

Certification and Medicaid Provider Application

Attendant Care for a Beneficiary of the
ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES
Medicaid Waiver Program

PROPOSED

DIVISION OF AGING & ADULT SERVICES
ARKANSAS DEPARTMENT OF HUMAN SERVICES

January 2013

PROPOSED

The Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program

The Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program allows enrolled beneficiaries to receive services at home, as opposed to an in-patient care facility. Please refer to the *Alternatives for Adults with Physical Disabilities Waiver Program Medicaid Manual* for regulations. The manual is available at:

https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/apdwvr.aspx

The offer of employment does not indicate approval as a Medicaid Provider. You are not authorized to begin work as a Medicaid Provider until and unless you are approved.

This office will review your application to ensure you meet the eligibility requirements published in the Medicaid Manual. Your application will then be considered according to the eligibility standards of all Medicaid Providers. The beneficiary's Home and Community-Based Services nurse/counselor or Counseling and Support Manager (CSM) will alert your employer when a determination on your Medicaid Provider Application is made.

BENFICIARY/EMPLOYER INFORMATION

This form must be completed in full and included with your certification application. If the beneficiary has a legal guardian or an attorney-in-fact who holds authority to manage the beneficiary's healthcare services and decisions, a copy of the court document/legal instrument that established the authority must be included.

Beneficiary's Name: _____ **Medicaid #** _____

Medicaid Provider Applicant's Name: _____ **Date:** _____

Check One:

PROPOSED

_____ The beneficiary will perform <u>all</u> employer tasks without any assistance (recruiting, hiring, training, supervision, terminating, monitoring my timesheets and approving payment).

_____
Beneficiary/Employer's Signature

_____
HCBS Nurse/Counselor or CSM

_____ The beneficiary will perform all employer tasks with assistance from a Decision-Making Partner.

_____
Beneficiary/Employer's Signature

Name of Decision-Making Partner: _____

Telephone Number: _____

Email Address: _____

Is the Decision-Making Partner authorized to sign your employee's timesheets?

___ YES ___ NO

_____
Decision-Making Partner's Signature

_____
HCBS Nurse/Counselor or CSM

PROPOSED

Employer Information Continued:

_____ The beneficiary's spouse will perform all employer tasks (recruiting, hiring, training, supervision, terminating, monitoring my timesheets and approving payment).

Name of Spouse/Employer: _____

Telephone Number: _____

Email Address: _____

_____
Spouse/Employer's Signature

_____ A legal representative (i.e. legal guardian or attorney-in-fact) performs all employer tasks (recruiting, hiring, training, supervision, terminating, monitoring my timesheets and approving payment) for the beneficiary.

Name of Legal Representative/Employer: _____

Authority Source: _____

Telephone Number: _____

Email Address: _____

_____ The court document/legal instrument that grants authority to perform the duties of employer for the beneficiary's care providers is attached.

_____
Legal Representative/Employer's Signature

IF NONE OF THE STATEMENTS ABOVE APPLY:

Please contact the HCBS nurse/counselor or CMS immediately.

The beneficiary's eligibility to self-direct must be re-assessed before a Certification/Medicaid Provider Application can be reviewed.

PROPOSED

APPLICATION FOR
AAPD CERTIFICATION / MEDICAID PROVIDER

Medicaid Provider Applicant's First Name **MI** **Last Name**

Mailing Address (where you want important documents to be mailed)

City/State/Zip Code

Street Address (where you live)

City/State/Zip Code

Home Phone (Area Code and Number) **Cell Phone** (Area Code and Number)

E-Mail Address

Name of the AAPD Beneficiary who indicated an interest in hiring you **Medicaid Number**

AAPD Beneficiary's Home Address **Home Phone Number**

City, AR **Zip Code** **Cell Phone Number**

PROVIDER ELIGILBILITY REQUIREMENTS

PROPOSED

1. Are you legally responsible for the AAPD Beneficiary?

a. Spouse	___ YES	___ NO
b. Legal Guardian	___ YES	___ NO
c. Attorney-in-Fact	___ YES	___ NO
d. Decision-Making Partner chosen by the Beneficiary	___ YES	___ NO

2. Are you 18 years of age or older? ___ YES ___ NO

a. Date of Birth: _____
mm/dd/year

b. Place of Birth: _____
City/State/County

3. Are you a United States citizen or legal immigrant authorized to work in the U.S?

___ YES ___ NO

4. Are you free from evidence of the following?

a. Abuse or fraud in any setting	___ YES	___ NO
b. Violations in the care of a dependent population	___ YES	___ NO
c. Conviction of a crime related to a dependent population	___ YES	___ NO
d. Conviction of a violent crime	___ YES	___ NO

5. **Are you able to read and write at a level sufficient to follow written instructions and maintain records?**

___ YES ___ NO

If no, identify the person who will read written instructions to the applicant:

Name of Assistant: _____

Telephone Number: _____

Email Address: _____ PROPOSED

_____

Assistant's Signature

6. **Are you able to do simple math in order to complete billing claim forms.**

___ YES ___ NO

If no, identify the person who will perform this task for the applicant:

Name of Assistant: _____

Telephone Number: _____

Email Address: _____

_____

Assistant's Signature

NOTE: To justify payment of Medicaid funds during audits, written claim forms that reflect the actual time worked must still be prepared, complete with signatures, and maintained, even if claims are submitted electronically.

Do you accept this requirement? ___ YES ___ NO

7. **Are you in adequate physical health to perform the job tasks required?**

___ YES ___ NO

8. **Do you have any disease that can be transmitted through casual contact?**

___ YES ___ NO

9. **Are you a state employee?** ___ YES ___ NO

____ If yes, attach a written waiver of § 19-11-705, which refers to employee conflict of interest, by the director of the Department of Finance and Administration granting permission to proceed with the transaction to such extent and upon such terms and conditions as may be specified. Such waiver and permission may be granted when the interests of the state so require or when the ethical conflict is insubstantial or remote.

10. **Have you read and do you accept the regulations published in the AAPD Medicaid Manual?**

https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/apdwvr.aspx

___ YES ___ NO

PROPOSED

Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program

Service Agreement between
Beneficiary/Legal Representative Employer
and
Attendant Care Provider Employee

PROPOSED

Beneficiary: _____

Legal Representative: _____
(if applicable)

Attendant Care Provider Hiring Choice: _____

As beneficiary or legal representative of a beneficiary in the AAPD program, I have chosen to self-direct by hiring the above-mentioned individual as AAPD Attendant Care Provider, and, as such, I am the employer. I understand that, as employer, it is my responsibility to train, manage and terminate, if necessary, this attendant care provider/employee, as well as monitor the employee's claims/timesheets for accuracy and approve payment.

As employer, I will direct the attendant care provider/employee to deliver the types of services as outlined in Medicaid policy and in accordance with the Plan of Care. I also will direct the schedule this attendant care provider/employee will follow.

I understand I must comply with the AAPD Medicaid policies.

This agreement will automatically terminate on the date this employee's Provider Certification expires, unless terminated earlier by me.

_____ _____
Employer Signature Date
Beneficiary/Legal Representative

_____ _____
Employee Signature Date

PROPOSED

Arkansas Department of Human Services
Participant Exclusion Rule
DHS Policy 1088

The term "participant" in this policy means a person seeking to become a party to a contract with DHS to furnish services (i.e. AAPD Attendant Care Medicaid Provider).

1088.1.1 Purpose

DHS shall conduct business only with responsible participants. Participants will be excluded from participation in DHS programs not as penalty, but rather to protect public funds, the integrity of publicly funded programs, and public confidence in those programs. It is also the intent of this policy to prevent excluded participants from substituting others, usually immediate family members, as surrogates to continue the practices that caused DHS to exclude the participant.

1088.2.3 Causes for Exclusion

DHS shall automatically exclude a participant if the participant is the subject of final determination that the participant has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or *nolo contendere*, to any crime related to:

A. Obtaining, attempting to obtain, or performing a public or private contract or subcontract

B. 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

C. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony

D. Federal antitrust statutes

E. The submission of bids or proposals

F. Any physical or sexual abuse or neglect when the offense is a felony

Based on this policy, all AAPD Medicaid Provider Applicants must understand and acknowledge the following:

Your application will be provided to HP Enterprises, a Medicaid Contractor, to ensure that all qualifications required of a Medicaid Provider of AAPD Attendant Care are met. Your application's review will include a national and state background check to

determine if you are placed on the DHS Provider Exclusion List or have a criminal record that contains a conviction. If a positive finding results, it will be reviewed by legal staff within the Medicaid Program Integrity Section, who will advise HP on whether a Medicaid Provider Identification Number (PIN) can be assigned.

You will be made aware of any adverse decision in writing by the Medicaid Program Integrity Section, along with what action to take if you desire to appeal the decision.

Medicaid Provider Applicant Acknowledgement:

By signing below, you indicate that you have read and understand the provided portions of DHS Policy 1088:

_____

Medicaid Provider Applicant's Printed Name

_____ _____

Medicaid Provider Applicant's Signature **Date**

PROPOSED

Alternatives for Adults with Physical Disabilities (AAPD) Waiver Program
Agreement between Attendant Care Provider and Beneficiary

REVISED

Beneficiary: _____

AAPD Attendant Care Provider: _____

As Beneficiary in the AAPD program, I have chosen to self-direct my care by hiring the individual above as my AAPD Attendant Care Provider.

I understand as employer, I recruit, hire, train, manage and fire my attendant care provider, as well as monitor the employee's timesheets and approve payment.

As employer, I direct the Attendant Care Provider to deliver the types of services as outlined in Medicaid policy and in accordance with my Plan of Care. I also direct the schedule the Attendant Care Provider will follow.

I understand I must comply with the AAPD Medicaid policies.

This agreement will automatically terminate one year from the date of signing by the parties or the date the certification expires, unless terminated by the beneficiary earlier due to unsatisfactory services by the Attendant Care Provider.

_____ _____

Beneficiary Signature Date

_____ _____

Attendant Care Provider Signature Date