

*TOC not required***212.000****Eligibility for the ARChoices Program****1-1-1921**

- 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.

The ARChoices Program processes for beneficiary intake, assessment and service plan development include:

1. Determination of categorical eligibility;<sub>1</sub>
  2. Determination of financial eligibility;<sub>1</sub>
  3. Determination of nursing facility level of care ~~determination~~;<sub>1</sub>
  4. Development of a person-centered service plan (PCSP);<sub>1</sub>
  5. Development of an individual services budget (ISB);<sub>1</sub>
  6. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services;<sub>1</sub> and <sub>1</sub>
  7. Choice by the beneficiary among certified providers.
- B. Applicants for participation in the program (or their representatives) must make application for services at the DHS office in the county of their residence. Medicaid eligibility is determined by the DHS Division of County Operations, the results of the independent assessment, and the Division of Provider Services and Quality Assurance (DPSQA) OLTC Eligibility Specialist and is based on non-functional and functional criteria. Income and resources comprise the non-functional criteria. The individual must be an individual with a functional need.
- C. 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 <sub>1</sub>
    - b. At least two (2) of the three (3) ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or <sub>1</sub>
  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 <sub>1</sub>
  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.
- D. Individuals who require a skilled level of care as defined in ~~Department of Human Services~~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 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 therefore is not eligible for the ARChoices waiver program.

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

For more information on ARIA, please see the ARIA Manual.

- F. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than twenty-one (21) days.
- G. Beneficiaries diagnosed with a serious mental illness or intellectual disability are not eligible for the ARChoices Program 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 having medical needs unrelated to the diagnosis of serious mental illness or intellectual disability when they meet the other qualifying criteria.
- H. Eligibility for the ARChoices Waiver program begins the date the DHS Division of County Operations 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.)
- I. The ARChoices Waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once beneficiaries meet all functional 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:
  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:
    - a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;
    - b. Waiver application determination date for persons being discharged from a

- nursing facility after a 90-day stay; 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

1-1-1921

- 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.
- BC. DHS RN means a registered nurse authorized by DHS to develop the person-centered service plan for a participant.
- CD. 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.
- DF. 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 ELIGIBILITY means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one (1) of the following three (3) criteria, as determined by a licensed medical professional:
  - 1. The individual is unable to perform either of the following:
    - a. At least one (1) of the three (3) activities of daily living (ADL's) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or
    - b. At least two (2) of the three (3) activities of daily living (ADL's) of transferring/locomotion, eating or toileting without limited assistance from another person; or
  - 2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,  
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.

- ~~EH~~. 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.
- ~~FI~~. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.
- ~~GJ~~. 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.
- ~~HK~~. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.
- ~~IL~~. 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.
- ~~JM~~. 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.
- ~~KO~~. 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.
- ~~LP~~. 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.

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

**NR.** 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.

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

**PT.** 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.

## 212.200 Prospective Individual Services Budget

1-1-4921

### 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) Division of Aging, Adult and Behavioral Health Services (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.
3. Each participant's Individual Services Budget shall be explained when the Department of Human Services Registered Nurse (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), ~~and~~/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:
  - ia. 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**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.

**212.312 Comprehensive Person-Centered Service Plan (PCSP)****1-1-4921**

Prior to the expiration date of the provisional PCSP, the DHS RN will send the comprehensive PCSP to the waiver beneficiary and all providers included on the PCSP. 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 from the date of the DHS RN's signature on form AAS-9503, the ARChoices PCSP. Once the ~~application~~ 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, financial and functional eligibility will be reviewed for renewal of the PCSP. Functional eligibility will be determined by an evaluation done by the DHS RN.

**212.500 Reporting Changes in Beneficiary's Status****1-1-4921**

Because the provider has more frequent contact with the beneficiary, many times the provider becomes aware of changes in the beneficiary's status sooner than DHS RN or 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 Status Form (AAS-9511) and send it to the DHS RN. A copy must be retained in the provider's beneficiary case record. Regardless of whether the change may result in action by the DHS Division of County Operations, providers must immediately report all changes in the beneficiary's status to the DHS RN.

The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in service need, referring the beneficiary for evaluation of any beneficiary complaints or change of condition~~for reassessment if necessary and reporting any beneficiary complaints and changes in status~~ to the DHS RN, or DHS RN Supervisor immediately upon learning of the change. The DHS RN will determine if 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.

TOC not required

211.100 Eligibility for the Living Choices Assisted Living Program

7-1-201-1-  
21

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

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

1. Determination of categorical eligibility;
  2. Determination of financial eligibility;
  3. Determination of nursing facility level of care;
  4. Development of a person-centered service plan (PCSP); and
  5. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services.
- B. Candidates for participation in the program (or their representatives) must make application for services at the DHS office in the county in which the Level II ALF is located. Medicaid eligibility is determined by the DHS County Office and is based on non-medical and medical criteria. Income and resources comprise the non-medical criteria. Medically, the candidate must be an individual with a functional disability.
- C. To be determined an individual with a functional disability, an individual must meet at least one (1) of the following three (3) criteria, as determined by a licensed medical professional.
1. The individual is unable to perform either of the following:
    - a. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon, another person; or
    - b. At least two (2) of the three (3) ADLs of transferring/locomotion, eating or toileting without limited assistance from another person; or
  2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or others; or
  3. The individual has a diagnosed medical condition that requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.
- D. Individuals who required skilled level of care as defined in the Department of Human Services regulations are not eligible for the Living Choices 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 person-centered service plan. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or reassessment. The tiers are intended to help inform waiver program oversight and administration and person-centered service planning. The tiers do not replace the Level of Care criteria described in Bullet C above, waiver eligibility determinations, or the person-centered service plan process.

1. Tier 0 (zero) and Tier 1 (one) indicate the individual's assessed needs, if any, do not support the need for either Living Choices services or nursing facility services.
2. Tier 2 (two) indicates the individual's assessed needs are consistent with services available through either the Living Choices Waiver program or a licensed nursing facility.
3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and, therefore, is not eligible for the Living Choices Waiver program.

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

For more information on ARIA, please see the ARIA Provider Manual.

- F. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition that is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than twenty-one (21) days.
- G. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.
- H. Eligibility for the Living Choices waiver program is determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the plan of care is signed by the DHS RN and beneficiary. If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process. If a beneficiary is moving from a Provider-Led Arkansas Shared Savings Entity (PASSE) to the Living Choices waiver program, the eligibility date will be no earlier than the first day following disenrollment from the PASSE.
- I. The Living Choices waiver provides for the entrance of all eligible persons on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:
  1. Each Living Choices application will be accepted and medical and financial eligibility will be determined.
  2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled, and that the applicant is number X in line for an available slot.
  3. Entry to the waiver will then be prioritized based on the following criteria:
    - a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;
    - b. Waiver application determination date for persons being discharged from a nursing facility after a 90-day stay; 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.

**211.125 Definitions****1-1-21**

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- B. ASSESSMENT means the process completed by the independent assessment contractor to collect information used in determining initial functional eligibility for waiver services.
- C. DHS RN means a registered nurse authorized by DHS to develop the person-centered service plan for a participant.
- D. EVALUATION means the process completed, at a minimum of every three hundred sixty-five (365) days, by the DHS RN to determine continued functional eligibility or a change in medical condition that may impact continued functional eligibility
- E. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.
- F. FUNCTIONAL ELIGIBILITY means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one (1) of the following three (3) criteria, as determined by a licensed medical professional:
  - 1. The individual is unable to perform either of the following:
    - a. At least one (1) of the three (3) activities of daily living (ADL's) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or,
    - b. At least two (2) of the three (3) activities of daily living (ADL's) of transferring/locomotion, eating or toileting without limited assistance from another person; or
  - 2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,
  - 3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.
- G. INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the ARIA assessment tool for the purpose of collecting information used in determining level of care and developing the person-centered service plan.
- H. REASSESSMENT means the process, completed at the request of DHS, by the independent assessment contractor to collect information used in determining continuing functional eligibility for waiver services.
- I. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other

psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.

### 211.150 Level of Care Determination

7-1-201-1-21

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

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

An evaluation is completed annually by the DHS RN to determine continued functional eligibility. Should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment. The Independent Assessment Contractor RN performs an assessment periodically (at least annually), and tThe Office of Long Term Care re-determines level of care annually. The results of the level of care determination and the re-evaluation are documented on form DHS-704, Decision for Nursing Home Placement.

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

### 211.200 Plan of Care

4-1-191-1-21

- A. Each beneficiary in the Living Choices Assisted Living Program must have a person-centered service plan, also referred to as an individualized Living Choices Plan of Care (AAS-9503). The authority to develop a Living Choices plan of care is given to the Medicaid State agency's designee, the DHS RN. The Living Choices plan of care developed by the DHS RN includes without limitation:
1. Beneficiary identification and contact information to include full name and address, phone number, date of birth, Medicaid number and the effective date of Living Choices Assisted Living waiver eligibility;
  2. Primary and secondary diagnosis;
  3. Contact person;
  4. Physician's name and address;
  5. The amount, frequency and duration of required Living Choices services and the name of the service provider chosen by the beneficiary or representative to provide the services;
  6. Other services outside the Living Choices services, regardless of payment source identified and/or ordered to meet the beneficiary's needs. Living Choices providers are not required to provide these services, but they may not impede their delivery;
  7. The election of community services by the waiver beneficiary; ~~and~~

8. The name and title of the DHS RN responsible for the development of the plan of care; ~~and,-~~
  9. Each beneficiary, or his or her representative, has the right to choose the provider of each non-waiver service. Non-waiver services are the services listed on the plan of care that are not included in the bundled services of the Living Choices Program (e.g., medical equipment rental). The plan of care names the provider that the beneficiary (or the beneficiary's representative) has chosen to provide each service.
- B. A copy of the plan of care signed by the DHS RN and the waiver beneficiary will be forwarded to the beneficiary and the Living Choices service provider(s) chosen by the beneficiary or representative, if waiver eligibility is approved by the DHS County Office. Each provider is responsible for developing an implementation plan in accordance with the beneficiary plan of care. The original plan of care will be maintained by the DHS RN.

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

1. Individualized to the beneficiary'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 welfare;
4. Monitored and adjusted as needed, based on changes to the waiver plan of care, as reported by the DHS RN;
5. Provided within a system that safeguards the beneficiary's rights; ~~and.~~
6. Documented carefully, with assurance that appropriate records will be maintained.

**NOTE: Each service included on the Living Choices plan of care 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.**

Living Choices services must be provided according to the beneficiary plan of care. Providers may bill only for services in the amount and frequency that is authorized in the plan of care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

**NOTE: Plans of care are updated annually by the DHS RN and sent to the assisted living provider prior to the expiration of the current plan of care. However, the provider has the responsibility for monitoring the plan of care expiration date and ensuring that services are delivered according to a valid plan of care. At least thirty (30) and no more than forty-five (45) days before the expiration of each plan of care, the provider shall notify the DHS RN via email and copy the RN supervisor of the plan of care expiration date.**

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

- C. The assisted living provider employs or contracts with a Registered Nurse (the "assisted living provider RN") who implements and coordinates plans of care, supervises nursing and direct care staff and monitors beneficiaries' status. At least once every three (3) months, the assisted living provider RN must evaluate each Living Choices beneficiary.
- D. The DHS RN must ~~reevaluate~~ a beneficiary's medical condition within fourteen days of being notified of any significant change in the beneficiary's condition. The assisted living RN is responsible for immediately notifying the DHS RN regarding beneficiaries whose status or condition has changed and who need ~~reevaluation-and-reassessment~~.

**REVISIONS TO A BENEFICIARY PLAN OF CARE MAY ONLY BE MADE BY THE DHS RN.**

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

- E. An individual may be served in a Level II Assisted Living Facility under a provisional plan of care developed by the beneficiary and the DHS RN and signed by the beneficiary or the beneficiary's representative and the DHS RN, if the beneficiary and the provider accept the risk of possible ineligibility.
1. A provisional plan of care may be effective for no more than sixty (60) days.
  2. If approved by the Division of County Operations, eligibility for the program will be determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the provisional plan of care is signed by the DHS RN and the beneficiary, and a plan of care will be sent to the provider.

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

**212.200 Periodic Nursing Evaluations****4-1-191-1-21**

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

Each Living Choices beneficiary will be evaluated at least annually by a DHS RN. The DHS RN evaluates the resident to determine whether a nursing home intermediate level of care is still appropriate and whether the plan of care should continue unchanged or be revised. ~~Re-~~evaluations-Evaluations and subsequent plan of care revisions must be made within fourteen (14) days of any significant change in the beneficiary's status.

*TOC not required*

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

**7-1-201-1-  
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 personal care individualized service plan, developed by the Personal Care provider, is still required.

~~As of~~ The ARChoices PCSP is effective for one (1) year from the date of the beneficiary’s most recent last independent 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 last independent 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 last independent 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.



## 1. Request Information

A. The State of  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):

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.)

<input type="radio"/>	3 years
<input checked="" type="radio"/>	5 years

<input type="checkbox"/>	New to replace waiver Replacing Waiver Number: <input style="width: 150px;" type="text"/>
<b>Base Waiver Number:</b>	<input style="width: 150px;" type="text"/>
<b>Amendment Number</b> (if applicable):	<input style="width: 150px;" type="text"/>
<b>Effective Date:</b> (mm/dd/yy)	<input style="width: 150px;" type="text"/>

D. Type of Waiver (select only one):

<input type="radio"/>	Model Waiver
<input checked="" type="radio"/>	Regular Waiver

E. Proposed Effective Date:

Approved Effective Date (CMS Use):

## 2. Brief Waiver Description

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

The 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 of age with a physical disability or 65 and older who require an 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 (RN), the waiver maintains Medicaid-eligible participants at home, promotes dignity, autonomy, privacy, and safety, fosters community inclusion, and precludes or postpones institutionalization of the participant.

ARChoices is administered by two state operating agencies, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of Provider Services and Quality Assurance (DPSQA). DAABHS and DPSQA operate under the authority of the Division of Medical Services (DMS), the Medicaid Agency. DAABHS, DPSQA, and DMS are all under the umbrella of the Arkansas Department of Human Services (DHS). DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS and DPSQA. DAABHS is responsible for the day-to-day administration of the waiver, establishing waiver program policies and procedures, and overseeing the development and management of person-centered service plans, among other functions. DPSQA, through its Office of Long Term Care (OLTC), is responsible for the final determination of level of care. DPSQA is also responsible for provider certification, licensure for ARChoices services such as adult day care and adult day healthcare, 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.

Functional eligibility for the waiver is determined using an initial ~~using~~ assessment completed by the Independent Assessment Contractor's team of registered nurses. ~~ts and~~ The annual evaluation is initiated by the DHS RN. Should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessments performed by the State's Independent Assessment Contractor using a new electronic instrument, the Arkansas Independent Assessment (ARIA) system and the contractor's team of registered nurses.

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

Services are provided according to individualized person-centered service plans that are developed and authorized by DHS RNs. Service needs are assessed by the Independent Assessment Contractor using the ARIA instrument. Participants' preferences, goals, desired outcomes, and risk factors are assessed 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 & facility-based).

Each ARChoices person-centered service plan includes the 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 the tier level assigned by the ARIA instrument to the participant. The tier level is based on the individual's functional needs as determined during the ARIA-based assessment process.

## 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.

State:	
Effective Date	

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, family and providers. Comments are reviewed and appropriate action taken to incorporate changes or modifications to benefit the participant, 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.

Arkansas DHS has determined that this amendment is non-substantive. The 30-day public comment period will run simultaneously with the submission from October 11, 2020 through November 9, 2020. The notice of rulemaking will be published in the Arkansas Democrat-Gazette on October 8 through 10, 2020. The change will be posted on both the Arkansas Medicaid website and DHS website beginning October 8, 2020 through one month after the amendment is adopted, approximately February 1, 2021. There will be no public hearing for this amendment.

~~Policy and form revisions, procedural changes and clarifications are based on input from participants, family and providers. Comments are reviewed and appropriate action taken to incorporate changes or modifications to benefit the participant, 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.~~

~~The agency first conducted five public meetings in the summer to outline the reforms being considered for the waiver amendments: Jonesboro (6/4/18); Fort Smith (6/6/18); Monticello (6/8/18); Hope (6/11/18); and Little Rock (6/14/18). The public notice was published in the statewide newspaper Arkansas Democrat Gazette on October 14-16, 2018. The comment period ended November 12, 2018. The entire waiver application was published for comment. Physical copies of the proposed waiver amendments were mailed to constituents upon request. A copy was also published on the state's Medicaid website at this link: <https://www.medicaid.state.ar.us/general/comment/comment.aspx>~~

~~The agency conducted five public hearings during the public comment period in different parts of the state: Fort Smith (10/15/18); Monticello (10/18/18); Hope (10/22/18); Little Rock (10/29/18); and Jonesboro (11/7/18). At each public comment hearing, members of the public were invited to provide oral and/or written comments regarding the proposed waiver amendments. A court reporter was provided at each location to transcribe the entire hearing and all comments received. The agency provided sign-in sheets for attendees who chose to register their attendance.~~

~~Summary of Public Comments and Responses~~

~~During the public comment period for the ARChoices in Homecare waiver, Arkansas DHS received comments from consumer groups, providers, advocacy groups, and other stakeholders. Comments were provided through physical letters mailed/delivered to the agency; e-mails; telephone voicemails; and oral statements at public hearings. Comments included:~~

~~Comment: The most common comment was a form e-mail publicized by an advocacy group expressing opposition to Medicaid "cuts" generally, and concern for a lack of transparency in the development of the proposed amendment, and for "inadequate data" and "incorrect assumptions" in the actuarial studies supporting proposed rate changes.~~

State:	
Effective Date	

~~Response: DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. DHS has conducted a total of 10 regional public meetings concerning these changes and two publicly available webinars, in addition to meeting with both provider and consumer stakeholder groups to explain the changes and gather input. The comments fail to specify what data or assumptions are supposedly inaccurate, and rate studies were prepared by nationally recognized actuaries.~~

~~Comment: The second most common comment was an objection to a proposal to restrict the ability of a beneficiary's family members and roommates to serve as a paid agency caregiver for that beneficiary. Several of the comments provided specific data illustrating that a significant number of paid caregivers are related to the beneficiaries they serve, and provider express particular concern that this restriction would create significant barriers to access to care for beneficiaries in rural areas.~~

~~Response: In light of the data provided in comments, DHS agrees that this proposal could unnecessarily restrict access to care. DHS has removed this proposal from the waiver amendment.~~

~~Comment: The third most common comment was an objection to Medicaid "cuts" generally.~~

~~Response: DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require.~~

~~Two additional comments and responses are contained in Main Section B, "Additional Needed Information (Optional)."~~

- 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.

State:	
Effective Date	

## 7. Contact Person(s)

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

<b>Last Name:</b>	<u>MillsGolden</u>			
<b>First Name:</b>	<u>DaveMac</u>			
<b>Title:</b>	<del>Business Operations Manager</del> <u>Attorney Specialist</u> , Office of Policy Coordination and Promulgation,			
<b>Agency:</b>	Arkansas Department of Human Services			
<b>Address :</b>	P.O. Box 1437, Slot S-295			
<b>Address 2:</b>				
<b>City:</b>	Little Rock			
<b>State:</b>	Arkansas			
<b>Zip:</b>	72203-1437			
<b>Phone:</b>	501-320-63 <u>8306</u>	<b>Ext:</b>	<input type="checkbox"/>	<b>TTY</b>
<b>Fax:</b>	501- <u>682-8009404-4619</u>			
<b>E-mail:</b>	<u>dave.millsMac.E.Golden@dhs.arkansas.gov</u>			

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

<b>Last Name:</b>	<del>White-Foster</del>			
<b>First Name:</b>	<u>Mark-Ashely</u>			
<b>Title:</b>	<del>Deputy Assistant</del> Director			
<b>Agency:</b>	Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services			
<b>Address:</b>	P.O. Box 1437, Slot <u>S-530W-241</u>			
<b>Address 2:</b>				
<b>City:</b>	Little Rock			
<b>State:</b>	Arkansas			
<b>Zip :</b>	72203-1437			
<b>Phone:</b>	501-320- <del>6009</del> <u>6345</u>	<b>Ext:</b>	<input type="checkbox"/>	<b>TTY</b>
<b>Fax:</b>	501-682-8155			
<b>E-mail:</b>	<u>Mark.whiteAshley.Fisher@dhs.arkansas.gov</u>			

State:	
Effective Date	

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

Individuals served in the existing waiver may continue to participate in this HCBS program under the amended waiver, provided they (1) continue to meet financial eligibility and (2) meet the functional level of care eligibility criteria for the program as defined in the state rule. And determined following their evaluation, reassessment under the new Arkansas Independent Assessment (ARIA) process.

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

Appendix A: Waiver Administration and Operation  
HCBS Waiver Application Version 3.6

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*):

<input checked="" type="radio"/>	<b>Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).</b> Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
	A contractor (“Independent Assessment Contractor”) will perform independent assessments that gather functional <u>need-eligibility</u> 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).
<input type="radio"/>	<b>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</b>

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

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

Level of Care Definitions:

State:	
Effective Date	

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 365 days, 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 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 following three 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) activities of daily living (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 himself or others; or,
3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening;

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 collect information used in determining continuing functional eligibility for wavier services.

Level of Care Criteria: The functional ~~level of care~~eligibility criteria for ARChoices in Homecare waiver eligibility are established in administrative rules 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).

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- 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*):

<input type="radio"/>	<b>The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.</b>
<input checked="" type="radio"/>	<p><b>A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.</b></p> <p>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.</p> <p>Level of Care Instrument for Institutional Care:</p> <p>The instrument used to evaluate institutional level of care is form DHS-703 (Evaluation of Medical Need Criteria). The DHS-703 is completed by a registered nurse (RN) and includes information obtained from the participant, family members, caregivers, and others. The DHS-703 was designed based on the minimum data set (MDS) and the State’s nursing home admission criteria. It includes the nurse's professional assessment of the participant and observations and evaluation of the participant's ability to perform activities of daily living, along with other relevant information regarding the individual’s medical history.</p> <p>Level of Care Instrument for Waiver Program:</p> <p><del>Currently, the instrument used to determine the level of care for the ARChoices program is ArPath, based on the interRAI tool. Following the transition period, the The</del> Arkansas Independent Assessment (ARIA) system <del>will is be</del> used to support the <del>level of care</del><u>functional eligibility</u> determination process.</p> <p>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.</p> <p>Both the ARIA instrument (<del>as with the current ArPath instrument</del>) 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.</p> <p>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</p>

- 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:

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

Under the new process, each waiver applicant needing an evaluation and each waiver participant needing a re-evaluation will receive an individual assessment performed by the Independent Assessment Contractor. Each assessment or re-assessment is performed by a licensed registered nurse (RN) using the Arkansas Independent Assessment (ARIA) instrument. The ARIA tool will generate a proposed level of care evaluation. The Office of Long Term Care (OLTC) in DPSQA will review the ARIA results and the ARIA-recommended tier level, and make the final level of care determination. Functional ~~need~~-eligibility is valid for one year, unless a shorter period is specified by OLTC.

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

Re-evaluations will continue to be performed on at least an annual basis, with the ~~level of care~~~~functional eligibility~~ re-affirmed or revised and a written determination issued by the Office of Long Term Care. A re-evaluation may also be ordered anytime (or scheduled on a more frequent than annual basis) by the DHS ~~registered nurse~~~~RN~~ responsible for the participant's person-centered service plan, said nurse's supervisor, the DPSQA Office of Long Term Care director (or his/her designee), or the DAABHS deputy director (or his/her designee). In cases where a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), an ~~evaluation-assessment~~ will be performed ~~by the DHS RN, who requests 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).

~~Once ARIA is operational, using assessment results and a DAABHS-approved tiering methodology, the~~ 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,

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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.

**In summary:**

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 the Office of Long-Term Care (OLTC).

(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.)

- 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 (~~Arkansas' term for a person-centered care 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 that DHS RNs "tickler" file system approach that DAABHS registered nurses (DHS RNs) and RN supervisors use to monitor upcoming review data and service plan expirations. The process of reassessment-evaluation begins two months prior to the expiration date of the current person-centered service plan or two months prior to the annual anniversary date of the last independent-functional eligibility determination evaluationassessment, whichever is earlier.

On at least a monthly basis, the DHS RN will identify participants who are due for evaluation-assessment. The DHS RN will add the cases to the assessment-evaluation ~~schedule of the Independent Assessment Contractor by submitting the participants' information through an online web portal maintained by the Independent Assessment Contractor.~~ The DHS RN will use the online tracking tool "tickler" file system, referenced above, to monitor for both the need for reassessment-evaluation, and for timely completion of the reassessment, when requested, by the Independent Assessment Contractor. Once ~~the re-assessment it has been determined that functional eligibility continues, is completed and the level of care is revised as appropriate,~~ the DHS RN begins development of the new person-centered service plan.

Reassessments are ordinarily submitted to the Independent Assessment Contractor with a contractually-required 30-day time limit for completion of the reassessment. However, the contract

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also allows DHS, at its discretion, to submit reassessments with a 10-day time limit or a 7-day time limit when DHS deems it necessary.

The DHS RN supervisory 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 ~~re~~-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 "Tiekler" system to track the Medicaid eligibility reevaluation date and the service plan expiration date. If the reassessment process has not been completed timely, the Targeted Case Manager notifies the DHS RN prior to the expiration date of the current service plan.~~

The Targeted Case Manager is responsible for monitoring the beneficiary status on a regular basis for changes in service need, referring the beneficiary to the DHS RN for evaluation of any beneficiary complaints or change of condition or DHS RN Supervisor immediately upon learning of the change. The DHS RN will determine if a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RN's evaluation of the beneficiary.

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations and oversight of the independent assessment process), the Division of Provider Services and Quality Assurance (DPSQA) (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~~ assessments, ~~and~~ reassessments and evaluations are completed by a registered nurse.

~~Level of Care assessments are~~ A functional eligibility determination of level of care is required annually, applying the functional eligibility criteria, with referral for the use of ~~using~~ the approved assessment instrument in the event of a change of condition that may affect functional eligibility. ~~(currently, the ArPath instrument, and under the amended waiver~~ When referred, the Independent Assessment Contractor conducts a reassessment using the Arkansas Independent Assessment (ARIA) instrument) and applying applies the level of care functional eligibility criteria. ~~For the ArPath instrument, the DHS RN~~

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~~supervisors currently complete a regional monthly activity report, which lists the number of level of care evaluations and re-evaluations conducted. Remediation efforts are included on the DHS RN supervisors' monthly report. For ARIA, t~~The DHS Independent Assessment Contractor will submit data reports to DMS at least monthly listing the number of ~~level of care evaluations and re-evaluation~~assessments and reassessments ~~as~~ 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.

## Appendix B-7: Freedom of Choice

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

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

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

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

If necessary, the DHS RN 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 will document the format requested and/or provided in the participant's record.

## Appendix C: Participant Services HCBS Waiver Application Version 3.6

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## 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:
<b>Service Definition (Scope):</b>	
<p>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.</p> <p>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.</p> <p>The goals of the personal emergency response system are:</p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> </ol> <p>PERS is not intended to be a universal benefit. It is specifically for those "high-risk" participants whose needs are determined through the <u>assessment/reassessment person centered service plan development</u> 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.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

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

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

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

Each month the DHS 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 at each assessment and reassessment 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 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.

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

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

### 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 ~~need~~-eligibility requirements for ARChoices ~~in Section 212.000~~ but does not meet the criteria for the ISB Levels of Intensive or Intermediate.

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# Appendix D: Participant-Centered Planning and Service Delivery

## Appendix D-1: Service Plan Development

- 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):

(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. 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.

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Person centered sService plans are revised by DHS RNs as needed between assessmentsevaluations, based on reports secured through providers, waiver participants and their support systems.

(g) Each reassessment-evaluation of functional eligibility and development of a person-centered service plan development 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.

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

Routine monitoring of ARChoices in Homecare participants also helps to assess and mitigate risk. DHS RNs 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 RNs also re-evaluate potential participant risks during monitoring visits. DHS RNs 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 RNs also provide patient education on safety issues during the each assessment-evaluation and annual reassessment. The annual contact by the DHS RN is a minimum contact standard. Visits are made as needed during the interim.

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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.

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

The participant must choose a provider for each waiver service selected. When a person-centered service plan is developed, the DHS 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 prior to securing the individual's signature. Along with signing the service plan, and the Freedom of Choice form, an up-to-date provider listing from DPSQA must be signed and initialed. If a family member/representative chooses a provider for the participant, the DHS RN must identify the individual who chose the providers on the service plan and on the Freedom of Choice form. Documentation is also included in the participant's record and reviewed during the DHS RN supervisory review process.

For reassessments During completion of the person centered service plan, the participant or representative must sign the Freedom of Choice form to show that no change in providers was made. The provider listing does not need to be initialed if there are no changes in providers. However, if a participant wishes to change providers at reassessment, both the Freedom of Choice form and provider listing must be signed and initialed indicating this change. Participants may request a change of providers at any time during a waiver year.

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

DHS RNs and Targeted Case Managers leave contact information with participants at each visit. The participant may contact the DHS RN at any time to find out more information about providers.

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## 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 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. Targeted Case Managers must follow the monitoring guidelines and timeframes outlined in the Medicaid Provider Manual.

DHS RNs:

DHS RNs monitor each waiver participant's status on an as-needed basis for changes in service need, ~~reassessment (if necessary)~~, 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 planning meeting, the DHS RN 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.

- b. Monitoring Safeguards.** *Select one:*

<input type="radio"/>	<b>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.</b>
<input checked="" type="radio"/>	<p><b>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.</b></p> <p>The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i></p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>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 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 person-centered service plan.</p> </div> <p>ARChoices in Homecare providers agree to render all services in accordance with the Arkansas Medicaid ARChoices in Homecare Home &amp; Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by the</p>

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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 in writing within one week of services being terminated documenting the termination effective date and the reason for termination.

ARChoices in Homecare providers assure the Division of Provider Services and Quality Assurance (DPSQA) (operating agency) 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 person-centered 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 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 are revised by DHS RNs as needed ~~between assessments~~, 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 ~~reassessment~~ evaluation by the DHS RN, 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 RNs 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 RNs and Targeted Case Managers are responsible for following through and taking any action deemed appropriate.

## 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.

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The form DCO-707 (Notice of Action) is issued by the DHS County Office to provide notice to an applicant or waiver participant of any action taken with regard to Medicaid and program eligibility, such as approval and eligibility effective dates, denial and denial effective dates, the reason for action taken, and requests that further information be provided to the DHS County Office by the applicant or participant.

Waiver applicants and participants are advised on the DCO-707 (Notice of Action) or the system-generated Notice of Action by the DHS County Office when adverse action is taken to deny, suspend, reduce, or terminate eligibility for ARChoices in Homecare. The notice explains the action taken, the effective date of the action, the reason for the action, and explains the applicant's or participant's right to a hearing if the individual disagrees with the action the DHS County Office plans to take, the 30-day deadline for requesting a hearing, how to file for a hearing, and the applicant's or participant's right to representation.

Fair hearings are the responsibility of the Department of Human Services, Appeals and Hearings Office. This information and the contact information for the Appeals and Hearings Office is provided on the form DCO-707. The form is available in Spanish and large print formats, and advises the applicant or participant of such.

DHS has set guidelines for retention of the form DCO-707 in the applicant's or participant's case record. If the DCO-707 is a request for information only, the form may be discarded when all requested information is received by the LTSS Eligibility Caseworker. If the information requested is not received, the form may be discarded five years from the month of origin of the request. All other DCO-707 forms will be retained in the applicant's or participant's case record for five years from the date of the last approval, closure or denial.

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

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

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

The service 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 the determination of an appeal 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

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Freedom of Choice form, and the participant signs the list of providers showing that the choice was made.

NOTE: During the development of the person centered service plan~~For reassessments~~, the freedom of choice form is utilized showing no changes are requested by the participant. No signatures are required on the provider listing; however, the freedom of choice form is signed by the participant or their representative.

## Appendix F-3: State Grievance/Complaint System

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

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

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- 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 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 RNs review this information with participants and family members ~~at the initial assessment and at each annual reassessment~~reevaluation 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.

- 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

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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 ~~Independent Assessment Contractor reviews the medication regimes at the time of assessment.~~ The DHS RN reviews the medication regimens at the time of ~~assessment~~ each evaluation and reassessment. All medications are documented. Any potentially harmful practices the ~~Independent Assessment Contractor or~~ DHS RN discovers ~~during the assessment evaluation or during a monitoring visit~~ are documented in the participant record, addressed, and tracked for resolution.

- 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 ~~at each assessment and reassessment~~ 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 during the development of each person centered service plan.~~ assessment and reassessment. 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.

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## 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): Living Choices Assisted Living Waiver

C. Type of Request: (the system will automatically populate new, amendment, or renewal)  
**Requested Approval Period:** (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

<input type="radio"/>	3 years
<input checked="" type="radio"/>	5 years

<input type="checkbox"/>	New to replace waiver Replacing Waiver Number: <span style="border: 1px solid black; padding: 2px 20px;"> </span>		
	<b>Base Waiver Number:</b>		
	<b>Amendment Number</b> (if applicable):	AR.0400.R03.032	
	<b>Effective Date:</b> (mm/dd/yy)		

D. Type of Waiver (select only one):

<input type="radio"/>	Model Waiver
<input checked="" type="radio"/>	Regular Waiver

E. Proposed Effective Date: 021/01/2021+9

Approved Effective Date (CMS Use):  

## 2. Brief Waiver Description

Functional eligibility for the waiver is determined using an initial assessment completed by the Independent Assessment Contractor's. The annual evaluation is initiated by the DHS RN. Should a change

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~~of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a s and reassessment, s performed by the State's Independent Assessment Contractor using a new electronic instrument, the Arkansas Independent Assessment (ARIA) system and the contractor's team of registered nurses.~~

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

## 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.

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

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

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

~~The public notice for this amendment was published in the Arkansas Democrat-Gazette on January 12-14, 2020. The comment period ended February 10, 2020. Physical copies of the proposed waiver amendment were mailed to constituents upon request. 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>. The agency received~~

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~~comments from two entities. An attorney representing the Arkansas Residential Assisted Living Association (ARALA) and a representative of the Alzheimer's Association, Arkansas Chapter.~~

~~Comment: Both commenters had concern over the rate decrease. Concerns include: This decrease is having an adverse effect on access, given that existing facilities have closed, and will have an adverse effect on new facilities being established. There will be limited access in minority communities. The decrease represented by the proposed rule is especially troubling in view of the minimum wage increase that is occurring in Arkansas. The proposed reimbursement rates will place additional financial obligations on these facilities which may make it harder for them to both maintain and increase the quality of care, retain qualified health care professionals, and meet the other requirements and regulatory standards imposed by Arkansas State Law.~~

~~Response: Comment considered. The proposed rule actually implements an increase in the rate for assisted living services, not a decrease. In 2016, when CMS approved the 5-year renewal of the Living Choices waiver program, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. In the summer of 2018, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. DHS then implemented that rate in a rule that was approved by CMS and by the Arkansas Legislative Council in December 2018. Because the recommended rate was less than the then-current rate, DHS agreed to phase in the rate reduction over the two years remaining on the waiver. DHS also agreed to conduct another rate study in the first quarter of 2019. DHS did so, and a total of 29 assisted living providers responded to the cost survey conducted by the actuaries. That rate study resulted in a proposed rate that was higher than the rate approved in December 2018. This proposed rule increases the payment amounts in the phase-in schedule to reflect this newer rate. If this rule is not approved, providers will continue to receive the lower rate.~~

~~Comment: The representative from the Alzheimer's Association proposed the following edits to the current eligibility language. Please note that the commenter's suggested deletion of language is in brackets: The individual has a [primary or secondary] diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual [because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or others; or]~~

~~Response: Comment considered. This proposed rule only addresses the payment rate for the Living Choices Assisted Living Medicaid waiver and technical clean up language. Revising the eligibility criteria for the waiver is outside the scope of the proposed rule changes. However, DHS will consider these comments for future changes to the waiver.~~

- 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.

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## 7. Contact Person(s)

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

<b>Last Name:</b>	<u>Mills-Golden</u>			
<b>First Name:</b>	<u>DaveMac</u>			
<b>Title:</b>	<del>Business Operations Manager</del> <u>Attorney Specialist</u> , Office of Policy Coordination and Promulgation,			
<b>Agency:</b>	Arkansas Department of Human Services, Division of Medical Services			
<b>Address :</b>	P.O. Box 1437, Slot S-295			
<b>Address 2:</b>				
<b>City:</b>	Little Rock			
<b>State:</b>	Arkansas			
<b>Zip:</b>	72203-1437			
<b>Phone:</b>	501-320-63 <u>8306</u>	<b>Ext:</b>	<input type="checkbox"/>	<b>TTY</b>
<b>Fax:</b>	501-404-4619 <u>682-8009</u>			
<b>E-mail:</b>	<u>dave.millsMac.E.Golden@dhs.arkansas.gov</u>			

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

<b>Last Name:</b>	<u>White-Fisher</u>			
<b>First Name:</b>	<u>Mark-Ashley</u>			
<b>Title:</b>	<u>Deputy-Assistant</u> Director			
<b>Agency:</b>	Arkansas Department. of Human Services, Division of Aging, Adult, and Behavioral Health Services			
<b>Address:</b>	P.O. Box 1437, Slot <u>S-530W241</u>			
<b>Address 2:</b>				
<b>City:</b>	Little Rock			
<b>State:</b>	Arkansas			
<b>Zip :</b>	72203-1437			
<b>Phone:</b>	501-320- <del>6009-6345</del>	<b>Ext:</b>	<input type="checkbox"/>	<b>TTY</b>
<b>Fax:</b>	<u>501-682-8155</u>			
<b>E-mail:</b>	<u>Mark.whiteAshley.Fisher@dhs.arkansas.gov</u>			

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

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

LEVEL OF CARE DEFINITIONS:

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 365 days, 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 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 following three 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) activities of daily living (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 himself or others; or,
3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening;

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.

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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.

Instrument/Tool Used:

~~Currently, ArPath is the instrument approved for use by registered nurses (RNs) from DHS to collect information used to determine (or re-determine) each applicant's or participant's level of care. The ArPath instrument, which is based primarily on the interRAI toolset, was federally approved for use in the current waiver.~~

~~Beginning on the effective date of this amended waiver, Arkansas will instead use a new instrument—the~~ The Arkansas Independent Assessment (ARIA)—~~to collect~~ information to evaluate ~~make a determination of~~ used in determining functional eligibility of level of care. Registered nurses from the Independent Assessment Contractor will use the ARIA instrument to conduct face-to-face, in-home assessments and reassessments at the request of DHS. Using the information collected during the assessment, the Office of Long Term Care in DPSQA will evaluate whether an individual meets the State's level of care functional eligibility criteria.

All State laws, regulations, and policies concerning level of care functional eligibility criteria and the assessment instrument ~~tool~~ (including ~~the current ArPath instrument,~~ the new ARIA instrument, the Living Choices 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 Independent Choices 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*):

<input type="radio"/>	<b>The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.</b>
<input checked="" type="radio"/>	<p><b>A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.</b></p> <p>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.</p> <p>Level of Care Instrument for Waiver Program:</p> <p>The level of care instrument for the Living Choices waiver program will be the Arkansas Independent Assessment (ARIA) system will be used to support the <u>level of care functional eligibility</u> determination process.</p> <p>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.</p>

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Both the ARIA instrument (~~as with the current ArPath 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.

T

- 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:

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

~~Re-Evaluations~~ will continue to be performed on at least an annual basis, with the ~~level of care~~~~functional eligibility~~ re-affirmed or revised and a written determination issued by the Office of Long Term Care. A ~~reassessment-evaluation~~ may also be ordered anytime (or scheduled on a more frequent than annual basis) by the DHS ~~registered-nurseRN~~ responsible for the participant's person-centered service plan, ~~thesaid~~ nurse's supervisor, the DPSQA Office of Long Term Care director (or his/her designee), or the DAABHS deputy director (or his/her designee). In cases where a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), ~~an re-assessmentevaluation~~ will be performed ~~by the DHS RN, who may requests 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.

~~Once ARIA is operational, using assessment results and a DAABHS approved tiering methodology, the~~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.

**~~In summary:~~**

1. Tier 0 (zero) and Tier 1 (one) indicate the individual's assessed needs, if any, do not support the need for either Living Choices waiver services or nursing facility services.
2. Tier 2 (two) indicates the individual's assessed needs are consistent with services available through either the Living Choices waiver program or a licensed nursing facility.
3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and not through the waiver program.

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

(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.)

- 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 (~~Arkansas' term for a person-centered care 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 interrogated dashboard functionality that DHS RNs "tickler" file system approach that DAABHS registered nurses (DHS RNs)~~ and RN supervisors use to monitor upcoming review data and service plan expirations. The process of ~~reassessment-evaluation~~ begins at a minimum of two months prior to the expiration date of the current person-centered service plan or at a minimum of two months prior to the annual anniversary date of the last ~~independent-functional eligibility determination evaluationassessment~~, whichever is earlier.

On at least a monthly basis, the DHS RN will identify participants who are due for ~~evaluationre-assessment~~. The DHS RN will add the cases to the ~~assessment-evaluation~~ schedule ~~of the Independent Assessment Contractor by submitting the participants' information through an online web portal maintained by the Independent Assessment Contractor~~. The DHS RN will use the online tracking tool "tickler" file system, referenced above, to monitor for both the need for ~~reassessmentevaluation~~, and for timely completion of the reassessment by the Independent Assessment Contractor. Once it has been determined that functional eligibility continues, the re-assessment is completed and the level of care is revised as appropriate, the DHS RN begins development of the new person-centered service plan.

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

The DHS RN supervisory 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 re-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.

The Targeted Case Manager is responsible for monitoring the beneficiary status on a regular basis for changes in service need, referring the beneficiary to the DHS RN for evaluation of any

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beneficiary complaints or change of condition or DHS RN Supervisor immediately upon learning of the change. The DHS RN will determine if a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RN's evaluation of the beneficiary. Each Targeted Case Manager is also required to maintain a "Tickler" system to track the Medicaid eligibility reevaluation date and the service plan expiration date. If the reassessment process has not been completed timely, the Targeted Case Manager notifies the DHS RN prior to the expiration date of the current service plan.

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations and oversight of the independent assessment process), the Division of Provider Services and Quality Assurance (DPSQA) (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 assessments and reassessments are completed by a registered nurse.

Level of Care assessmentsA functional eligibility determination of level of care is required annually, applying the functional eligibility criteria, with referral for use of the approved assessment instrument in the event of a change of condition that may affect functional eligibility. ~~A functional eligibility determination of level of care is required annually. DHS RNs complete the annual evaluation using the approved assessment evaluation instrument (currently, the ArPath instrument, and under the amended waiver. When referred, the Independent Assessment Contractor conducts a reassessment using the Arkansas Independent Assessment (ARIA) instrument) and applying applies the level of care functional eligibility criteria.~~ The DHS RN supervisors complete a regional monthly activity report, which lists the number of level of care evaluations and re-evaluations conducted. Remediation efforts are included on the DHS RN supervisors' monthly report.

## Appendix B-7: Freedom of Choice

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

At the time of ~~assessment and re-assessment~~the development of the person centered service plan for of the waiver participant, the DHS RN explains the services available through the Living Choices

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waiver, discusses the qualified assisted living providers in the state and develops an appropriate person-centered service plan. As part of the service plan development process, the participant (or representative) documents their choice to have services provided in the community setting through the HCBS waiver as opposed to receiving services in an institutional setting. In addition, freedom of choice is explained through a Freedom of Choice form and the applicable qualified provider listing; both are signed by the waiver participant or their representative. This is documented on the service plan, which includes the signature of the waiver participant (or representative) and the DHS RN, and included in the participant's electronic record. NOTE: For reassessmentschanges to the person centered service plan, the Freedom of Choice form is utilized showing if changes are requested by the participant. If no changes are requested, no signatures are required on the provider listing; however, the Freedom of Choice form is signed and dated by the participant or representative. The participant's signature on the service plan, as entered by the participant or representative, documents that the participant (or representative) has made an informed decision to receive HCBS rather than services in an institutional setting and that HCBS are based on the participant's assessment of needs. Freedom of Choice documentation is tracked through the record review process, all staff performance evaluations and monthly reporting.

## Appendix C-2: General Service Specifications

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

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

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

Each month the DHS RN receives a provider list for each county included in their geographical area. This provider list may be used at each assessment and reassessment 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.

## Appendix D: Participant-Centered Planning and Service Delivery

### Appendix D-1: Service Plan Development

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**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):

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

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DHS RN, who is the only authorized individual who may adjust a participant's service plan. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices 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 Living Choices 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 Living Choices 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 sService plans are revised by DHS RNs as needed between assessmentsevaluations, based on reports secured through providers, waiver participants and their support systems.

(g) Each reassessmentevaluation of functional eligibility and development of a person-centered service plan development 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.

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- 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.

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 RNs also re-evaluate potential participant risks during monitoring visits. DHS RNs 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 RNs also provide patient education on safety issues during the ~~assessment each evaluation and annual reassessment~~. The annual contact by the DHS RN is a minimum contact standard. Visits are made as needed during the interim.

- 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.

~~For reassessments~~ During completion of the person centered service plan, the participant or representative must sign the Freedom of Choice form to show that no change in providers was made. The provider listing does not need to be initialed if there are no changes in providers. However, if a participant wishes to change providers ~~at reassessment~~, both the Freedom of Choice form and provider listing must be signed and initialed indicating this change. Participants may request a change of providers at any time during a waiver year.

## 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.

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

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

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# Appendix F: Participant Rights

## Appendix F-1: Opportunity to Request a Fair Hearing

**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.

During the assessment and 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 ~~At reassessments~~, if no change in provider is requested, the provider list is not signed by the participant.

## Appendix F-3: State Grievance/Complaint System

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

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

# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

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 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

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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 RNs review this information with participants and family members ~~at the initial assessment and at each annual reassessment~~ 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.

## Appendix G-3: Medication Management and Administration

- 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 ~~at each assessment and reassessment~~ and reported in the Record Review Summary Report. APS reports specific cases of abuse and neglect affecting waiver participants to DAABHS waiver staff. Findings are reported to the DPSQA QA Unit.

DAABHS staff are required to review the APS information with participants and other interested parties ~~during the development of at each assessment and reassessment~~ 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.

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# MEDICAL SERVICES POLICY MANUAL, SECTION C Mark UP

## C-200 Alternative Application Processes

### C-265 PACE Disenrollment

MS Manual 01/01/2107/01/20

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

1. The participant's failure to pay if he/she has a payment responsibility
2. The participant's disruptive or threatening behavior
3. The participant moving out of the PACE service delivery area
4. The participant no longer meeting the nursing facility Level of Care requirement
5. The participant's death
6. The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers
7. A PACE program agreement is not renewed

The PACE Organization may appeal an adverse decision to the Division of Aging, Adult and Behavioral Health Services (DAABHS). If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.



# MEDICAL SERVICES POLICY MANUAL, SECTION I-Mark-up

## I-600 Changes

### I-630 ARChoices Waiver

#### I-630 ARChoices Waiver

MS Manual ~~07/01/2001/01/21~~

Recipients will be advised to report any changes in the amount of household income or resources.

If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) determines that cost effectiveness is not met, that the client no longer meets the requirements for Intermediate Level of Care, or that the client is no longer receiving Waiver services, the County Office will be notified, and the Waiver case will be closed. If the Waiver case is closed for any reason, the eligibility worker will determine if the client is eligible for any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ARChoices Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month (e.g., land rent paid annually), procedures at [MS E-410](#) will be followed, advance notice given, and the case adjusted.

If the Waiver client will be ineligible for more than one month, the case will be closed and a new application will be required.

A Waiver client may appeal an adverse decision made on his/her case as outlined in [MS L 100-173](#) of the Medical Services Policy manual. ~~if the client chooses, the ARChoices Waiver case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client and the service provider. If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.~~

# MEDICAL SERVICES POLICY MANUAL, SECTION I

## I-600 Changes

### I-641 Temporary Absences from the Assisted Living Facility

#### I-640 Assisted Living Facility (ALF)

MS Manual ~~07/01/2001/01/21~~

ALF Waiver recipients will be advised to report any changes in income or resources to the DHS County Office. If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or the Office of Long Term Care determines that cost effectiveness is not met or that the client no longer meets the requirements for an Intermediate Level of Care, the County Office will be notified and the ALF case will be closed. If the case is closed for any reason, the eligibility worker will determine if the client is eligible in any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ALF Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month, procedures at [MS E-410](#) will be followed, advance notice given, and the case adjusted at the appropriate time.

If the ALF recipient will be ineligible for more than one month, the case will be closed and a new application will be required to reopen.

An ALF Waiver recipient may appeal an adverse decision made on his/her case as outlined in [MS Section L](#). ~~If the client chooses, the ALF case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client and the facility. If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.~~

## **L-120 Continuation of Assistance or Services during Appeal Process**

### **Mark Up**

MS Manual 01/01/2021

In cases where an adverse action is taken against a beneficiary who qualifies for an institutional level of care (e.g. ARChoices, Living Choices, TEFRA, Autism, PACE, CES/DD, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and LTC/nursing home), if a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits pending the hearing decision, they must opt out.

In all other cases, if a petitioner files an appeal for a hearing within the ten (10) day notice period, or five (5) days in the case of probable fraud, the case will remain open at the petitioner's request until the hearing decision ~~is received from OAH~~ Otherwise, benefits will NOT continue.

At the conclusion of the hearing, the hearing official will decide whether the case should be closed or services reduced prior to the rendering of the hearing decision. The criteria for determining whether adverse action is taken prior to the rendering of the hearing decision will be based on whether or not a fact or judgment situation exists. If it is determined that the sole issue is one of state or federal law or policy, the proposed action will be taken.

Examples of issues of fact:

- Verified earned or unearned income which caused net income to be in excess of the maximum income limitations.
- Protest of Agency Policy-The recipient agrees that his income or resources exceed the limitation but feels that the policy imposing these limitations is unreasonable.

If the sole issue is one of judgment relating to a state or federal law or policy, no adverse action is taken prior to the hearing decision.

Examples of judgment are:

- Disability in MRT cases.
- Value of real or personal property.

The petitioner will be advised at the beginning of the hearing that a decision will be made at the conclusion of the hearing regarding whether the benefits will be reduced or terminated prior to the rendering of the hearing decision. If the decision by the hearing official is to reduce or terminate benefits, a Notice of Action will be prepared by DCO and mailed for immediate action. This ~~is-Notice is~~ not an additional ~~ten (10) day notice-appealable~~ adverse action as it is simply an affirmation of the agency's original action.

If a subsequent change in the petitioner's open case occurs that results in adverse action

while the hearing decision is pending and the petitioner does not timely appeal ~~such that~~  
new adverse action, ~~within the ten (10) day notice period, appropriate action will be~~  
~~taken~~the change will occur on the date specified in the notice.

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