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Special Report Summary

Arkansas Department of Human Services (DHS)

Community First Choice Option (CFCO)

Issued November 13, 2014

Background
This report primarily covers the period March 14, 2014 through September 30, 2014, and provides information about CFCO, a Medicaid-funded state plan program that would provide HCB services to recipients who, without these services, may need to receive institution-alized care.

Purpose
To summarize the HCB programs currently in place and to obtain and verify information about CFCO in response to legislator questions.

Acronyms
CFCO = Community First Choice Option

CMS = Centers for Medicare and Medicaid Services

FMAP = Federal Medical Assistance Percentage

HCB = Home and Community-Based

SDSB = Self-Directed Model with Service Budget

Current Home and Community-Based (HCB) Services

HCB services are currently provided through five HCB waivers:

1. Alternatives for Adults with Physical Disabilities (AAPD) Waiver
2. Autism Waiver
3. Division of Developmental Disabilities Alternative Community Service (DDS ACS) Waiver
4. ElderChoices Waiver
5. Living Choices Assisted Living (LCAL) Waiver

HCB services are also offered under several Medicaid State Plan Programs.

Risks Associated with HCB Programs

HCB waiver and state plan programs are considered “high risk” based on (a) a special fraud alert concerning home health care issued by the U.S. Department of Health and Human Services Office of Inspector General and (b) the three most recent State of Arkansas Single Audit reports, which contained eight total findings with questioned costs of $3.7 million.

Community First Choice Option (CFCO)

Created by the Affordable Care Act, CFCO is a Medicaid-funded state plan program that allows individuals with disabilities to receive services in a home or community setting. DHS submitted Arkansas's Community First Choice State Plan Program draft amendment to CMS on March 14, 2014, with an anticipated effective date of January 1, 2015. *As of report date, the amendment had not been approved by CMS.*

If CFCO is Approved and Implemented

- The State's FMAP would increase by 6% for CFCO services.
- Certain services would be provided under CFCO rather than the AAPD, DDS ACS, and ElderChoices Waivers or certain Medicaid State Plan Programs.
- Recipients would undergo a standardized care needs assessment, which the State has contracted with Pine Bluff Psychological Associates to perform.
- Services would be provided under two service-delivery models: (a) Agency-provider (services are provided by entities under contract) and (b) SDSB (a designated "employer," which could be the recipient, legal guardian, or recipient's representative, directs services provided by an "employee," who can be a family member but not a legal guardian).
- Required financial management and counseling support services could be provided for SDSB under two contracts DHS currently has with PALCO.
- Depending on recipient type, providers would be paid based on one of two methods: (a) a plan of care that authorizes a number of "units" of services and based on the service delivery model selected or (b) recipient assignment to a tier level with a maximum dollar amount and based on the service delivery model selected. The tier levels are being developed under a contract with the University of Michigan.
- The number of recipients residing in nursing homes and intermediate care facilities could be affected, which would also affect the fees Arkansas collects from nursing homes and intermediate care facilities.

Report ID: SPSA00614

For questions related to this report, contact
Deputy Legislative Auditor Jon Moore at 501-683-8600.

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Special Report

Legislative Joint Auditing Committee
November 13, 2014

Arkansas Department of Human Services

Community First Choice Option

INTRODUCTION

This report is presented in response to a request, approved by the Executive Committee of the Legislative Joint Auditing Committee (LJAC), for the Division of Legislative Audit (DLA) to provide information about the Community First Choice Option (CFCO), a Medicaid-funded state plan program that would provide home and community-based services to qualified individuals who, without these services, may need to receive institutionalized care.

OBJECTIVES

The objectives of this review were to summarize the home and community-based programs currently in place and to obtain and verify information about CFCO in response to questions raised by members of the General Assembly.

SCOPE AND METHODOLOGY

This report primarily covers the period March 14, 2014 through September 30, 2014. The information provided in this report was obtained from the Arkansas Department of Human Services (DHS), Section 2401 of the Affordable Care Act, Section 1915(k) of the Social Security Act, the Federal Register Final Rule for the Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS), and the Arkansas Community First Choice State Plan Program draft amendment.

The methodology used in conducting this review was developed uniquely to address the stated objectives; therefore, this review was more limited in scope than an audit or attestation engagement performed in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States.

CURRENT HOME AND COMMUNITY-BASED (HCB) SERVICE PROGRAMS

Home and community-based services are provided to Medicaid recipients in their own homes or in a community setting. Services can be provided to a variety of recipients, including, but not limited to, those with physical, intellectual, or developmental disabilities as well as aging individuals. Services can be provided through the 1915(c) Home and Community-Based (HCB) waivers or under the Medicaid State Plan, as discussed in the sections that follow.

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HCB Waivers

The Social Security Act authorizes several waiver programs to offer states flexibility in operating their Medicaid Programs. Under Social Security Act Section 1915(c), the HCB waivers allow states to provide a variety of medical and non-medical services to Medicaid recipients in their homes and communities, rather than in institutional settings. States may obtain a waiver from CMS to provide such services. Currently, Arkansas has five HCB waivers, as discussed below:

1. **Alternatives for Adults with Physical Disabilities (AAPD) Waiver** provides services to individuals between ages 21 and 64 with physical disabilities.
2. **Autism Waiver** offers services to children ages 1 to 6 with an autism diagnosis.
3. **Division of Developmental Disabilities Alternative Community Service (DDS ACS) Waiver** provides services to individuals of all ages with developmental disabilities, including autism.
4. **ElderChoices Waiver** offers alternatives to nursing home placement to recipients age 65 and older who require an intermediate level of care.
5. **Living Choices Assisted Living (LCAL) Waiver** allows recipients ages 21 to 64 with physical disabilities or individuals age 65 and older to live in apartment-style assisted living facilities.

Under all five waivers, recipients can have income levels up to 300% of the Social Security Income (SSI) Federal Benefit Rate. As of September 30, 2014, 300% of the SSI Federal Benefit Rate was $2,163 per month or $25,956 annually for an individual.

Services

Recipient direction of care includes selection of service provider, budget management, or both. For the five HCB waivers currently in place, only the AAPD Waiver allows recipient direction of services directly under the waivers. ElderChoices recipients may opt to receive homemaker and adult companion services through the Independent Choices Program, which allows recipient direction of services.

With the exception of the Autism Waiver, services may be provided by a recipient's relatives as long they are not legally responsible for the recipient. This policy exists to prevent conflicts of interest that could result from the person responsible for a recipient also providing services for that recipient. **Appendix A** provides a list of services provided under each of the five HCB waivers.

Enrollment Limits

All five HCB waivers have enrollment limits for the number of individuals who can receive services at any point in time and for the number of "unduplicated beneficiaries."[1] Enrollment limits for both groups, as of September 30, 2014, are provided in **Exhibit I on page 5**, and Arkansas's number of unduplicated HCB recipients for each waiver for state fiscal year (SFY) 2010 through 2014 is provided in **Exhibit II on page 5**.

[1] *Unduplicated beneficiaries* refers to the number of distinct individuals who can receive services during a 12-month period, which is based on the original effective date of the waiver.

Exhibit I

Home and Community-Based Waivers
Enrollment Limits
As of September 30, 2014

Home and Community-Based Waiver	Point-in-time beneficiaries (Note 1)	Unduplicated beneficiaries (Note 2)
Alternatives for Adults with Physical Disabilities (AAPD)	2,300	3,400
Autism	100	150
Division of Developmental Disabilities Alternative Community Services (DDS ACS)	4,183	4,303
ElderChoices	No limit	7,950
Living Choices Assisted Living (LCAL)	1,000	1,300

Note 1: Number of individuals allowed to receive services at any point in time.
Note 2: Number of individuals allowed to receive services during a 12-month period, which is based on the original effective date of the waiver.

Source: *Home and Community-Based 1915(c) Waiver Series, Appendix B (unaudited by the Division of Legislative Audit)*

Exhibit II

Arkansas Department of Human Services
Home and Community-Based Waivers
Unduplicated Beneficiary Counts in Arkansas
For State Fiscal Years 2010 through 2014

Home and Community-Based Waiver	Number of Unduplicated Beneficiaries for State Fiscal Year 2014	2013	2012	2011	2010
Alternatives for Adults with Physical Disabilities (AAPD)	2,752	2,728	2,714	2,672	2,598
Autism	119	84	0	0	0
Division of Developmental Disabilities Alternative Community Services (DDS ACS)	4,154	4,198	4,170	4,132	4,086
ElderChoices	6,890	7,349	7,810	7,929	7,732
Living Choices Assisted Living (LCAL)	1,108	1,004	899	802	708

Note: The Autism Waiver effective date was October 1, 2012; therefore, there were zero unduplicated beneficiaries in SFY 2010 through SFY 2012.

Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

The DDS ACS Waiver program has a long-term waiting list that totaled 2,857 individuals on October 10, 2014, according to DHS. DHS management also stated that individuals in nursing homes or intermediate care facilities are not placed on this waiting list but, instead, are placed on a separate priority waiting list, upon request. As of November 6, 2014, 118 individuals were on the priority waiting list. Priority waiting list slots are assigned as follows, according to DHS:

a. In order of waiver application determination date for persons determined to have successfully applied for the waiver but who, through administrative error, were or are inadvertently omitted from the waiver waiting list.

b. In order of waiver application determination date of persons for whom waiver services are necessary to permit discharge from an institution (i.e., residents of intermediate care facilities for individuals with intellectual disabilities, nursing facility residents, and Arkansas State Hospital patients; or admission to or residence in a Supported Living Arrangement [group homes and apartments]).

c. In order of date of DHS custodian choice of waiver services for eligible persons in the custody of the DHS Division of Children and Family Services or DHS Adult Protective Services.

When there are no longer any individuals remaining on the priority waiting list, individuals on the regular DDS ACS waiting list receive services based on the waiver application determination date.

The ElderChoices Waiver does not currently have a waiting list. A waiting list does exist for the AAPD Waiver; however, DHS does not consider it a long-term waiting list because individuals are on the waiting list for an average of 43 days. As of November 6, 2014, there were 123 people on the AAPD waiting list. Individuals may choose to enter an institutional setting if the wait time for the community setting is too long. However, if the wait time for institutional and community services are equal, factors other than decreased time frame may influence an individual's choice.

HCB State Plan Programs

Other programs exist that offer HCB services but are operated under the Medicaid State Plan, rather than the HCB waivers. The three programs discussed below were identified by DHS as likely to be impacted by CFCO:

1. **Personal Care Program** provides medically-necessary services authorized by a physician to assist recipients with physical dependency needs (e.g., eating, bathing, etc.). These services cannot be provided to a recipient who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental illness. Services must be provided by a qualified individual who is not a recipient's family member (i.e., spouse; minor's parent, stepparent, or foster parent; legal guardian; or attorney-in-fact).

2. **Independent Choices Program** is similar to the Personal Care Program but allows elderly recipients or recipients with disabilities to self-direct services by selecting the provider. Services are to be provided in a recipient's home or workplace and may be provided by a family member as long as he or she is not legally responsible for the recipient. Once a recipient-approved timesheet is submitted to PALCO, the financial management services (FMS) provider, a cash allowance is disbursed to the service provider in accordance with an approved cash expenditure plan.

3. **Developmental Day Treatment Clinic Services (DDTCS)** are provided only in clinical settings licensed by the Division of Developmental Services. These comprehensive day treatment centers must offer core services related to diagnosis, evaluation, and habilitation.

Appendix B provides a list of services provided under each of the HCB state plan programs. **Appendix C** provides HCB program paid amounts for both waiver and state plan programs for SFY 2010 through 2014.

Overall Risks Related to HCB Programs

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued a special fraud alert concerning home health care. Problems noted include cost report frauds, billing for excessive services or services not rendered, and use of unlicensed staff. The full alert was published in the Federal Register on August 10, 1995 (page 40,847), and is available on the HHS OIG website (http://oig.hhs.gov/) under the Compliance tab (Special Fraud Alerts, Bulletins, and Other Guidance section), as shown below.

As a result of the special fraud alert and the eight findings reported in the three most recent State of Arkansas Single Audit reports, HCB programs are considered high-risk. Total questioned costs for these eight findings totaled $3.7 million and related to the following programs:

- Alternatives for Adults with Physical Disabilities (AAPD).
- Division of Developmental Disabilities Alternative Community Services (DDS ACS).
- Elder Choices.
- Living Choices Assisted Living (LCAL).
- Personal Care Services.
- Prosthetics.

The underlying issue for these findings was lack of adequate supporting documentation for services billed and subsequently paid with Medicaid funds. The various HCB provider manuals state that providers must maintain sufficient written documentation in a recipient's case file supporting the billing for services rendered. Examples of required documentation include the following:

- Physician information.
- Plan of care.
- Specific services provided.
- Date and time services are performed.
- Signature of the service provider.
- Notes regarding recipient progress or condition.[2]

With the implementation of CFCO, a significant increase in the number of providers for home health services is a possibility. As a result, an increase in Single Audit findings because of inadequate documentation maintained in provider files supporting services billed is also possible.

[2]It should be noted that these examples are not all-inclusive or representative of each HCB program.

COMMUNITY FIRST CHOICE OPTION (CFCO)

Relevant Legislation

The Community First Choice Option (CFCO) is a Medicaid-funded state plan program created by Section 2401 of the Affordable Care Act, which amended Section 1915(k) of the Social Security Act.[3] CFCO implementation enables states to comply with the 2009 U.S. Supreme Court decision in the case of *Olmstead v. L.C.* The Court ruled that, under the Americans with Disabilities Act, individuals with disabilities have the right to live in the community rather than institutions if community placement is deemed appropriate by medical professionals and can be accommodated by the state. Noncompliance with the *Olmstead* ruling could place DHS at risk for litigation as well as costs associated with noncompliance.

CFCO services must be provided in a home or community setting, and the State's Federal Medical Assistance Percentage (FMAP) would increase by 6% for services provided under CFCO. Because CFCO would be a state program governed by existing federal regulations, the number of individuals who could receive services would be unlimited, as long as the recipients were deemed eligible.

DHS submitted Arkansas's Community First Choice State Plan Program draft amendment to CMS on March 14, 2014, with an anticipated effective date of January 1, 2015. *However, as of report date, the amendment had not been approved by CMS.* The complete text of the draft amendment can be found at https://www.medicaid.state.ar.us/Download/general/comment/CFCODraft.doc.

Intent of CFCO (This section was provided by DHS.)

CFCO is a state option to provide home and community-based attendant services and supports to people with disabilities, with a primary focus on developmental and physical disabilities and the frail elderly.

CFCO provides a permanent 6% increase in FMAP for CFCO services, as well as federal funding to provide access to lower-cost community-based services that delay or avoid facility-based care. Furthermore, DHS believes CFCO will strengthen the person-centered nature of the long-term care system by providing a broad range of options and enhanced community integration. The CFCO program ultimately aims to improve quality of life.

According to DHS, the savings the State will realize from the enhanced FMAP rate will cover the cost of eligible individuals, including approximately 2,900 children and adults with developmental disabilities who have been on the DDS ACS waiting list, some for as long as eight years. Additionally, the enhanced FMAP rate will allow DHS to increase rates for specific services like adult day cares that have gone without a rate increase for a significant period of time.

Development and Implementation Council

For approval of a CFCO state plan amendment, Section 1915(k) of the Social Security Act requires the creation of a Development and Implementation Council, with a majority of its members being individuals who are elderly or have disabilities and their representatives. These stakeholders are tasked with collaborating with the State to develop and implement a CFCO plan.

[3]Section 1915(k) of the Social Security Act can be found at http://www.ssa.gov/OP_Home/ssact/title19/1915.htm.

To fulfill this requirement, DHS established the 18-member Community First Choice Council (CFCC). Between November 2012 and May 2013, the CFCC met six times. According to DHS, CFCC members reviewed the State's CFCO draft amendment prior to submission to CMS, and since the May 2013 meeting, members have been updated on developments regarding CFCO.

Current HCB Programs to be Affected by CFCO Implementation

Certain services currently provided under the three HCB waiver programs and three Medicaid State Plan programs listed below will be offered under Arkansas's CFCO program, if implemented:

HCB Waiver Programs	Medicaid State Plan Programs
• Alternatives for Adults with Physical Disabilities (AAPD) Waiver • Division of Developmental Disabilities Alternative Community Services (DDS ACS) Waiver • ElderChoices Waiver	• Developmental Day Treatment Clinic Services (DDTCS) • Independent Choices • Personal Care

The remaining two HCB waiver programs discussed previously, the Autism Waiver and the Living Choices Assisted Living (LCAL) Waiver, will continue as stand-alone programs that are not part of CFCO.

CFCO Program Recipient Eligibility Criteria

As noted in the proposed CFCO Provider Manual, which is also awaiting CMS approval, CFCO is not a Medicaid eligibility category. Rather, it is an option for recipients already receiving services under Medicaid. To qualify for CFCO, an individual must meet the following requirements:

1. Be eligible for medical assistance under the Medicaid State Plan.
2. Be in an eligibility group under the Medicaid State Plan that either includes nursing facility services, intermediate care facility for individuals with intellectual disabilities, hospitals, or institutions for mental illness OR, if in an eligibility group that does not include these services, have an income that is at or below 150% of the federal poverty level. As of September 30, 2014, 150% of the federal poverty rate was $17,505 annually for an individual.
3. Be determined annually to meet the institutional level of care requirements.

DHS has also submitted for CMS approval draft proposals for two new HCB waivers: Division of Developmental Disabilities HCB Waiver and Aging and Physical Disability Access to Homecare Waiver.[4] These waivers would replace some existing waivers and are discussed in the **"New Home and Community-Based Waivers" section on page 18**. If these waivers are approved and implemented and an individual is deemed eligible under them, the individual must continue to meet all waiver requirements and receive at least one waiver service per month to receive services through CFCO. Like the existing waivers, the proposed waivers would have enrollment limits. It should also be noted that, if deemed eligible under a waiver, individuals can have income up to 300% of the SSI Federal Benefit Rate.

[4]According to information provided by DHS on November 5, 2014, the two new HCB waivers were withdrawn from CMS consideration, pending further discussions with CMS, and will be resubmitted at a later date.

CFCO Service Delivery Models

According to the proposed CFCO Provider Manual, CFCO will offer two service delivery models:

- **Agency-provider model**, in which services are provided by entities under contract.
- **Self-directed model with service budget (SDSB)**, in which a recipient, legal guardian, or recipient's representative is designated as the "employer," directs the recipient's care, and ensures services authorized are provided by the "employee," who can be the recipient's family member but not his or her legal guardian.[5] The employer establishes the job description, hires the employee, establishes the work schedule, monitors performance, and, when necessary, dismisses the employee.

If a recipient chooses the SDSB model, counseling support services are required to help the employer fulfill his or her responsibilities. In addition, financial management services (FMS) are required to comply with Internal Revenue Service (IRS) regulations and process payroll based on timesheets submitted by the employer. Also under the SDSB model, the FMS provider receives monthly prospective payments[6] based on the active CFCO recipients as indicated in the Medicaid Management Information System (MMIS). PALCO, the current FMS provider, could also provide financial management services under CFCO.

Conversely, DHS could opt to contract with a different provider for CFCO services by following procurement guidelines required for large professional services contracts. However, it should be noted that PALCO currently has two contracts with DHS under which CFCO services could be provided using the SDSB model:

- PALCO acts as the fiscal agent for the SDSB delivery model to Medicaid recipients in the Independent Choices Program by providing services necessary to process payroll and comply with IRS regulations. The contract, in the amount of $3.4 million, is valid through June 30, 2015. According to DHS, the current contract amount is sufficient to manage any fluctuations due to CFCO implementation, and expenditures will correspond to actual enrollee counts.[7]
- PALCO provides counseling support services to participants in the existing Independent Choices Program, which offers the SDSB delivery model. These services aid a recipient in meeting the responsibilities associated with being the employer of record. The contract, in the amount of $55.5 million, is valid through June 30, 2020.

CFCO Provider Reimbursement

Provider reimbursement for CFCO services varies according to recipient type, as explained in the sections that follow.

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[5]This policy exists to prevent conflicts of interest that could result from the person responsible for a recipient also providing services for that recipient.

[6]*Prospective payments* are pre-calculated amounts based on anticipated services provided, rather than on services actually rendered.

[7]DHS has a third contract that allows PALCO to serve as the FMS provider for the existing AAPD Waiver program. This contract, in the amount of $289,725, is valid through December 31, 2014. However, CFCO services could not be provided under this contract.

Division of Aging and Adult Services (DAAS) Recipient

For a DAAS recipient, provider reimbursement is based on a fee schedule methodology, which is depicted in **Exhibit III on page 12**. Based on the results of a standardized needs assessment, a plan of care is developed and lists the number of "units" of various services authorized for a recipient. The amount paid for each unit of service is the lesser of the amount billed or the amount allowed.

The DAAS recipient then selects a service delivery model: Under the **self-directed model with service budget (SDSB)**, an estimate of monthly expenses for a recipient is paid to the financial management services (FMS) provider, which then pays the employee Under the **agency-provider model**, providers submit bills to Hewlett Packard (HP), the fiscal intermediary. The fiscal intermediary then pays the provider.

Division of Developmental Disabilities (DDS) Recipient

For a DDS recipient, provider reimbursement is based on an assessment-based prospective episode methodology, which is depicted in **Exhibit IV on page 13**. Based on the results of a standardized needs assessment, a recipient is assigned to a tier level that has a maximum annual dollar amount associated with it. This amount is used to cover all of a recipient's services for the year.

Once the DDS recipient has been assigned to a tier, he or she then selects a service delivery model, which determines the payment method: Under the **SDSB model**, the annual episode amount, based on a recipient's tier, is paid in prorated, periodic payments to the FMS provider, who then pays the employee providing services. Under the **agency-provider model**, HP is the fiscal intermediary, and payment is made to the Lead Service Provider, who receives a cumulative bundled episode payment based on the combined levels of need of the entire group of individuals served. The Lead Service Provider then pays the provider(s).

The State has two contracts with Pine Bluff Psychological Associates for management of the assessment process. A $5.1 million contract for performing the DDS standardized assessments to approximately 5,000 adults receiving developmental disabilities services is valid through June 30, 2019. A second contract, in the amount of $930,600, was awarded to Pine Bluff Psychological Associates for performance of assessments of school-aged children. This contract is valid through June 30, 2020. The total amount paid to this vendor for SFY 2013 through September 30, 2014, was $1.2 million.

Additionally, according to DHS, the tiered payment system currently exists only in draft form, and the completion date is unknown. A contract to develop the framework for the various tier levels and associated dollar amounts was awarded to the University of Michigan, with a total contract amount of $879,040. This contract was valid through June 30, 2014. DHS has a second contract with the University of Michigan for $877,891 that is valid through June 30, 2015. The total amount paid to this vendor for SFY 2013 through September 30, 2014, was $814,085.

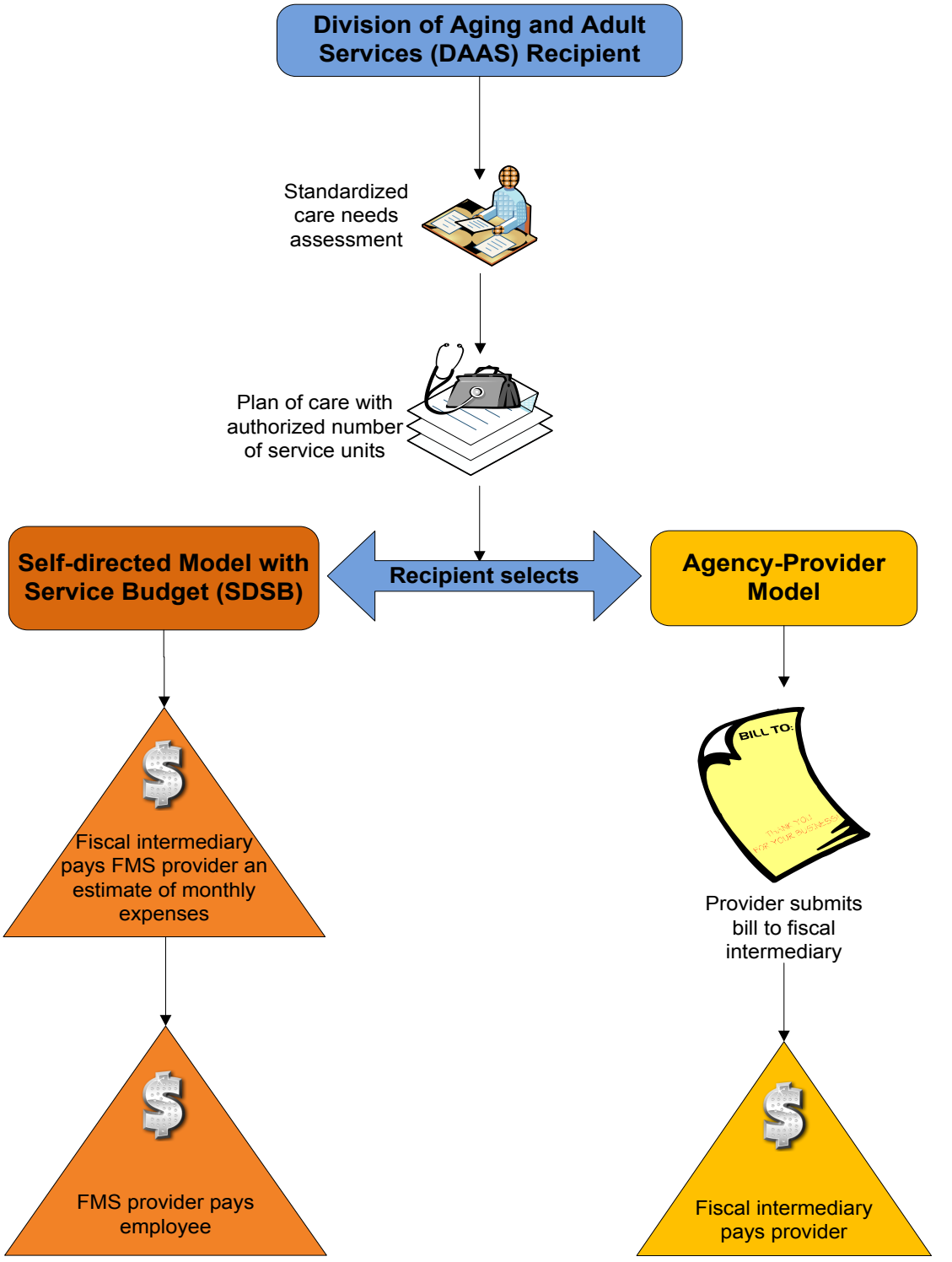
Public Notice, Public Comment, and Promulgation Process

The standard promulgation process for new state plan amendments, including the proposed CFCO amendment and provider manual, requires that DHS follow the steps outlined in **Exhibit V on page 14**. Dates of implementation are included, if applicable. According to DHS, if a material change[8] were to occur, the standard promulgation process would be repeated, beginning with the Notice of Rulemaking (step 2).

[8]A *material change* alters the intent of the rule, including changes to rates, procedure codes, provider requirements, or recipient eligibility requirements.

Exhibit III

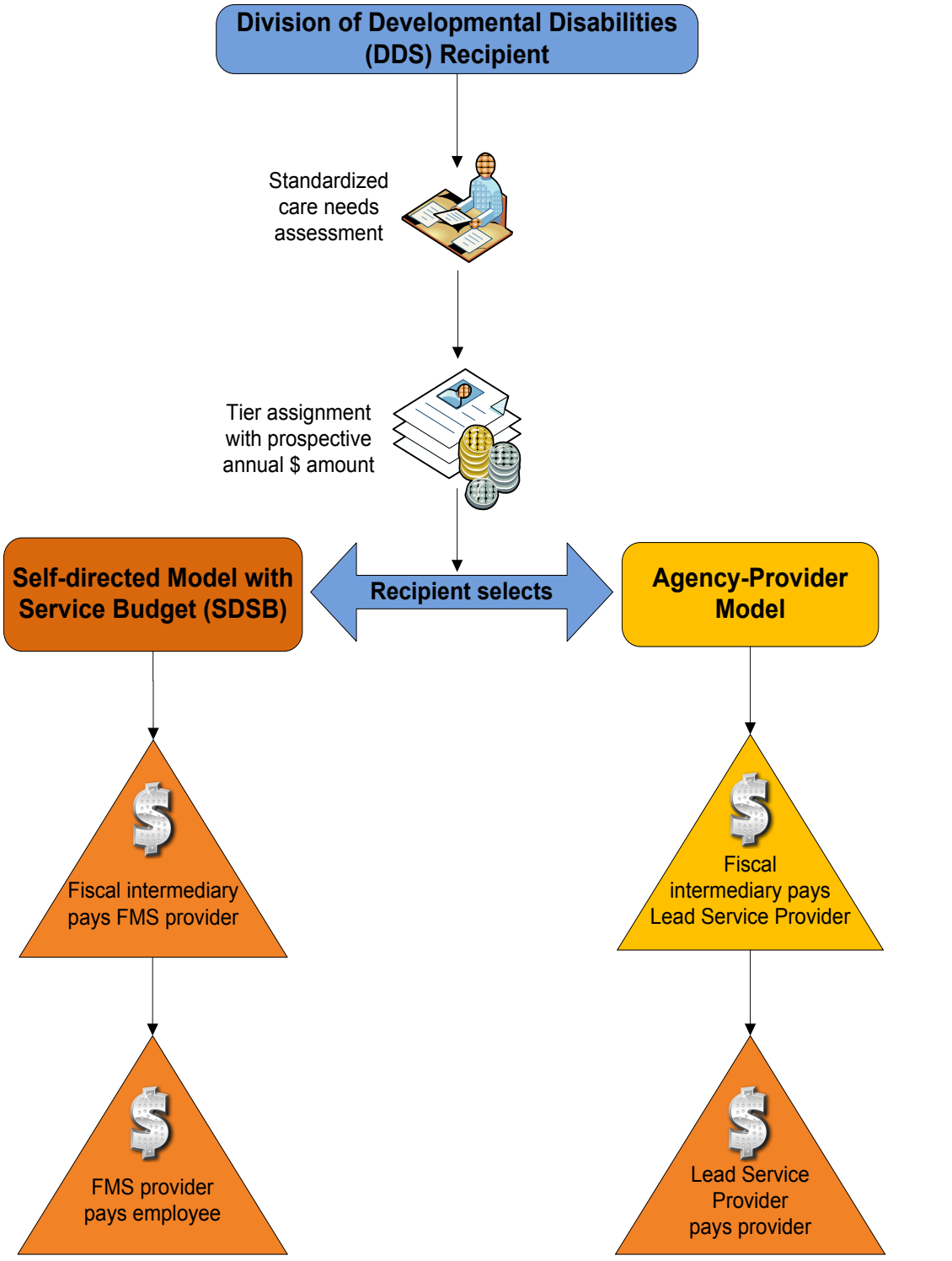
Community First Choice Option (CFCO)
Provider Reimbursement for Division of Aging and Adult Services (DAAS) Recipient



FMS provider = financial management services provider
Source: *Draft Community First Choice Option (CFCO) Provider Manual (unaudited by the Division of Legislative Audit)*

Exhibit IV

Community First Choice Option (CFCO)
Provider Reimbursement for Division of Developmental Disabilities (DDS) Recipient



FMS provider = financial management services provider
Source: *Draft Community First Choice Option (CFCO) Provider Manual (unaudited by the Division of Legislative Audit)*

Exhibit V

Arkansas Department of Human Services
Promulgation Process for New State Plan Amendments

Promulgation Process Step	Completion Date	
	CFCO State Plan Amendment	CFCO Provider Manual
1. Submit amendment to Centers for Medicare and Medicaid Services (CMS).	3/14/2014	Not required
2. Publish a Notice of Rulemaking in the newspaper for three days.	3/10/2014	9/1/2014
3. Begin a 30-day public comment period.	3/10/2014	9/1/2014
4. Hold a public hearing.	3/20/2014	Scheduled for 9/26/14; cancelled
5. File a copy of the rule with the Public Health and Rules and Regulations Committees.	Not yet completed	Not yet completed
6. Respond to comments.	Not yet completed	Not yet completed
7. Submit comments, responses, and a copy of the rule with changes to the Rules and Regulations Committee and the Bureau of Legislative Research (BLR) by the 15th of the month to place the rule on the Rules and Regulations Committee agenda.	Not yet completed	Not yet completed
8. Obtain CMS approval.	Not yet completed	Not yet completed
9. Allow review by the Public Health and Rules and Regulations Committees. If changes occur, the rule is amended and the amendment promulgated.	Not yet completed	Not yet completed
10. File the final amendment with the Secretary of State, Arkansas State Library, and BLR.	Not yet completed	Not yet completed

CFCO = Community First Choice Option
Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

DHS Projected State General Revenue Expenditures for HCB Services Under Three Scenarios

On August 28, 2014, DHS presented to the Public Health Committee a projection of state general revenue expenditures for HCB services under three different scenarios, as shown in **Exhibit VI on page 15**:

1. **Status quo**, with projections based on 7% growth in HCB services.
2. **CFCO implementation**, with projections based on 4% growth in HCB services; expenses related to woodwork costs, which vary by program (see **Exhibit VII on page 16**); expenses related to providing services for those currently on the Division of Developmental Disabilities Alternative Community Service (DDS ACS) Waiver waiting list[9]; and the 6% increase in FMAP for services provided.
3. **Olmstead enforcement**, which assumes the 7% growth rate and the addition of services for all individuals on the current DDS ACS Waiver waiting list.[10]

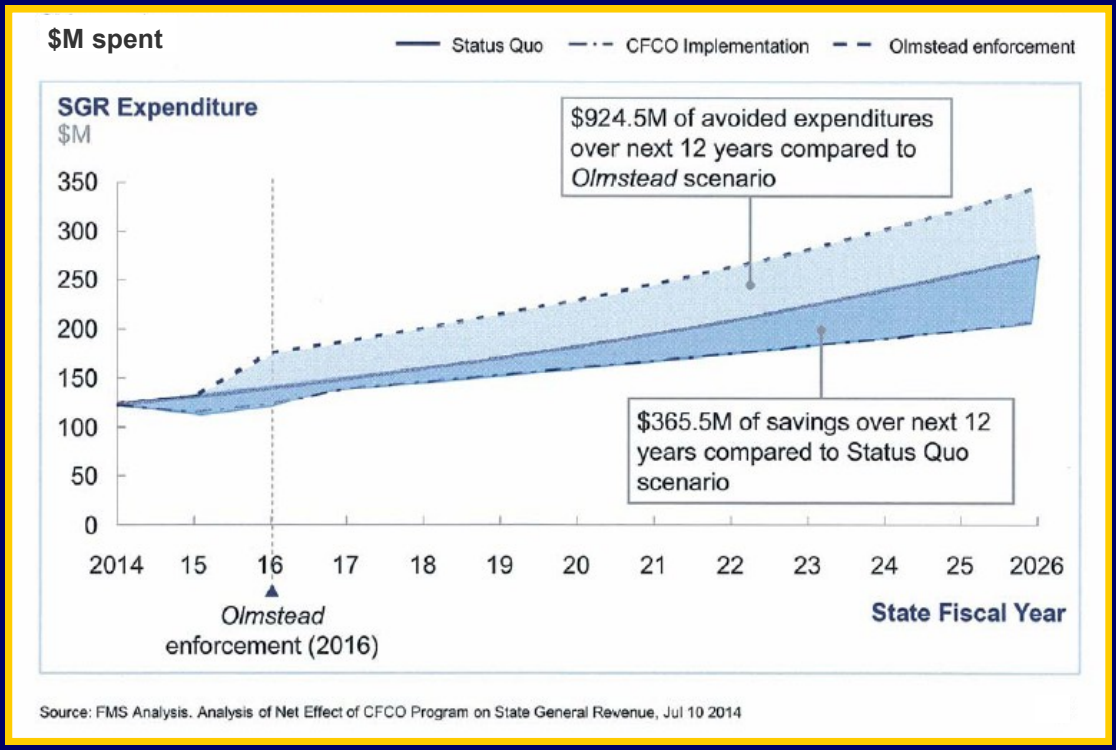
DHS projections indicate that, over the next 12 years, CFCO implementation would save the State $365.5 million compared to the cost of maintaining the status quo and $924.5 million compared to Olmstead enforcement, as shown in **Exhibit VI on page 15**.

[9]DHS calculations assume that a total of 882 people on the DDS ACS waiting list are gradually added during SFY15 (January 2015 to June 2015) and a total of 2,638 people on the DDS ACS waiting list are added by the end of SFY 2016.

[10]See page 8 for discussion of the Olmstead requirement and the potential effects of noncompliance on the State.

Exhibit VI

Arkansas Department of Human Services
Projected State General Revenue Expenditures
for Home and Community-Based Services Under Three Scenarios
For State Fiscal Years 2014 through 2026



Source: FMS Analysis. Analysis of Net Effect of CFCO Program on State General Revenue, Jul 10 2014

$M spent

	State Fiscal Year													
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
A Status Quo	121.7	130.2	139.4	149.1	159.6	170.7	182.7	195.5	209.2	223.8	239.5	256.2	274.2	2,451.7
B Scenario: CFCO Imple-mentation	121.7	114.6	123.3	139.3	146.6	154.0	161.2	168.2	175.5	183.1	191.1	199.4	208.2	2,086.1
C Scenario: *Olmstead* enforcement	121.7	130.2	174.8	187.0	200.1	214.1	229.1	245.1	262.3	280.7	300.3	321.3	343.8	3,010.6
Cost Savings for CFCO from Status Quo (A-B)	0.0	15.6	16.1	9.9	12.9	16.8	21.5	27.3	33.7	40.7	48.4	56.8	66.0	365.5

Source: FMS Analysis. Analysis of Net Effect of CFCO Program on State General Revenue, Jul 10 2014
FMS Key Assumptions: A) current Federal match rate is 70.7%, annual HCBS growth rate is 10% to SFY2014 and 7% thereafter due to Payment Improvement Initiative and population growth . B) Federal match increases by 6% for duration of CFCO, individuals on waitlist are enrolled in HCBS in SFY2015-16. C) Olmstead enforcement in 2016, Federal match rate remains at 70.7%, annual HCBS growth rate is 10% to SFY2014 and 7% thereafter due to Payment Improvement Initiative and population growth

Note: DHS savings projections do not assume any impact on the number of recipients in nursing homes and intermediate care facilities.

Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

Per the FMS Key Assumptions at the bottom of **Exhibit VI on page 15**, DHS notes an annual growth rate of 10% for SFY 2014 and 7% thereafter due to the Arkansas Payment Improvement Initiative and population growth. Amounts und er the status quo and Olmstead enforcement were calculated by applying the 7% growth rate to SFY 2014 actual expenditures. DHS indicated that the 7% annual growth rate was based on historical growth rates from 2007 to 2012, with outliers removed to not artificially inflate the rate. This 3% decline in the growth rate was assumed by DHS and was not audited or validated by DLA staff. Additionally, under scenario two, CFCO implementation, the 4% growth rate, per documentation provided by DHS, was due to two factors: 2% medical inflation plus 2% rise due to demographic changes. These DHS assumptions were also not audited or validated by DLA staff.

Residency Concerns and Woodwork Costs

Implementation of CFCO could entice some individuals who were already eligible for services to apply for CFCO. Costs associated with this phenomenon are referred to as *woodwork costs*. **Exhibit VII** presents DHS management's assumptions of expenditure growth rates related to woodwork costs. The growth rates from SFY 2015 through 2026 are provided in **Exhibit VIII on page 17**.

Exhibit VII

Arkansas Department of Human Services
Projected Expenses Related to Woodwork Costs
For State Fiscal Year 2015

Program	2014 Actual Expenses (Note 1)	2015 Projected Expenditure Growth for CFCO Woodwork Costs	2015 Projected Expenses for Woodwork Costs	Federal Portion (Note 2)	State Portion
Alternatives for Adults with Physical Disabilities (AAPD) Waiver	$ 45,067,252	5%	$ 2,253,363	$ 1,728,104	$ 525,259
Developmental Day Treatment Clinic Services (DDTCS)	83,766,937	2%	1,675,339	1,284,817	390,522
Division of Developmental Disabilities Alternative Community Services (DDS ACS) Waiver	180,655,809	0%	0	0	0
ElderChoices Waiver	51,068,035	5%	2,553,402	1,958,204	595,198
Independent Choices	15,592,049	5%	779,602	597,877	181,725
Personal Care	39,091,717	5%	1,954,586	1,498,972	455,614
Totals	$ 415,241,799		$ 9,216,291	$ 7,067,974	$ 2,148,318

Note 1: These are overall program expenditures, including both state and federal portions, for only those recipients who need an institutional level of care. It should be noted that Personal Care, DDTCS, and Independent Choices have expenses for individuals who do not meet an institutional level of care need; those individuals have been excluded from these amounts since a CFCO program requirement is that recipients must need an institutional level of care. Additionally, expenses related to case management and supported employment services for the DDS ACS Waiver program and expenses related to case management, adult day care, and adult day health services for the ElderChoices Waiver program were excluded from the 2014 expenses since these specific services will not be provided under CFCO.

Note 2: Federal match of 76.69% is based on the state fiscal year (SFY) 2015 actual match rate of 70.69% plus the 6% enhanced Federal Medical Assistance Percentage (FMAP) for CFCO services. These projected amounts were calculated as if CFCO were implemented on July 1, 2014 (i.e., the beginning of SFY15). According to DHS, there is currently no projected effective date for CFCO implementation since it has yet to receive CMS approval.

Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

Exhibit VIII

Arkansas Department of Human Services
Projected Expenditure Growth Related to Woodwork Costs
For State Fiscal Years 2015 through 2026

Program	State Fiscal Year											
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Alternatives for Adults with Physical Disabilities (AAPD) Waiver	5%	5%	4%	3%	2%	1%	0%	0%	0%	0%	0%	0%
Developmental Day Treatment Clinic Services (DDTCS)	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Division of Developmental Disabilities Alternative Community Services (DDS ACS) Waiver	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
ElderChoices Waiver	5%	5%	4%	3%	2%	1%	0%	0%	0%	0%	0%	0%
Independent Choices	5%	5%	4%	3%	2%	1%	0%	0%	0%	0%	0%	0%
Personal Care	5%	5%	4%	3%	2%	1%	0%	0%	0%	0%	0%	0%

Note: The projected expenditure growth is a cumulative calculation. The growth percentages noted will be applied to actual expenditures, which will include actual woodwork costs, from the previous fiscal year. Projections for 2015 were calculated by DHS and are presented in **Exhibit VII**.

Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

Fees Received from Nursing Homes and Intermediate Care Facilities

Act 635 of 2001 authorized the State to collect quality assurance fees from nursing homes based on the number of occupied beds in the facility. These collected amounts can be claimed by nursing homes as a reimbursable expense and are also used as part of the required state match for Medicaid expenditures.

Similarly, Act 433 of 2009 authorized the State to collect a provider fee of 6% of gross receipts from intermediate care facilities. These collections are also used as part of the required state match for Medicaid expenditures.

CFCO implementation could affect the number of recipients residing in nursing homes and intermediate care facilities. Consequently, the amount of revenue Arkansas collects from nursing homes for quality assurance fees and from intermediate care facilities for provider fees could also be affected. **Exhibit IX** provides quality assurance and provider fees for SFY 2010 through 2014.

Exhibit IX

Arkansas Department of Human Services
Quality Assurance and Provider Fees Collected by the State
For State Fiscal Years 2010 through 2014

	State Fiscal Year				
	2014	2013	2012	2011	2010
Quality Assurance Fees (Note 1)	$76,402,110	$77,704,113	$72,211,066	$65,259,267	$63,867,630
Provider Fees (Note 2)	10,348,066	11,044,151	9,622,537	8,909,353	7,256,501

Note 1: Received from nursing homes.
Note 2: Received from intermediate care facilities.

Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

NEW HOME AND COMMUNITY-BASED WAIVERS

DHS has submitted proposals to CMS for two new HCB waivers, both with effective dates of January 1, 2015:[12]

- **Aging and Physical Disability Access to Homecare Waiver** would replace the ElderChoices Waiver and the Alternatives for Adults with Physical Disabilities (AAPD) Waiver. This waiver's purpose is to provide case management and the health care component of adult day health care services to individuals over age 65 or individuals ages 21 to 64 with physical disabilities.
- **Division of Developmental Disabilities HCB Waiver** would replace the current Division of Developmental Disabilities Alternative Community Services (DDS ACS) Waiver and provide case management and supported employment services to individuals with developmental disabilities, including autism.

According to DHS, CFCO does not create a new eligibility category. Therefore, income level eligibility criteria appropriate for eligibility category through which a person becomes Medicaid eligible would apply. Waivers provide eligibility category; CFCO does not. If an individual is eligible for Medicaid State Plan services, including CFCO services, by virtue of being enrolled in the Waiver, income level criteria would be up to 300% of the SSI Federal Benefit Rate. Under CFCO eligibility criteria, the 150% federal poverty level limitation only applies to individuals in an eligibility group that does not include nursing facility services.

Both of these proposed waivers would have no enrollment limits for the number of individuals who can receive services at any point in time but would have limits for the number of unduplicated beneficiaries who can receive services during the year, as shown in **Exhibit X**.

Exhibit X

Arkansas Department of Human Services
Proposed Home and Community-Based Waivers
Enrollment Limits

Home and Community-Based Waiver	Point-in-time beneficiaries (Note 1)	Unduplicated beneficiaries (Note 2)
Aging and Physical Disability Access to Homecare	No limit	11,350
Division of Developmental Disabilities Home and Community-Based Services	No limit	8,668

Note 1: Number of individuals allowed to receive services at any point in time.
Note 2: Number of individuals allowed to receive services during a 12-month-period, which is based on the original effective date of the waiver. For the Aging and Physical Disability Access to Homecare Waiver, this limit would apply in years 2-5; the limit for year 1 would be 6,037. For the Division of Developmental Disabilities Home and Community-Based Services Waiver, this limit would apply in years 1-5.

Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

The remainder of services offered under the three current HCB waivers but not specifically mentioned as covered by the two proposed waivers would be provided under the proposed CFCO program. These services include the following:

[12]According to information provided by DHS on November 5, 2014, the two new HCB waivers were withdrawn from CMS consideration, pending further discussions with CMS, and will be resubmitted at a later date.

- Assistive Technology/Adaptive Equipment
- Attendant Services and Supports
- Chore Services
- Community Transition Services
- Consultation Services
- Crisis Intervention
- Environmental Modifications
- Goods and Services
- Home-Delivered Meals
- Non-Medical Transportation
- Personal Emergency Response System
- Positive Behavioral Support Services
- Relief Care Services
- Specialized Medical Supplies
- Supportive Living Services
- Vehicle Modifications

VARIOUS ADDITIONAL QUESTIONS AND ANSWERS

The next portion of the report contains specific questions asked by members of the General Assembly and answers provided by DHS. The questions are organized by topic.

Movement of Recipients

Q1: Discuss the projected movement of clients from nursing homes and human development centers (HDC). Specifically for HDC, funding is being cut by 10-20% in anticipation of clients being moved to homes to receive care. What is the basis of this projection?

A1: DHS has no plans to move clients out of any type of facility but instead was considering the scenario where individuals who are about to need such services are afforded the choice of receiving them in the community. The basis for the original projections was to examine the financial impact that would result if 5% of people coming into the system chose to be served in a community setting rather than a facility. This factor was later determined to be unnecessary and was removed from the final projections submitted to the legislature. There are no plans or considerations on cutting HDC funding by 10 to 20% in anticipation of residents being moved to homes to receive care.

DLA note: As long as a recipient meets the eligibility requirements, he or she can choose to receive services in a home or community-based setting (under CFCO, if implemented) or in an institutional setting.

Q2: Are there incentives doctors can receive for moving clients from nursing homes or human development centers to personal homes?

A2: No.

Funding

Q3: Discuss the current HCB Federal Medical Assistance Percentage (FMAP) and the enhanced CFCO FMAP. How many years will the State receive the 6% enhanced match?

A3: The FMAP rate for SFY14 is 70.12% [see **Appendix C**]. A significant benefit of CFCO is the addition of a 6% bump in the FMAP rate to the favor of participating states. There is not any sunset provision for this additional 6% bump.

Q4: How will CFCO be sustained? How will the State sustain the costs after the enhanced matched is gone?

A4: Since the model [see **Exhibit VI**] shows savings in Arkansas resources and funding throughout the model period, it follows that there will be no new General Revenue required. Therefore, CFCO should be maintained by the existing resources available for the drawdown of federal monies. As noted above, there is not any sunset provision for the enhanced 6% FMAP rate.

Legal Requirements

Q5: Act 1670 of 2005 created the Community Services Oversight and Planning Council. Why has this committee ceased to meet?

A5: The Council membership was set forth to consist of Arkansas Senate and House members and provider representatives and was to be convened by the co-chairs of the Community and Services Oversight and Planning Council. DHS has no role in convening the Council.

Q6: Act 1792 of 2001 defines the relationship between the State and communities (community-based programs). In accordance with Section 2 (a)(3), "there shall be a quarterly progress report to the Joint Interim Committee on Public Health by the Department of Human Services on the categories of services and respective service limits, service eligibility guidelines for each service component, and the rate structure based on prospective costs." In addition, Section 2 (b), "subject to state and federal funding restrictions the reimbursement rates shall be revised annually with market basket rate adjustments to provide resources to the community-based programs necessary to provide persons choosing community-based services quality care assurance in a safe, healthy environment." Why has this never happened?

A6: Because so many years have elapsed since the passage of Act 1792 of 2001, DHS has been unable to definitively determine if or when the required reports were submitted. Current DHS staff do not recall working on or presenting such a report. It is unknown whether reports were ever submitted; if they were submitted at one time, it is unknown if the reports stopped as a result of an agreement between DHS and the then-leadership of the Public Health Committees or if it was simply an oversight. Along these lines, it is noteworthy that in 2005, the same legislator passed Act 1670, which created a legislative committee known as the Community Services Oversight and Planning Council, with jurisdiction to review all funding issues related to community-based services. DHS staff believe that the information required in the Act 1792 report may have simply been transferred and reported through the new council created by Act 1670. As for section 2(b) of Act 1792, the Act expressly conditions rate adjustments on "state and federal funding restrictions." DHS has always complied with this requirement.

Developmental Disability (DD) Episodes

Q7: What is the Developmental Disability (DD) episode?

A7: The DD Episode is part of the Arkansas Payment Improvement Initiative (APII) episode-based care delivery strategy. Arkansas Medicaid will utilize assessment-based prospective episodes methodology to pay for home and community-based services for individuals with intellectual disability/developmental disability (ID/DD). Under prospective assessment-based episodes, payment is based upon the results of a standardized assessment. The episode amount is determined prospectively and is informed by the assessment results. In order to qualify for an assessment-based episode and to determine level of need, all eligible individuals

must undergo a standardized assessment corresponding to their respective age, administered by an independent third party. The results of the assessment categorize the individual into a tier based on his/her level of need; this tier is then matched to an annual bundled episode amount. Prospective episode amounts are determined through analysis of costs and needs for individuals at each tier.

Q8: What are the details of episode design?

A8: Details of the episode design are still under development with stakeholder input and include:

- Establishing a Lead Service Provider for defined episodes of care who is responsible for managing services and overseeing coordination for complex-needs populations;
- Adopting prospective budgeting based on an independent assessment result for service episodes to encourage provider flexibility in achieving outcomes and delivering individualized services;
- Utilizing episode-based data to evaluate the efficiency, economy, quality of, and access to services delivered in the course of the episode;
- Establishing two service delivery models that preserve individual choice. These models include agency model with a Lead Service Provider, and self-directed service delivery model for defined episodes of care for complex-needs populations;
- Incentivizing improved quality of services and quality of life for individuals served, efficiency, and economy by rewarding high-quality services and outcomes;
- Promoting best practices and enhanced care coordination to improve quality of services; and
- Encouraging referrals when necessary to efficient and economic providers who furnish high-quality services.

Q9: When will the episode provider manual be finished, and when will the public comment period begin?

A9: The drafted DD Episode provider manual is currently under review by stakeholders. DHS estimates the formal public comment period will be held in the first quarter of 2015.

Q10: What are the DD episode mechanics, the reporting, the case mix, and other design elements?

A10: Details of the episode design and reporting are still under development with stakeholder input. The drafted Arkansas Developmental Disability Services payment methodology will employ a classification system called Case-Mix Groups for persons with Developmental Disabilities (CMGDD). Within each CMGDD Group, persons have similar personal characteristics. Associated with each unique group is a case mix index (CMI). The CMI value reflects the relative resource use (expenditures) among persons in the particular group. For instance, a person in a group with a CMI of 1.20 would on average have 20% higher resource use than would a person in a group with a CMI of 1.00. To develop relative Case Mix Indexes, the mean per diem claims for each CMGDD group was normalized by the mean claims for a frequent group. For example, for the adults, with most frequent group assigned the value of 1.00, the other most frequent group had a CMI of 0.91, or 91% of the cost of the reference group.

Q11: Define other design elements.

A11: See information provided in response to DD episode questions above. Details of the episode design are still under development with stakeholder input.

Q12: How was the cost savings on the DD Episode Budget information determined? How will DDS save $6 million in 2015 and $10 million in 2016?

A12: The total financial impact of the DD episode implementation shows the effect of an assessment-based episode on the reduction of the growth rates in spending on home and community-based services. Episode-based payment utilizes independent standardized assessments as the foundation of objective, needs-based resource allocation. Additionally, the episode-based payment incentivizes providers to deliver efficient, high-quality services within total episode budget. Both assessment-based resource allocation and incentives are projected to result in reduction in the overall growth rate in spending for HCB services. The estimated savings reflect the impacts of the CFCO enhanced match rate and the difference between maintaining status quo and the anticipated growth rate.

DLA note: DHS did not provide any documentation on how the projected savings were calculated other than the response provided above.

Miscellaneous

Q13: When will the results of the medical assessments conducted by Pine Bluff Psychological be released?

A13: Results of the functional assessments cannot be released because they contain protected health information and can only be viewed by the individual, legal guardian, and authorized individuals. Information provided by the assessments was used to develop the case mix index for the episode-based payment model for DD services.

DLA note: DHS provided preliminary summary information for adults who comprised the majority of assessed DD clients, as shown in **Appendix D.**

Q14: How much was paid to the McKinsey Group?

A14: McKinsey had no role or expenses related to CFCO.

DLA note: Three contracts were awarded to the McKinsey Group for consultation fees associated with the Arkansas Payment Improvement Initiative and included development work regarding episodes of care, the Patient-centered Medical Home model, health home development across home and community-based settings of behavioral health, long-term services and supports, and developmental disabilities: (1) for $4 million, valid from July 27, 2011 through June 30, 2014; (2) for $57 million, valid from July 1, 2012 through June 30, 2014; and (3) for $23.05 million, valid from July 1, 2014 through June 30, 2015. The total amount paid to this vendor for SFY 2012 through September 30, 2014, was $73.9 million.

Q15: Provide expenditures paid over the last three fiscal years for consultants utilized by DHS.

A15: No consultants were engaged in projects related to CFCO. All the modeling and projections were produced by the Agency.

SUMMARY

This report provided an overview of the HCB programs currently in place in the State, including both 1915(c) waivers and Medicaid State Plan programs, basic purpose, target population, enrollment limits, and services covered. The level of risk associated with these programs was also discussed.

Information regarding the proposed CFCO program was provided as well, including relevant legislation, the role the Development and Implementation Council, current programs that would be affected by implementation, a summary of newly-proposed HCB waivers and their connections with CFCO, services provided, recipient eligibility, available delivery models, and provider reimbursement, including the possible vendor to be utilized.

DHS management's projections of HCB expenditures and calculated savings related to CFCO implementation were presented. Possible additional costs related to woodwork expenses and loss of state revenue from reduced quality assurance fees collected from nursing homes and provider fees collected from intermediate care facilities were noted. Finally, the report provided a series of specific questions from members of the General Assembly and answers provided by DHS.

APPENDICES

Appendix A – Arkansas Department of Human Services – Services Provided under the Home and Community-Based (HCB) 1915(c) Waiver Series

Appendix B – Arkansas Department of Human Services – Services Provided under Home and Community-Based (HCB) State Plan Programs

Appendix C – Arkansas Department of Human Services – Home and Community-Based (HCB) Program Paid Amounts for State Fiscal Years 2010 through 2014

Appendix D – Arkansas Department of Human Services – Preliminary Summary Information for Medical Assessments Performed by Pine Bluff Psychological Associates – Developmental Disability (DD) Clients

APPENDIX A

Arkansas Department of Human Services
Services Provided under the
Home and Community-Based (HCB) 1915(c) Waiver Series

Home and Community-Based 1915(c) Waivers and Services Provided
Alternatives for Adults with Physical Disabilities (AAPD) Waiver
Counseling Support Management
Attendant Care Services
Environmental Accessibility Adaptations/Adaptive Equipment
Autism Waiver
Consultative Clinical and Therapeutic Services
Individual Assessment/Treatment Development
Lead Therapy Intervention
Line Therapy Intervention
Plan Implementation and Monitoring of Intervention Effectiveness
Provision of Therapeutic Aides and Behavioral Reinforcers
Division of Developmental Disabilities Alternative Community Services (DDS ACS) Waiver
Case Management
Respite
Supported Employment
Supportive Living
Specialized Medical Supplies
Adaptive Equipment
Community Transition Services
Consultation
Crisis Intervention
Environmental Modifications
Supplemental Support
ElderChoices Waiver
Adult Day Health
Homemaker
Respite
Adult Companion Services
Adult Day Care
Adult Family Home
Chore Services
Home-Delivered Meals
Personal Emergency Response System (PERS)
Living Choices Assisted Living (LCAL) Waiver
Attendant Care Services
Therapeutic Social and Recreational Activities
Periodic Nursing Evaluations
Limited Nursing Services
Assistance with Medication
Assistance Obtaining Non-Medical Transportation

Source: *Home and Community-Based 1915(c) Waiver Series, Appendix C (unaudited by the Division of Legislative Audit)*

APPENDIX B

Arkansas Department of Human Services
Services Provided under
Home and Community-Based (HCB) State Plan Programs

Home and Community-Based State Plan Programs and Services Provided
Developmental Day Treatment Clinic Services (DDTCS)
Diagnosis and Evaluation
Habilitation
Optional services including Occupational, Physical, and Speech Therapy
Independent Choices
Personal Care Type Services (as listed above)
Adult Companion (for ElderChoices beneficiaries)
Homemaker Services (for ElderChoices beneficiaries)
Personal Care
Activities of Daily Living (ADL), including eating, bathing, personal hygiene, toileting, and ambulating
Instrumental Activities of Daily Living (IADL), including meal preparation, incidental housekeeping, laundry, and medication assistance

Source: *DDTCS, Independent Choices, and Personal Care Provider Manuals (unaudited by the Division of Legislative Audit)*

APPENDIX C

Arkansas Department of Human Services
Home and Community-Based (HCB) Program Paid Amounts
For State Fiscal Years 2010 through 2014

Home and Community-Based Program	State Fiscal Year 2014	2013	2012	2011	2010
Alternatives for Adults with Physical Disabilities (AAPD) Waiver	$ 45,176,493	$ 43,660,168	$ 42,516,332	$ 41,675,732	$ 41,942,404
Autism Waiver	2,056,632	157,177	0	0	0
Developmental Day Treatment Clinic Services (DDCTS)	150,684,002	152,948,945	153,491,634	148,943,144	130,975,022
Division of Developmental Disabilities Alternative Community Services (DDS ACS) Waiver	190,253,400	180,663,580	173,134,527	160,404,445	139,744,190
ElderChoices Waiver	53,580,358	59,696,840	64,090,573	66,145,099	62,923,629
Independent Choices	25,021,278	26,628,477	26,238,785	24,027,144	21,081,374
Living Choices Assisted Living (LCAL) Waiver	16,261,703	14,818,474	12,601,472	10,228,400	8,575,057
Personal Care	95,053,290	89,422,882	84,364,958	78,225,960	70,920,704
Total Program Paid Amounts	$ 578,087,156	$ 567,996,543	$ 556,438,281	$ 529,649,924	$ 476,162,380
Federal Medical Assistance Percentage (FMAP)	70.12%	70.31%	70.88%	76.28%	80.82%
State Match Percentage	29.88%	29.69%	29.12%	23.72%	19.18%

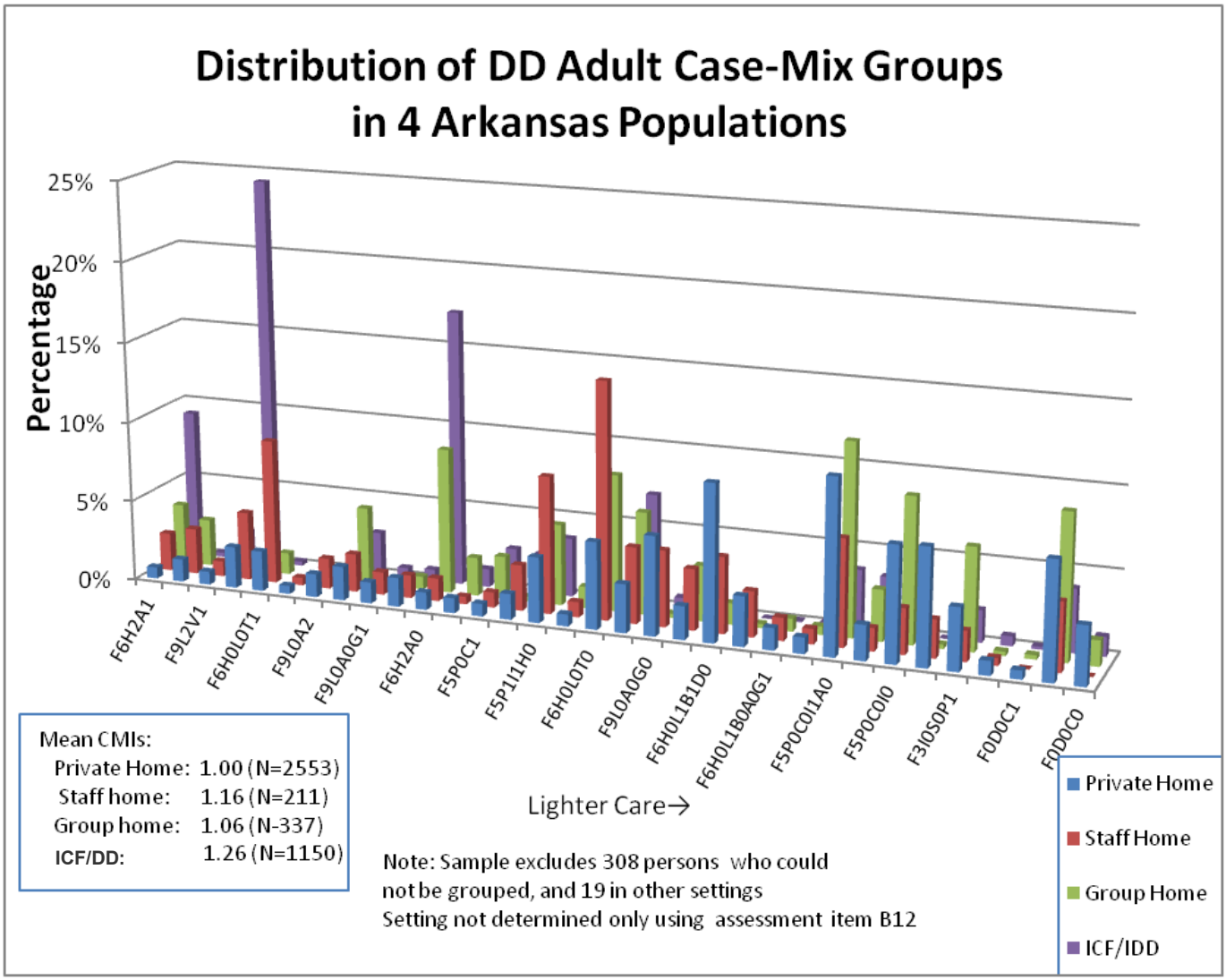
Federal Portion	State Fiscal Year 2014	2013	2012	2011	2010
Alternatives for Adults with Physical Disabilities (AAPD) Waiver	$ 31,677,757	$ 30,697,464	$ 30,135,576	$ 31,790,248	$ 33,897,851
Autism Waiver	1,442,110	110,511	0	0	0
Developmental Day Treatment Clinic Services (DDTCS)	105,659,622	107,538,403	108,794,870	113,613,830	105,854,013
Division of Developmental Disabilities Alternative Community Services (DDS ACS) Waiver	133,405,684	127,024,563	122,717,753	122,356,511	112,941,254
ElderChoices Waiver	37,570,547	41,972,848	45,427,398	50,455,482	50,854,877
Independent Choices	17,544,920	18,722,482	18,598,051	18,327,905	17,037,966
Living Choices Assisted Living (LCAL) Waiver	11,402,706	10,418,869	8,931,923	7,802,224	6,930,361
Personal Care	66,651,367	62,873,228	59,797,882	59,670,762	57,318,113
Total Program Paid Amounts	$ 405,354,713	$ 399,358,368	$ 394,403,453	$ 404,016,962	$ 384,834,435

State Portion	State Fiscal Year 2014	2013	2012	2011	2010
Alternatives for Adults with Physical Disabilities (AAPD) Waiver	$ 13,498,736	$ 12,962,704	$ 12,380,756	$ 9,885,484	$ 8,044,553
Autism Waiver	614,522	46,666	0	0	0
Developmental Day Treatment Clinic Services (DDTCS)	45,024,380	45,410,542	44,696,764	35,329,314	25,121,009
Division of Developmental Disabilities Alternative Community Services (DDS ACS) Waiver	56,847,716	53,639,017	50,416,774	38,047,934	26,802,936
ElderChoices Waiver	16,009,811	17,723,992	18,663,175	15,689,617	12,068,752
Independent Choices	7,476,358	7,905,995	7,640,734	5,699,239	4,043,408
Living Choices Assisted Living (LCAL) Waiver	4,858,997	4,399,605	3,669,549	2,426,176	1,644,696
Personal Care	28,401,923	26,549,654	24,567,076	18,555,198	13,602,591
Total Program Paid Amounts	$ 172,732,443	$ 168,638,173	$ 162,034,828	$ 125,632,962	$ 91,327,945

Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

APPENDIX D

Arkansas Department of Human Services
Preliminary Summary Information for
Medical Assessments Performed by Pine Bluff Psychological Associates
Developmental Disability (DD) Clients



ICF/DD = Intermediate Care Facilities for individuals with Developmental Disabilities
Source: *Arkansas Department of Human Services (unaudited by the Division of Legislative Audit)*

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