Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals

Statement of Necessity

This rule streamlines the Personal Care (PC) Medicaid Provider Manual and Arkansas Independent Assessment (ARIA) Medicaid Provider Manual. The resulting changes make the manuals easier to understand and use and result in significant cost savings. This rule also implements Acts 625 and 853 of the 2025 session. Act 625 mandates adoption of an abbreviated independent assessment process for certain beneficiaries enrolled in a risk-based provider organization. Act 853 moved private care agency certification to the Department of Health.

The PC manual currently contains information that is beyond the scope of State Plan Personal Care (SPPC). This rule repeals the current PC manual and issues a new, simplified, and streamlined manual to include only information regarding SPPC, as opposed to services contained in waivers to the state plan. These changes dispel confusion among overlapping programs, waivers, and policies, as well as better describe the parameters of SPPC. All removed information has been cross-referenced and linked to other program manuals to ensure availability of services. The rule also separates services for adults from services for those under twenty-one. And the repeal implements Act 853, noted above.

The ARIA manual currently contains information on how to administer independent assessments using the standardized ARIA tool to determine functional eligibility for Home and Community Based Services (HCBS) waiver/1915 state plan optional programs. While an independent assessment is mandatory to determine the functional need for waiver/1915 benefits, a standardized assessment tool (like ARIA) is not required (see 42 CFR Section 441.720) for SPPC. Accordingly, this rule removes the personal care section from the ARIA manual for consistency with the changes summarized below and confirms that use of the ARIA tool is not required.

The Personal Care Medicaid Provider Manual outlines the new streamlined process for evaluation review to SPPC, replacing the ARIA for determining eligibility. The new Medical Eligibility Review process for SPPC will be operated by the same vendor that operates the ARIA at a much lower cost. It will use claims data to verify the requestor's medical condition/diagnosis on file related to a physical impairment that creates barriers to Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) before approving the beneficiary for SPPC. The full process is outlined in the updated Personal Care Medicaid Provider Manual. Further, the rule changes the prior authorization (PA) time period from six (6) months to one (1) year. These two revisions will result in lower assessment costs and PA costs.

The other change being made to the ARIA Manual is the addition of explicit sections that describe how to administer an independent assessment using the standardized ARIA tool for Arkansas' aging waivers (ARChoices, Living Choices Assisted Living, and Program of All-Inclusive Care for the Elderly (PACE)). This is a needed update of the ARIA Manual to include information on how the ARIA is utilized for those aging waivers. These processes are already in practice but were not previously included in this manual.

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Summary of Changes

Personal Care Manual:

- Repeals the currently promulgated Personal Care Medicaid Manual and creates a new version.
- Streamlines the manual to focus on stand-alone SPPC;
- Transitions away from the ARIA tool as the medical and functional assessment test for SPPC and replaces it with the streamlined, lower-cost evaluation referral which is a Medical Eligibility Review process performed by the DHS-designated vendor that already performs the ARIA.
- Institutes a standardized format for SPPC functional assessments and treatment plans across personal care providers, required to be completed by personal care registered nurses .
- Lengthens time for PAs and Extensions of Benefits (EoB) from six (6) months to twelve (12) months;
- Establishes that PAs will remain in place for all populations receiving SPPC Services;
- Clarifies that the sixty-four (64) hours per month service cap will remain, but that youths may receive over sixty-four (>64) hours per month with EOB;
- Updates processes to implement the following: (1) The Evaluation Referral for SPPC is conducted by Optum through a Medical Eligibility Review to approve medical necessity for SPPC based on medical diagnosis/condition; (2) a registered nurse with the personal care provider will conduct an in-person assessment of the beneficiary's functional needs utilizing a DHS-approved tool; (3) require all forms be submitted for prior authorization.

ARIA Manual

- Removes reference to SPPC in § 201.000;
- Adds new sections regarding assessments and Tier Logic Tables for the ARChoices (§ 230.000 et seq.), Living Choices Assisted Living (§ 240.000 et seq.), and PACE (§ 250.000 et seq.). *Note:* The new sections explain the independent assessment processes that already are in practice and do not constitute new processes.

SECTION II – STATE PLAN PERSONAL CARE

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260.210 Electronic Visit Verification (EVV)

200.000 GENERAL INFORMATION

200.100 Participation Requirements for State Plan Personal Care Providers 1-1-27

A. State Plan Personal Care providers are designated high-risk providers based on the lack of licensure or certification from the Department of Human Services and the potential for fraud, waste, and abuse. As such, and as a condition of enrollment in the Arkansas Medicaid program, Arkansas Medicaid requires State Plan Personal Care providers to have:

1. On-site visits conducted by Arkansas Medicaid in accordance with 42 CFR 455.432, which includes pre-enrollment and post enrollment site visits as well as unannounced on-site inspections of any provider location.
2. Federal fingerprint-based checks in accordance with 42 CFR 455.434 and 42 CFR 455.50(c). All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq.

B. Each employee must successfully pass the following:

1. A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann.§ 20-38-103;
2. An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;
3. An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;
4. An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and
5. At least a five (5) panel drug screen upon hiring and prior to any contact with clients, and as required thereafter by Ark. Code Ann. §20-77-128(b).

C. A provider must meet the following participation requirements to qualify as a State Plan Personal Care provider under Arkansas Medicaid:

1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual; and
2. Obtain a license as a private care agency or be a certified Home Health Agency Class A or B; Assisted Living Facility (ALF) I; or Residential Care Facility (RCF).

200.200 Participation Requirements for Personal Care Providers that are School Districts or Education Service Cooperatives 1-1-27

A. A school district or education service cooperative must meet the following participation requirements to qualify as a State Plan Personal Care provider under Arkansas Medicaid.

1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual; and
2. Be certified as a Local Educational Agency (LEA) by the Arkansas Department of Education.
3. School personnel providing billable Personal Care services must be trained and certified by the Division of Elementary and Secondary Education (DESE).

200.300 Personal Care Services at School 1-1-27

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A. Beneficiaries under the age of twenty-one (21) may receive personal care services when attending school. For these purposes:

1. A "school" is an entity accredited by the Arkansas Department of Education to provide elementary or secondary education services;

2. A school setting is not limited to just the school-building or campus as long as the setting is related to the beneficiary's receipt of educational services from the school (i.e. attending a field trip to a museum);

3. The beneficiary's home is not considered a "school" place of service when a parent elects to home school.

B. Medicaid Program requirements are the same as for services delivered in the beneficiary's home.

C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the beneficiary receives services.

D. Beneficiaries receiving personal care in schools may receive a number of services in accordance with an Individualized Education Program (IEP).

1. The IEP may not supersede or substitute for the personal care treatment plan.

2. The Personal Care Program requires a distinct and separate assessment and treatment plan.

200.400 Out-of-State Limited Services Personal Care Providers 1-1-27

Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and they have a claim or claims to file with Arkansas Medicaid. To enroll, providers must download an Arkansas Medicaid application and contract from the DMS website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. **View or print the provider enrollment and contract package (Application Packet).** A provider number will be assigned upon approval of the provider application and Medicaid contract. **View Medicaid Provider Enrollment Unit contact information.**

210.000 PERSONAL CARE AIDE PARTICIPATION REQUIREMENTS

210.100 Personal Care Aide Participation Requirements 1-1-27

210.200 Personal Care Aide 1-1-27

An individual must meet the following requirements to serve as a personal care aide for a personal care services provider:

A. Have one of the following active certifications in good standing:

1. Certified Nursing Assistant (CNA) or higher nursing credential;

2. Home Health Aide; or

3. Certified Personal Care Aide;

B. Enroll as an Arkansas Medicaid rendering provider unless employed as school personnel and certified by the Division of Elementary and Secondary Education (DESE).

C. School personnel providing billable school-based Personal Care services must be trained and certified by the Division of Elementary and Secondary Education (DESE).

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220.000 DOCUMENTATION REQUIREMENTS

220.100 Documentation Requirements for all Medicaid Providers 1-1-27

See section 140.000 of **Section I** of this manual for the documentation that is required for all Arkansas Medicaid providers.

220.200 State Plan Personal Care Provider Documentation Requirements 1-1-27

A. State Plan Personal Care providers must maintain in each beneficiary's service record:

1. The beneficiary's:
   a. Applicable medical records;
   b. Age and Date of Birth;
   c. Medicaid ID number;
   d. All DMS-618 functional Assessments;
   e. All treatment plans;
   f. Frequency of In-home Supervisory visits; and
   g. Discharge notes and summary, if applicable.
2. Service log documentation, which must be completed at the time-of-service delivery and at a minimum include:
   a. Beneficiary name;
   b. Beneficiary's Medicaid ID number and date of birth;
   c. The date and beginning and ending time for each personal care service performed each day;
      i. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.
      ii. It is not necessary to itemize the time spent on each activity of daily living (ADL) or instrumental activity of daily living (IADL) task for a given beneficiary, provided these tasks were performed by the same personal care aide on the same visit on the same day and at the same location;
      iii. If the personal care aide discontinues or interrupts the beneficiary's service-plan-required activities at one location to begin service-plan-required activities at another location, the aide must record the beginning and ending times of service at each location.
      iv. If a personal care aide does not perform a scheduled treatment plan task, the personal care aide must document and justify why the task was not performed as scheduled;
   d. The location where the service was performed;
   e. Any service performance difficulties;
   f. Notes on the beneficiary's condition or other data or criteria required by the treatment plan;
   g. When an emergency or special circumstances requires a personal care aide to perform a task not included on the personal care treatment plan, documentation describing:
      i. The nature of the emergency or special situation;
      ii. The action or task required to resolve the emergency or special situation;
      iii. The date, start time, end time, location, nature and scope of the

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unscheduled task performed;

iv. When supervisor approval for the unscheduled task was obtained; and

v. If supervisor approval was not obtained prior to performing the unscheduled task, justification for why pre-approval was not possible

h. Name(s), credential(s), and signature(s) of the personal care aide who performed the service; and

3. Weekly or more frequent progress notes outlining the condition of the beneficiary;

4. If service delivery involves delivering services to multiple beneficiaries, the following additional service log documentation requirements apply:

a. When service delivery involves two (2) beneficiaries concurrently (i.e. cleaning a bathroom shared by two beneficiaries), then the personal care aide must also document in each beneficiary's service delivery log the name of the other individual who received the concurrent personal care service;

b. When service delivery is in a congregate setting (i.e. involves more than two (2) beneficiaries), then the personal care aide must:

i. Record the date and time the congregate service began and ended; and

ii. The name of each individual who received congregate services;

c. The provider must equally split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took twenty (20) minutes, the personal care aide would document ten (10) minutes to each beneficiary for the service).

B. Every personal care provider must maintain the required employment, certification, and licensure records for all individuals employed or contracted to provide personal care services on behalf of the provider. If an individual performs personal care services on behalf of a personal care provider pursuant to a contract, then a copy of the contractual agreement must be maintained.

220.300 Electronic Signatures 1-1-27

Arkansas Medicaid will accept electronic signatures in compliance with Arkansas Code Ann, § 25-31-103 et seq.

230.000 PROGRAM ELIGIBILITY

230.100 Scope 1-1-27

Arkansas Medicaid will reimburse enrolled providers for covered personal care services when such services are provided to a treatment plan to beneficiaries who meet the eligibility requirements of this Medicaid manual. Medicaid reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

230.200 Beneficiary Eligibility Requirements 1-1-27

230.300 Evaluation Referral 1-1-27

A. Personal Care services require an initial Evaluation Referral signed and dated by DHS, or its vendor as a part of determining medical necessity based upon an appropriate medical diagnosis.

B. DHS or its vendor utilizes the Medicaid claims management system to search for beneficiary documentation of a medical diagnosis from the ICD-10-CM coding related to a physical impairment that creates barriers to Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). The Evaluation Referral must contain this relevant medical

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diagnosis in order for a beneficiary to be eligible for personal care services. If no documentation exists, the applicant will have the opportunity to provide medical records to DHS or its vendor documenting the medical diagnosis related to a physical impairment that creates barriers ADLs or IADLs.

C. An evaluation Referral is required for a beneficiary's initial evaluation for state plan personal care services. Annual renewals also require an Evaluation Referral performed by the designated DHS contractor to determine the continued medical necessity for personal care services, unless subsection D applies.

D. If the beneficiary has a permanent, chronic medical diagnosis related to physical impairment that creates barriers to ADLs or IADLs, then an annual Evaluation Referral is not required for subsequent renewals. A permanent, chronic diagnosis is defined as a condition that is not expected to be cured and the ADL functions affected by the qualifying diagnosis are not expected to improve.

E. Any participant with a significant break in Personal Care services who is returning will require a new Evaluation Referral. A significant break in service is defined as not receiving Personal Care within the prior one hundred twenty (120) days.

230.310 Functional Needs Assessment 1-1-27

A. Personal care services must be medically necessary as demonstrated by the results of an annual functional needs assessment.

1. A diagnosis alone on the evaluation referral is not sufficient to demonstrate medical necessity.
2. A beneficiary is no longer eligible for personal care services if the annual functional needs assessment demonstrating medical necessity in accordance with this section - is not renewed within twelve (12) months.

B. A functional needs assessment for personal care services must be completed using the approved DHS functional assessment form:

1. A beneficiary twenty (20) years of age and under must use the "Youth Personal Care Functional Assessment & Treatment Plan" (View or print the Youth Personal Care Functional Assessment & Treatment Plan); and
2. A beneficiary twenty-one (21) years of age or older must use the "Adult Personal Care Functional Assessment & Treatment Plan" (View or print the Adult Personal Care Functional Assessment & Treatment Plan).

C. All Personal Care Functional Assessment & Treatment Plan functional needs assessments must be completed, signed, and dated by a licensed Registered Nurse.

D. All aspects of the Assessment for personal care services, including the administration, must be communicated and conducted in the beneficiary's primary or preferred language.

E. A new Personal Care Functional Assessment & Treatment Plan is not required when a beneficiary:

1. Transitions from one personal care provider to another personal care provider before the expiration of the current Functional Assessment & Treatment Plan; or
2. Changes primary care providers.

235.000 PROGRAM SERVICES

235.100 Non-covered Services 1-1-27

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A. Personal care services can only supplement, and are prohibited from being used to supplant, otherwise available beneficiary resources.

B. Personal care cannot be provided to individuals:

1. Admitted to an inpatient hospital,
2. Admitted to a nursing facility,
3. Enrolled in the Living Choices Waiver
4. Admitted to intermediate care facility for individuals with intellectual disabilities (ICF/IID); or
5. Admitted to an institution for mental diseases (IMD).

C. Arkansas Medicaid will not reimburse for personal care services performed by a member of the beneficiary's family. The following individuals are considered a member of the beneficiary's family:

1. A spouse.
2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent.
3. Legal guardian of the person of the beneficiary; and
4. Attorney-in-fact granted authority to direct the beneficiary's care.

D. Arkansas Medicaid will not reimburse for personal care services delivered via telehealth. Telehealth means the use of electronic documentation and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a beneficiary.

235.200 Covered Services 1-1-27

A. Arkansas Medicaid will only reimburse for the personal care services listed in Section 235.300 delivered in a manner in compliance with the treatment plan and this Medicaid manual, manual update transmittals, and official program correspondence.

B. A provider of personal care services must contract with or employ the personal care aides that perform personal care services on its behalf.

1. The provider must identify the personal care aide performing the personal care services as the performing provider on the claim when billing Arkansas Medicaid for the service.
2. Each personal care aide listed as the performing provider on a personal care provider claim must be enrolled with Arkansas Medicaid, as per section 140.000 of this Medicaid manual.

235.300 Personal Care Services 1-1-27

A. Personal care services are medically necessary services that assist a beneficiary with assessed physical dependency needs in the performance of their routine activities of daily living or instrumental activities of daily living. 42 C.F.R. § 441.505

B. A personal care provider may be reimbursed for performing the following medically necessary personal care services in accordance with the beneficiary's treatment plan:

1. Bathing;
2. Dressing;
3. Feeding/eating;

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4. Grooming;

5. Toileting;

6. Transferring;

7. Walking;

8. Cleaning;

9. Laundry;

10. Preparing meals;

11. Shopping; and

12. Transportation to and from medical appointments, employment, or seeking employment, that meets the requirements of section 235.400 of this Medicaid manual (no mileage costs associated with the transportation would be covered).

Note: Transportation is not a stand-alone billable service; The beneficiary must have documented ADL and /or IADL needs that require the continued presence and assistance of the personal care aide during travel and at the medical appointment.

C. Medical necessity for personal care services is established by:

1. The Evaluation Referral completed with medical diagnosis in accordance with this Medicaid Manual; and

2. The results of Personal Care Functional Assessment & Treatment Plan completed in accordance with this Medicaid manual.

D. All personal care services must be performed by a certified personal care aide. See section 210.200 of this Medicaid manual.

E. The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered. A qualified supervisor is a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.

1. The qualified supervisor must complete the following at least monthly:

a. Review the beneficiary's service delivery logs and documentation;

b. Document the time and date of their service documentation review;

c. Actively train or assist assigned personal care aide with personal care service delivery when necessary;

d. Document any training or assistance provided to an assigned personal care aide.

2. A supervising registered nurse must conduct an on-site evaluation of a day's service delivery to a beneficiary as required in the treatment plan, but no less often than annually. On each on-site evaluation, the supervising registered nurse must

a. Observe and document;

i. The condition of the beneficiary;

ii. The type and quality of the personal care aide's service provision;

iii. The interaction and relationship between the beneficiary and the personal care aide; and

iv. Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.

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b. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

3. An individual who provides personal care services to a beneficiary may not supervise another personal care aide providing personal care services to that same beneficiary.

F. A provider must obtain the following before initiating a permanent change to personal care service delivery:

1. A registered nurse must complete an updated Personal Care Functional Assessment & Treatment Plan; and

2. Request a Prior Authorization from the DHS professional staff or DHS designated contractor(s) responsible for prior authorization (PA) of personal care services

G. Personal care services are reimbursable on a per unit basis. See section 240.000 of this Medicaid manual regarding submitting a request for a prior authorization.

235.400 Employment-Related Personal Care Outside the Home 1-1-27

Outside of the home personal care services may be included in a beneficiary's treatment plan when it allows a beneficiary to obtain or retain employment and each of the following requirements are met:

A. The beneficiary is sixteen (16) years of age or older;

B. The beneficiary must be "disabled" as defined by Social Security/SSI [20 CFR 404.1505];

C. The beneficiary must be working (or be actively seeking employment where they would be working):

1. At least forty (40) hours per month; and

2. In an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability); and

D. The beneficiary is earning at least minimum wage (or be actively seeking employment that pays at least minimum wage);

E. Employment-related personal care associated with transportation is covered as follows:

1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking;

2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; in the service plan and all pertinent service documentation;

3. Medicaid does not cover mileage associated with any personal care service;

4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking is included in the 64-hour per month personal care benefit limit for beneficiaries aged twenty-one (21) and older.

235.500 Personal Care Services at School 1-1-27

A. Beneficiaries under the age of twenty-one (21) may receive personal care services when attending school. For these purposes:

1. A "school" is an entity accredited by the Arkansas Department of Education to provide elementary or secondary education services;

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2. A school setting is not limited to just the school-building or campus as long as the setting is related to the beneficiary's receipt of educational services from the school (i.e. attending a field trip to a museum);

3. The beneficiary's home is not considered a "school" place of service when a parent elects to home school.

B. All other aspects of personal care service delivery at school are the same as for personal care services delivered at the beneficiary's home.

235.600 Concurrent Treatment Service Delivery by Different Providers 1-1-27

Personal care services must be delivered by a single provider, unless a beneficiary is receiving personal care services outside the home as permitted in sections 235.400 and 235.500 of this Medicaid manual, in which case a second provider may deliver those allowable outside the home personal care services included in the beneficiary's treatment plan.

235.700 Transitioning Personal Care Providers 1-1-27

A. This section does not apply to school-based personal care providers, RCFs, or ALF I's.

B. A beneficiary has freedom of choice in selecting a personal care provider. However, the requirements of this section must be followed to ensure the continuity and smooth transition of personal care services when a beneficiary selects a new personal care provider.

C. Personal Care providers must comply with each of the following when a beneficiary elects to transition from one provider to another:

1. The beneficiary or, if applicable, the beneficiary's parent or legal guardian, must complete a personal care provider transition request form. **View or print a Personal Care Provider Transition Request form**.

2. The newly selected personal care provider must:

a. Notify the current provider of the beneficiary's decision to switch personal care providers; and

b. Deliver the current provider a copy of the completed Personal Care Provider Transition Request form.

c. Request a Prior Authorization from the DHS designated vendor responsible for prior authorization (PA) of personal care services

The new provider should maintain verifiable proof of the date and method of its required notification and transition request form delivery.

3. The current personal care service provider will continue to provide services to the beneficiary in accordance with this Medicaid manual until the last day of the month after the month the new provider completed the notification and delivery requirements in subpart (2.) directly above (i.e. if notified on May 11th, then current provider would continue providing personal care services until June 30th so new provider can begin services July 1st).

a. The current provider is responsible for forwarding the beneficiary's complete service record to the newly selected personal care provider before the current provider's last day of service, as described in subpart (3.) directly above.

b. The beneficiary's complete service record includes, at minimum: the beneficiary's active current Assessment and Treatment Plan.

D. Switching from one personal care provider to another personal care provider does not automatically require a new:

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1. Evaluation referral; or

2. Functional needs Assessment and Treatment Plan.

E. The new provider will obtain a new prior authorization from DHS, or its designated vendor, responsible for prior authorization (PA) of personal care services upon submission of all required documents.

240.000 PRIOR AUTHORIZATION

A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries.

B. Prior authorization does not guarantee payment for the service.

1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.

2. The provider must follow the billing procedures in this manual.

C. The DHS approved form for Personal Care Functional Assessment & Treatment Plan is the assessment instrument to be used by registered nurses of personal care providers to collect information used in determining the beneficiary's physical dependency needs for hands-on services and in calculating the suggested number of personal care hours that can be requested for the beneficiary. This Personal Care Functional Assessment & Treatment Plan must be accompanied by a prior authorization in order for services to be billable.

240.100 Prior Authorization Responsibility 1-1-27

A. DHS or its designated vendor are responsible for prior authorization (PA) of personal care services for beneficiaries.

B. DHS or its designated vendor reviews the personal care evaluation referral and the provider's completed Functional Assessment & Treatment Plan submitted for personal care services. Based on the information within, they prior authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.

C. DHS or its designated vendor has a right to review the beneficiary's medical information.

240.200 Personal Care Prior Authorization (PA) Request Procedure 1-1-27

A. Providers must use the form designated by DHS to request PA.

1. **View or print the form designated by DHS (English)** (PA request on last page).

2. **View or print the form designated by DHS (Spanish)** (PA request on last page).

B. Providers should submit prior authorization forms to DHS or its designated vendor, or if there is no contractor designated by DHS, to DHS professional staff.

C. Requests for prior authorization must be submitted within thirty (30) calendar days of the start of care. Approvals will be retroactive to the beginning date of service if the request is received within the 30-day time frame and is approved.

D. There will be no prior authorization, including any retroactive prior authorization, if the beneficiary is determined by DHS or its designated vendor to not require medically necessary services.

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240.300 Duration of Prior Authorization 1-1-27

Personal Care PAs are generally assigned for twelve (12) months from the date of the last Treatment Plan, unless the beneficiary has a change in condition.

240.400 Administrative Reconsideration and Appeals 1-1-27

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

240.500 Reserved 1-1-27

250.000 EXTENSION OF BENEFITS

250.100 Extension of Benefits for Personal Care Services 1-1-27

A. If a beneficiary requires more hours of personal care than what has been prior authorized on their Treatment Plan, the personal care provider can submit a request for an extension of benefits for medically necessary personal care services.

B. For beneficiaries twenty-one (21) years of age and older, the maximum monthly limit for state plan personal care is two hundred fifty-six (256) units per month. If an adult beneficiary requires more extensive care, the beneficiary should apply for HCBS Waiver services. See: **https://humanservices.arkansas.gov/newsroom/hcbs**

C. For beneficiaries twenty (20) years of age and younger, the maximum monthly limit for state plan personal care noted in part B can be exceeded if determined medically necessary. Medicaid Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) mandates coverage of all services that are medically necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions (42 U.S.C. § 1396d(r)).

260.000 REIMBURSEMENT

260.100 Residential Care Facility and Assisted Living Facility Level I Personal Care Reimbursement Methodology 1-1-27

A. The RCF and ALF I Personal Care reimbursement methodology is designed with the intent that reimbursement under the multi-hour Daily Service Rate system closely approximates what reimbursement would have been if the providers were to have billed by units of service furnished.

B. Whenever the unit rate (i.e., the maximum allowable amount per fifteen minutes service) for personal care services changes, Daily Service Rates under the RCF and ALF I methodology are correspondingly adjusted in accordance with the initial methodology by which they were established and which is described in detail in the following sections.

C. The Daily Service Rate paid for personal care services is based on a Payment Level determined from the resident's service plan.

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260.110 Payment Level 1-1-27

There are ten (10) Payment Levels, each based on the average number of 15-minute units of service per month required to fulfill a beneficiary's service plan.

A. Level 1 includes RCF and ALF I Personal Care beneficiaries whose service plans comprise one hundred (100) units or less per month of medically necessary personal care.

B. Level 10 includes RCF and ALF I Personal Care beneficiaries whose service plans comprise two hundred fifty six (256) or more units per month of medically necessary personal care.

C. Level 2 through Level 9 were established in equal increments between one hundred one (101) and two hundred fifty-five (255) units per month.

260.120 Payment Level Determination 1-1-27

A. The average of a service plan's monthly units of service is used to determine each beneficiary's Payment Level.

B. Calculate a beneficiary's average number of monthly units of personal care as follows.

1. Add the Weekly Minute Totals from the prior authorization approved by DHS using the Task and Hour Standards.
2. Divide the minutes by **15** (*15 minutes equals one unit of service*) to calculate weekly average units of service.
3. Multiply the weekly average units from step 2 by **52** (*Weeks in a year*) and divide the product by **12** (*Months in a year*) to calculate monthly average units of service.
4. Consult the "RCF and ALF I Personal Care Service Rate Schedule" on the Arkansas Medicaid Personal Care Fee Schedule to find the applicable Daily Multi-Hour Service Rate for each Payment Level. Procedure code T1020 is the applicable code for RCF and ALF I Personal Care providers.

260.130 Personal Care in an RCF or ALF I 1-1-27

A. To bill for RCF or ALF I Personal Care, use HCPCS procedure code **T1020** and the modifier corresponding to the beneficiary's Payment Level in effect for the date(s) of service being billed.

B. The Payment Level that a provider bills must be consistent with the beneficiary's service plan in effect on the day that the provider furnished the personal care services billed.

Payment Level Specifications and Modifiers for Procedure Code T1020

Payment Levels	Minimum Service Units	Maximum Service Units	Modifier
Level 1	Less than 100	100	U1
Level 2	101	119	U2
Level 3	120	139	U3
Level 4	140	158	U4
Level 5	159	177	U5
Level 6	178	196	U6
Level 7	197	216	U7

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Payment Level Specifications and Modifiers for Procedure Code T1020

Payment Levels	Minimum Service Units	Maximum Service Units	Modifier
Level 8	217	235	U8
Level 9	236	255	U9
Level 10	256	256	UA

260.140 Billing RCF and ALF I Personal Care Services 1-1-27

A. RCF and ALF I Personal Care providers may not bill for days during which a beneficiary received no personal care services (for instance, he or she was away for a day or more); therefore, do not include in the billed dates of service any days the beneficiary was absent.

B. For each unbroken span of days of service, multiply the days of service by the applicable Daily Service Rate and bill that amount on the corresponding claim detail.

C. Documentation requirements outlined in the Medicaid Personal Care Policy **Section 220.100 (Documentation Requirements for all Medicaid Providers)** must be adhered to when providing Personal Care services at all ALF I facilities.

260.150 Unit Billing Methodology for Private Care Agencies and Home Health Agencies 1-1-27

260.160 Unit Billing 1-1-27

A. Fifteen (15) minutes of authorized, documented and logged personal care equals one unit of personal care aide service.

B. Providers may not bill for less than fifteen (15) minutes of service; however personal care aides' time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day, and the sum—in minutes—divided by fifteen (15) to calculate the number of units of service provided during that day.

C. The estimated daily maximum service time in the beneficiary's service plan is the upper limit for daily billing.

D. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary.

E. There is no "carryover" of time from one day to another or from one beneficiary to another.

F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

260.170 Unit Billing Restrictions 1-1-27

A. Concurrent billing is not allowed unless specifically permitted herein. It is considered concurrent billing when multiple practitioners bill Medicaid for services provided to the same beneficiary during the same time increment.

B. Lengthy or frequent unscheduled personal breaks that interfere with job responsibilities to the beneficiary or service delivery are not billable. Break times between service delivery are not billable.

MARKUP

C. Time spent on documentation alone is not billable as a treatment service.

D. Providers may bill the total units of service for a single date of service but may not bill for units of service that span over more than one date of service. Each calendar date must be billed separately. For example, a provider may provide personal care services to an eligible beneficiary on Monday and then again on Tuesday. The provider may, then, bill for the total amount of time spent on Monday and a separate claim-line, or separate claim, for the total amount of time spent on Tuesday, but may not bill for the total amount of time spent both days on a single claim-line.

E. Daily Service Time Limits

1. Providers may bill Medicaid only up to the aggregate daily maximum service time authorized in the member's approved Treatment Plan. Service time authorized for delivery across distinct days may not be combined and billed as a single visit. Providers are prohibited from exceeding the daily aggregate maximum to compensate for missed visits or to front-load services (e.g., billing six (6) hours in one day when the Treatment Plan authorizes a four (4) hour daily maximum).

2. Any billing in excess of the aggregate daily maximum authorized in the Treatment Plan without supplemental medical paperwork is subject to post-payment review, audit, and recoupment of Medicaid funds.

260.180 Calculating Units 1-1-27

A. Personal Care providers must bill Medicaid by 15-minute units.

B. Total the daily personal care service-time for a single beneficiary in minutes, using the beginning and ending service times from the service logs.

C. Set your calculator to compute to three decimal places.

D. Divide the total time (expressed in minutes) by fifteen (15) and

E. Bill for the lesser of:

1. The rounded, whole-number quotient of the division or

2. The maximum time estimate in the service plan.

260.190 Rounding 1-1-27

When a quotient contains decimals, look at the numbers after the decimal point.

A. If the number after the decimal point is 500 (e.g., 3.500) or less (e.g., 3.495) round downward to the whole number displayed before the decimal point (3, in this example)

B. If the number after the decimal is 501 (e.g., 3.501) or greater (e.g., 3.576) round upward to the whole number one greater than the whole number displayed before the decimal point (4 in this example, because it is a whole number one greater than 3).

260.200 Fee Schedules 1-1-27

Arkansas Medicaid provides **fee schedules on the DMS website**. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

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Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

260.210 Electronic Visit Verification (EVV) **1-1-27**

A. In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) in-home personal care services paid by Medicaid must use Electronic Visit Verification (EVV). Refer to **Provider Manual Section I, General Policy**, subsection 145.000 for complete EVV requirements regarding personal care services.

B. An EVV system is a telephone, computer, or other technology-based system under which visits conducted as part of personal care services are electronically verified.

C. All personal care services are electronically verified with respect to:

1. The type of service(s) performed;
2. The individual receiving the service(s);
3. The date of the service(s);
4. The location of service delivery;
5. The individual providing the service(s); and
6. The time the service(s) begins and ends.

D. The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

MARK UP

SECTION II – STATE PLAN PERSONAL CARE

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260.210 Electronic Visit Verification (EVV)

200.000 GENERAL INFORMATION

200.100 Participation Requirements for State Plan Personal Care Providers 1-1-27

A. State Plan Personal Care providers are designated high-risk providers based on the lack of licensure or certification from the Department of Human Services and the potential for fraud, waste, and abuse. As such, and as a condition of enrollment in the Arkansas Medicaid program, Arkansas Medicaid requires State Plan Personal Care providers to have:

1. On-site visits conducted by Arkansas Medicaid in accordance with 42 CFR 455.432, which includes pre-enrollment and post enrollment site visits as well as unannounced on-site inspections of any provider location.
2. Federal fingerprint-based checks in accordance with 42 CFR 455.434 and 42 CFR 455.50(c). All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq.

B. Each employee must successfully pass the following:

1. A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann.§ 20-38-103;
2. An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;
3. An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;
4. An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and
5. At least a five (5) panel drug screen upon hiring and prior to any contact with clients, and as required thereafter by Ark. Code Ann. §20-77-128(b).

C. A provider must meet the following participation requirements to qualify as a State Plan Personal Care provider under Arkansas Medicaid:

1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual; and
2. Obtain a license as a private care agency or be a certified Home Health Agency Class A or B; Assisted Living Facility (ALF) I; or Residential Care Facility (RCF).

200.200 Participation Requirements for Personal Care Providers that are School Districts or Education Service Cooperatives 1-1-27

A. A school district or education service cooperative must meet the following participation requirements to qualify as a State Plan Personal Care provider under Arkansas Medicaid.

1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual; and
2. Be certified as a Local Educational Agency (LEA) by the Arkansas Department of Education.
3. School personnel providing billable Personal Care services must be trained and certified by the Division of Elementary and Secondary Education (DESE).

200.300 Personal Care Services at School 1-1-27

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A. Beneficiaries under the age of twenty-one (21) may receive personal care services when attending school. For these purposes:

1. A “school” is an entity accredited by the Arkansas Department of Education to provide elementary or secondary education services;
2. A school setting is not limited to just the school-building or campus as long as the setting is related to the beneficiary’s receipt of educational services from the school (i.e. attending a field trip to a museum);
3. The beneficiary’s home is not considered a "school" place of service when a parent elects to home school.

B. Medicaid Program requirements are the same as for services delivered in the beneficiary’s home.

C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the beneficiary receives services.

D. Beneficiaries receiving personal care in schools may receive a number of services in accordance with an Individualized Education Program (IEP).

1. The IEP may not supersede or substitute for the personal care treatment plan.
2. The Personal Care Program requires a distinct and separate assessment and treatment plan.

200.400 Out-of-State Limited Services Personal Care Providers 1-1-27

Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and they have a claim or claims to file with Arkansas Medicaid. To enroll, providers must download an Arkansas Medicaid application and contract from the DMS website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. **View or print the provider enrollment and contract package (Application Packet).** A provider number will be assigned upon approval of the provider application and Medicaid contract. **View Medicaid Provider Enrollment Unit contact information.**

210.000 PERSONAL CARE AIDE PARTICIPATION REQUIREMENTS

210.100 Personal Care Aide Participation Requirements 1-1-27

210.200 Personal Care Aide 1-1-27

An individual must meet the following requirements to serve as a personal care aide for a personal care services provider:

A. Have one of the following active certifications in good standing:

1. Certified Nursing Assistant (CNA) or higher nursing credential;
2. Home Health Aide; or
3. Certified Personal Care Aide;

B. Enroll as an Arkansas Medicaid rendering provider unless employed as school personnel and certified by the Division of Elementary and Secondary Education (DESE).

C. School personnel providing billable school-based Personal Care services must be trained and certified by the Division of Elementary and Secondary Education (DESE).

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220.000 DOCUMENTATION REQUIREMENTS

220.100 Documentation Requirements for all Medicaid Providers 1-1-27

See section 140.000 of **Section I** of this manual for the documentation that is required for all Arkansas Medicaid providers.

220.200 State Plan Personal Care Provider Documentation Requirements 1-1-27

A. State Plan Personal Care providers must maintain in each beneficiary's service record:

1. The beneficiary's:
   a. Applicable medical records;
   b. Age and Date of Birth;
   c. Medicaid ID number;
   d. All DMS-618 functional Assessments;
   e. All treatment plans;
   f. Frequency of In-home Supervisory visits; and
   g. Discharge notes and summary, if applicable.
2. Service log documentation, which must be completed at the time-of-service delivery and at a minimum include:
   a. Beneficiary name;
   b. Beneficiary's Medicaid ID number and date of birth;
   c. The date and beginning and ending time for each personal care service performed each day;
      i. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.
      ii. It is not necessary to itemize the time spent on each activity of daily living (ADL) or instrumental activity of daily living (IADL) task for a given beneficiary, provided these tasks were performed by the same personal care aide on the same visit on the same day and at the same location;
      iii. If the personal care aide discontinues or interrupts the beneficiary's service-plan-required activities at one location to begin service-plan-required activities at another location, the aide must record the beginning and ending times of service at each location.
      iv. If a personal care aide does not perform a scheduled treatment plan task, the personal care aide must document and justify why the task was not performed as scheduled;
   d. The location where the service was performed;
   e. Any service performance difficulties;
   f. Notes on the beneficiary's condition or other data or criteria required by the treatment plan;
   g. When an emergency or special circumstances requires a personal care aide to perform a task not included on the personal care treatment plan, documentation describing:
      i. The nature of the emergency or special situation;
      ii. The action or task required to resolve the emergency or special situation;
      iii. The date, start time, end time, location, nature and scope of the

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unscheduled task performed;

iv. When supervisor approval for the unscheduled task was obtained; and

v. If supervisor approval was not obtained prior to performing the unscheduled task, justification for why pre-approval was not possible

h. Name(s), credential(s), and signature(s) of the personal care aide who performed the service; and

3. Weekly or more frequent progress notes outlining the condition of the beneficiary;

4. If service delivery involves delivering services to multiple beneficiaries, the following additional service log documentation requirements apply:

a. When service delivery involves two (2) beneficiaries concurrently (i.e. cleaning a bathroom shared by two beneficiaries), then the personal care aide must also document in each beneficiary's service delivery log the name of the other individual who received the concurrent personal care service;

b. When service delivery is in a congregate setting (i.e. involves more than two (2) beneficiaries), then the personal care aide must:

i. Record the date and time the congregate service began and ended; and

ii. The name of each individual who received congregate services;

c. The provider must equally split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took twenty (20) minutes, the personal care aide would document ten (10) minutes to each beneficiary for the service).

B. Every personal care provider must maintain the required employment, certification, and licensure records for all individuals employed or contracted to provide personal care services on behalf of the provider. If an individual performs personal care services on behalf of a personal care provider pursuant to a contract, then a copy of the contractual agreement must be maintained.

220.300 Electronic Signatures 1-1-27

Arkansas Medicaid will accept electronic signatures in compliance with Arkansas Code Ann, § 25-31-103 et seq.

230.000 PROGRAM ELIGIBILITY

230.100 Scope 1-1-27

Arkansas Medicaid will reimburse enrolled providers for covered personal care services when such services are provided to a treatment plan to beneficiaries who meet the eligibility requirements of this Medicaid manual. Medicaid reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

230.200 Beneficiary Eligibility Requirements 1-1-27

230.300 Evaluation Referral 1-1-27

A. Personal Care services require an initial Evaluation Referral signed and dated by DHS, or its vendor as a part of determining medical necessity based upon an appropriate medical diagnosis.

B. DHS or its vendor utilizes the Medicaid claims management system to search for beneficiary documentation of a medical diagnosis from the ICD-10-CM coding related to a physical impairment that creates barriers to Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). The Evaluation Referral must contain this relevant medical

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diagnosis in order for a beneficiary to be eligible for personal care services. If no documentation exists, the applicant will have the opportunity to provide medical records to DHS or its vendor documenting the medical diagnosis related to a physical impairment that creates barriers ADLs or IADLs.

C. An evaluation Referral is required for a beneficiary's initial evaluation for state plan personal care services. Annual renewals also require an Evaluation Referral performed by the designated DHS contractor to determine the continued medical necessity for personal care services, unless subsection D applies.

D. If the beneficiary has a permanent, chronic medical diagnosis related to physical impairment that creates barriers to ADLs or IADLs, then an annual Evaluation Referral is not required for subsequent renewals. A permanent, chronic diagnosis is defined as a condition that is not expected to be cured and the ADL functions affected by the qualifying diagnosis are not expected to improve.

E. Any participant with a significant break in Personal Care services who is returning will require a new Evaluation Referral. A significant break in service is defined as not receiving Personal Care within the prior one hundred twenty (120) days.

230.310 Functional Needs Assessment 1-1-27

A. Personal care services must be medically necessary as demonstrated by the results of an annual functional needs assessment.

1. A diagnosis alone on the evaluation referral is not sufficient to demonstrate medical necessity.
2. A beneficiary is no longer eligible for personal care services if the annual functional needs assessment demonstrating medical necessity in accordance with this section - is not renewed within twelve (12) months.

B. A functional needs assessment for personal care services must be completed using the approved DHS functional assessment form:

1. A beneficiary twenty (20) years of age and under must use the "Youth Personal Care Functional Assessment & Treatment Plan" (View or print the Youth Personal Care Functional Assessment & Treatment Plan); and
2. A beneficiary twenty-one (21) years of age or older must use the "Adult Personal Care Functional Assessment & Treatment Plan" (View or print the Adult Personal Care Functional Assessment & Treatment Plan).

C. All Personal Care Functional Assessment & Treatment Plan functional needs assessments must be completed, signed, and dated by a licensed Registered Nurse.

D. All aspects of the Assessment for personal care services, including the administration, must be communicated and conducted in the beneficiary's primary or preferred language.

E. A new Personal Care Functional Assessment & Treatment Plan is not required when a beneficiary:

1. Transitions from one personal care provider to another personal care provider before the expiration of the current Functional Assessment & Treatment Plan; or
2. Changes primary care providers.

235.000 PROGRAM SERVICES

235.100 Non-covered Services 1-1-27

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A. Personal care services can only supplement, and are prohibited from being used to supplant, otherwise available beneficiary resources.

B. Personal care cannot be provided to individuals:

1. Admitted to an inpatient hospital,
2. Admitted to a nursing facility,
3. Enrolled in the Living Choices Waiver
4. Admitted to intermediate care facility for individuals with intellectual disabilities (ICF/IID); or
5. Admitted to an institution for mental diseases (IMD).

C. Arkansas Medicaid will not reimburse for personal care services performed by a member of the beneficiary's family. The following individuals are considered a member of the beneficiary's family:

1. A spouse.
2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent.
3. Legal guardian of the person of the beneficiary; and
4. Attorney-in-fact granted authority to direct the beneficiary's care.

D. Arkansas Medicaid will not reimburse for personal care services delivered via telehealth. Telehealth means the use of electronic documentation and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a beneficiary.

235.200 Covered Services 1-1-27

A. Arkansas Medicaid will only reimburse for the personal care services listed in Section 235.300 delivered in a manner in compliance with the treatment plan and this Medicaid manual, manual update transmittals, and official program correspondence.

B. A provider of personal care services must contract with or employ the personal care aides that perform personal care services on its behalf.

1. The provider must identify the personal care aide performing the personal care services as the performing provider on the claim when billing Arkansas Medicaid for the service.
2. Each personal care aide listed as the performing provider on a personal care provider claim must be enrolled with Arkansas Medicaid, as per section 140.000 of this Medicaid manual.

235.300 Personal Care Services 1-1-27

A. Personal care services are medically necessary services that assist a beneficiary with assessed physical dependency needs in the performance of their routine activities of daily living or instrumental activities of daily living. 42 C.F.R. § 441.505

B. A personal care provider may be reimbursed for performing the following medically necessary personal care services in accordance with the beneficiary's treatment plan:

1. Bathing;
2. Dressing;
3. Feeding/eating;

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4. Grooming;
5. Toileting;
6. Transferring;
7. Walking;
8. Cleaning;
9. Laundry;
10. Preparing meals;
11. Shopping; and
12. Transportation to and from medical appointments, employment, or seeking employment, that meets the requirements of section 235.400 of this Medicaid manual (no mileage costs associated with the transportation would be covered).

    Note: Transportation is not a stand-alone billable service; The beneficiary must have documented ADL and /or IADL needs that require the continued presence and assistance of the personal care aide during travel and at the medical appointment.

C. Medical necessity for personal care services is established by:

1. The Evaluation Referral completed with medical diagnosis in accordance with this Medicaid Manual; and
2. The results of Personal Care Functional Assessment & Treatment Plan completed in accordance with this Medicaid manual.

D. All personal care services must be performed by a certified personal care aide. See section 210.200 of this Medicaid manual.

E. The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered. A qualified supervisor is a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.

1. The qualified supervisor must complete the following at least monthly:
    a. Review the beneficiary's service delivery logs and documentation;
    b. Document the time and date of their service documentation review;
    c. Actively train or assist assigned personal care aide with personal care service delivery when necessary;
    d. Document any training or assistance provided to an assigned personal care aide.
2. A supervising registered nurse must conduct an on-site evaluation of a day's service delivery to a beneficiary as required in the treatment plan, but no less often than annually. On each on-site evaluation, the supervising registered nurse must
    a. Observe and document;
        i. The condition of the beneficiary;
        ii. The type and quality of the personal care aide's service provision;
        iii. The interaction and relationship between the beneficiary and the personal care aide; and
        iv. Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.

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b. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

3. An individual who provides personal care services to a beneficiary may not supervise another personal care aide providing personal care services to that same beneficiary.

F. A provider must obtain the following before initiating a permanent change to personal care service delivery:

1. A registered nurse must complete an updated Personal Care Functional Assessment & Treatment Plan; and

2. Request a Prior Authorization from the DHS professional staff or DHS designated contractor(s) responsible for prior authorization (PA) of personal care services

G. Personal care services are reimbursable on a per unit basis. See section 240.000 of this Medicaid manual regarding submitting a request for a prior authorization.

235.400 Employment-Related Personal Care Outside the Home 1-1-27

Outside of the home personal care services may be included in a beneficiary's treatment plan when it allows a beneficiary to obtain or retain employment and each of the following requirements are met:

A. The beneficiary is sixteen (16) years of age or older;

B. The beneficiary must be "disabled" as defined by Social Security/SSI [20 CFR 404.1505];

C. The beneficiary must be working (or be actively seeking employment where they would be working):

1. At least forty (40) hours per month; and

2. In an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability); and

D. The beneficiary is earning at least minimum wage (or be actively seeking employment that pays at least minimum wage);

E. Employment-related personal care associated with transportation is covered as follows:

1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking;

2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; in the service plan and all pertinent service documentation;

3. Medicaid does not cover mileage associated with any personal care service;

4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking is included in the 64-hour per month personal care benefit limit for beneficiaries aged twenty-one (21) and older.

235.500 Personal Care Services at School 1-1-27

A. Beneficiaries under the age of twenty-one (21) may receive personal care services when attending school. For these purposes:

1. A "school" is an entity accredited by the Arkansas Department of Education to provide elementary or secondary education services;

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2. A school setting is not limited to just the school-building or campus as long as the setting is related to the beneficiary's receipt of educational services from the school (i.e. attending a field trip to a museum);

3. The beneficiary's home is not considered a "school" place of service when a parent elects to home school.

B. All other aspects of personal care service delivery at school are the same as for personal care services delivered at the beneficiary's home.

235.600 Concurrent Treatment Service Delivery by Different Providers 1-1-27

Personal care services must be delivered by a single provider, unless a beneficiary is receiving personal care services outside the home as permitted in sections 235.400 and 235.500 of this Medicaid manual, in which case a second provider may deliver those allowable outside the home personal care services included in the beneficiary's treatment plan.

235.700 Transitioning Personal Care Providers 1-1-27

A. This section does not apply to school-based personal care providers, RCFs, or ALF I's.

B. A beneficiary has freedom of choice in selecting a personal care provider. However, the requirements of this section must be followed to ensure the continuity and smooth transition of personal care services when a beneficiary selects a new personal care provider.

C. Personal Care providers must comply with each of the following when a beneficiary elects to transition from one provider to another:

1. The beneficiary or, if applicable, the beneficiary's parent or legal guardian, must complete a personal care provider transition request form. **View or print a Personal Care Provider Transition Request form**.

2. The newly selected personal care provider must:

   a. Notify the current provider of the beneficiary's decision to switch personal care providers; and

   b. Deliver the current provider a copy of the completed Personal Care Provider Transition Request form.

   c. Request a Prior Authorization from the DHS designated vendor responsible for prior authorization (PA) of personal care services

The new provider should maintain verifiable proof of the date and method of its required notification and transition request form delivery.

3. The current personal care service provider will continue to provide services to the beneficiary in accordance with this Medicaid manual until the last day of the month after the month the new provider completed the notification and delivery requirements in subpart (2.) directly above (i.e. if notified on May 11th, then current provider would continue providing personal care services until June 30th so new provider can begin services July 1st).

   a. The current provider is responsible for forwarding the beneficiary's complete service record to the newly selected personal care provider before the current provider's last day of service, as described in subpart (3.) directly above.

   b. The beneficiary's complete service record includes, at minimum: the beneficiary's active current Assessment and Treatment Plan.

D. Switching from one personal care provider to another personal care provider does not automatically require a new:

PROPOSED

1. Evaluation referral; or
2. Functional needs Assessment and Treatment Plan.

E. The new provider will obtain a new prior authorization from DHS, or its designated vendor, responsible for prior authorization (PA) of personal care services upon submission of all required documents.

240.000 PRIOR AUTHORIZATION

A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries.

B. Prior authorization does not guarantee payment for the service.

1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.
2. The provider must follow the billing procedures in this manual.

C. The DHS approved form for Personal Care Functional Assessment & Treatment Plan is the assessment instrument to be used by registered nurses of personal care providers to collect information used in determining the beneficiary's physical dependency needs for hands-on services and in calculating the suggested number of personal care hours that can be requested for the beneficiary. This Personal Care Functional Assessment & Treatment Plan must be accompanied by a prior authorization in order for services to be billable.

240.100 Prior Authorization Responsibility 1-1-27

A. DHS or its designated vendor are responsible for prior authorization (PA) of personal care services for beneficiaries.

B. DHS or its designated vendor reviews the personal care evaluation referral and the provider's completed Functional Assessment & Treatment Plan submitted for personal care services. Based on the information within, they prior authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.

C. DHS or its designated vendor has a right to review the beneficiary's medical information.

240.200 Personal Care Prior Authorization (PA) Request Procedure 1-1-27

A. Providers must use the form designated by DHS to request PA.

1. **View or print the form designated by DHS (English)** (PA request on last page).
2. **View or print the form designated by DHS (Spanish)** (PA request on last page).

B. Providers should submit prior authorization forms to DHS or its designated vendor, or if there is no contractor designated by DHS, to DHS professional staff.

C. Requests for prior authorization must be submitted within thirty (30) calendar days of the start of care. Approvals will be retroactive to the beginning date of service if the request is received within the 30-day time frame and is approved.

D. There will be no prior authorization, including any retroactive prior authorization, if the beneficiary is determined by DHS or its designated vendor to not require medically necessary services.

PROPOSED

240.300 Duration of Prior Authorization 1-1-27

Personal Care PAs are generally assigned for twelve (12) months from the date of the last Treatment Plan, unless the beneficiary has a change in condition.

240.400 Administrative Reconsideration and Appeals 1-1-27

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

240.500 Reserved 1-1-27

250.000 EXTENSION OF BENEFITS

250.100 Extension of Benefits for Personal Care Services 1-1-27

A. If a beneficiary requires more hours of personal care than what has been prior authorized on their Treatment Plan, the personal care provider can submit a request for an extension of benefits for medically necessary personal care services.

B. For beneficiaries twenty-one (21) years of age and older, the maximum monthly limit for state plan personal care is two hundred fifty-six (256) units per month. If an adult beneficiary requires more extensive care, the beneficiary should apply for HCBS Waiver services. See: https://humanservices.arkansas.gov/newsroom/hcbs

C. For beneficiaries twenty (20) years of age and younger, the maximum monthly limit for state plan personal care noted in part B can be exceeded if determined medically necessary. Medicaid Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) mandates coverage of all services that are medically necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions (42 U.S.C. § 1396d(r)).

260.000 REIMBURSEMENT

260.100 Residential Care Facility and Assisted Living Facility Level I Personal Care Reimbursement Methodology 1-1-27

A. The RCF and ALF I Personal Care reimbursement methodology is designed with the intent that reimbursement under the multi-hour Daily Service Rate system closely approximates what reimbursement would have been if the providers were to have billed by units of service furnished.

B. Whenever the unit rate (i.e., the maximum allowable amount per fifteen minutes service) for personal care services changes, Daily Service Rates under the RCF and ALF I methodology are correspondingly adjusted in accordance with the initial methodology by which they were established and which is described in detail in the following sections.

C. The Daily Service Rate paid for personal care services is based on a Payment Level determined from the resident's service plan.

PROPOSED

260.110 Payment Level 1-1-27

There are ten (10) Payment Levels, each based on the average number of 15-minute units of service per month required to fulfill a beneficiary's service plan.

A. Level 1 includes RCF and ALF I Personal Care beneficiaries whose service plans comprise one hundred (100) units or less per month of medically necessary personal care.

B. Level 10 includes RCF and ALF I Personal Care beneficiaries whose service plans comprise two hundred fifty six (256) or more units per month of medically necessary personal care.

C. Level 2 through Level 9 were established in equal increments between one hundred one (101) and two hundred fifty-five (255) units per month.

260.120 Payment Level Determination 1-1-27

A. The average of a service plan's monthly units of service is used to determine each beneficiary's Payment Level.

B. Calculate a beneficiary's average number of monthly units of personal care as follows.

1. Add the Weekly Minute Totals from the prior authorization approved by DHS using the Task and Hour Standards.
2. Divide the minutes by **15** (*15 minutes equals one unit of service*) to calculate weekly average units of service.
3. Multiply the weekly average units from step 2 by **52** (*Weeks in a year*) and divide the product by **12** (*Months in a year*) to calculate monthly average units of service.
4. Consult the "RCF and ALF I Personal Care Service Rate Schedule" on the Arkansas Medicaid Personal Care Fee Schedule to find the applicable Daily Multi-Hour Service Rate for each Payment Level. Procedure code T1020 is the applicable code for RCF and ALF I Personal Care providers.

260.130 Personal Care in an RCF or ALF I 1-1-27

A. To bill for RCF or ALF I Personal Care, use HCPCS procedure code **T1020** and the modifier corresponding to the beneficiary's Payment Level in effect for the date(s) of service being billed.

B. The Payment Level that a provider bills must be consistent with the beneficiary's service plan in effect on the day that the provider furnished the personal care services billed.

Payment Level Specifications and Modifiers for Procedure Code T1020

Payment Levels	Minimum Service Units	Maximum Service Units	Modifier
Level 1	Less than 100	100	U1
Level 2	101	119	U2
Level 3	120	139	U3
Level 4	140	158	U4
Level 5	159	177	U5
Level 6	178	196	U6
Level 7	197	216	U7

PROPOSED

Payment Level Specifications and Modifiers for Procedure Code T1020

Payment Levels	Minimum Service Units	Maximum Service Units	Modifier
Level 8	217	235	U8
Level 9	236	255	U9
Level 10	256	256	UA

260.140 Billing RCF and ALF I Personal Care Services 1-1-27

A. RCF and ALF I Personal Care providers may not bill for days during which a beneficiary received no personal care services (for instance, he or she was away for a day or more); therefore, do not include in the billed dates of service any days the beneficiary was absent.

B. For each unbroken span of days of service, multiply the days of service by the applicable Daily Service Rate and bill that amount on the corresponding claim detail.

C. Documentation requirements outlined in the Medicaid Personal Care Policy **Section 220.100 (Documentation Requirements for all Medicaid Providers)** must be adhered to when providing Personal Care services at all ALF I facilities.

260.150 Unit Billing Methodology for Private Care Agencies and Home Health Agencies 1-1-27

260.160 Unit Billing 1-1-27

A. Fifteen (15) minutes of authorized, documented and logged personal care equals one unit of personal care aide service.

B. Providers may not bill for less than fifteen (15) minutes of service; however personal care aides' time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day, and the sum—in minutes—divided by fifteen (15) to calculate the number of units of service provided during that day.

C. The estimated daily maximum service time in the beneficiary's service plan is the upper limit for daily billing.

D. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary.

E. There is no "carryover" of time from one day to another or from one beneficiary to another.

F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

260.170 Unit Billing Restrictions 1-1-27

A. Concurrent billing is not allowed unless specifically permitted herein. It is considered concurrent billing when multiple practitioners bill Medicaid for services provided to the same beneficiary during the same time increment.

B. Lengthy or frequent unscheduled personal breaks that interfere with job responsibilities to the beneficiary or service delivery are not billable. Break times between service delivery are not billable.

PROPOSED

C. Time spent on documentation alone is not billable as a treatment service.

D. Providers may bill the total units of service for a single date of service but may not bill for units of service that span over more than one date of service. Each calendar date must be billed separately. For example, a provider may provide personal care services to an eligible beneficiary on Monday and then again on Tuesday. The provider may, then, bill for the total amount of time spent on Monday and a separate claim-line, or separate claim, for the total amount of time spent on Tuesday, but may not bill for the total amount of time spent both days on a single claim-line.

E. Daily Service Time Limits

1. Providers may bill Medicaid only up to the aggregate daily maximum service time authorized in the member's approved Treatment Plan. Service time authorized for delivery across distinct days may not be combined and billed as a single visit. Providers are prohibited from exceeding the daily aggregate maximum to compensate for missed visits or to front-load services (e.g., billing six (6) hours in one day when the Treatment Plan authorizes a four (4) hour daily maximum).
2. Any billing in excess of the aggregate daily maximum authorized in the Treatment Plan without supplemental medical paperwork is subject to post-payment review, audit, and recoupment of Medicaid funds.

260.180 Calculating Units 1-1-27

A. Personal Care providers must bill Medicaid by 15-minute units.

B. Total the daily personal care service-time for a single beneficiary in minutes, using the beginning and ending service times from the service logs.

C. Set your calculator to compute to three decimal places.

D. Divide the total time (expressed in minutes) by fifteen (15) and

E. Bill for the lesser of:

1. The rounded, whole-number quotient of the division or
2. The maximum time estimate in the service plan.

260.190 Rounding 1-1-27

When a quotient contains decimals, look at the numbers after the decimal point.

A. If the number after the decimal point is 500 (e.g., 3.500) or less (e.g., 3.495) round downward to the whole number displayed before the decimal point (3, in this example)

B. If the number after the decimal is 501 (e.g., 3.501) or greater (e.g., 3.576) round upward to the whole number one greater than the whole number displayed before the decimal point (4 in this example, because it is a whole number one greater than 3).

260.200 Fee Schedules 1-1-27

Arkansas Medicaid provides **fee schedules on the DMS website**. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

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Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

260.210 Electronic Visit Verification (EVV) 1-1-27

A. In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) in-home personal care services paid by Medicaid must use Electronic Visit Verification (EVV). Refer to **Provider Manual Section I, General Policy**, subsection 145.000 for complete EVV requirements regarding personal care services.

B. An EVV system is a telephone, computer, or other technology-based system under which visits conducted as part of personal care services are electronically verified.

C. All personal care services are electronically verified with respect to:

1. The type of service(s) performed;
2. The individual receiving the service(s);
3. The date of the service(s);
4. The location of service delivery;
5. The individual providing the service(s); and
6. The time the service(s) begins and ends.

D. The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

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TOC required

201.000 Arkansas Independent Assessment (ARIA) System Overview 1-1-247

The Arkansas Independent Assessment (ARIA) system is comprised of several parts that are administered through separate steps for each eligible Medicaid individual served through one of the state's waiver programs ~~or state plan Personal Care services~~. The purpose of the ARIA system is to perform a functional-needs assessment to assist in the development of an individual's Person-Centered Service Plan (PCSP), ~~Personal Care services plan~~ and for certain populations to establish the per member per month payment to a managed care entity. As such, it assesses an individual's capabilities and limitations in performing activities of daily living, including bathing, toileting, and dressing. It is not a medical diagnosis, although the medical history of an individual is an important component of the assessment as a functional deficiency may be caused by an underlying medical condition. In the case of an individual in need of behavioral health services, or waiver services, the independent assessment does not determine whether an individual is Medicaid eligible. That determination is made prior to and separately from the assessment of an individual.

Federal statutes and regulations require states to use an independent assessment for determining eligibility for certain services offered though Home and Community-Based Services (HCBS) waivers. It also is important to Medicaid beneficiaries and their families that any type of assessment is based on tested and validated instruments that are objective and fair to everyone. In 2017, Arkansas selected the ARIA system. It has been phased in over time for different population groups. When implemented for a population, the ARIA system replaces and voids any previous IA systems.

The ARIA system is administered by a vendor under contract with the Arkansas Department of Human Services (DHS). The basic foundation of the ARIA system is MnCHOICES, a comprehensive functional assessment tool originally developed by state and local officials in Minnesota for use in assessing the long-term services and supports (LTSS) needs of elderly individuals. Many individuals with developmental disabilities (DD)/intellectual disabilities (ID) and individuals with severe behavioral health needs also have LTSS needs. Therefore, the basic MnCHOICES tool has common elements across the different population groups. DHS and its vendor further customized MnCHOICES to reflect the Arkansas populations.

The assessment is administered by professional assessors who have successfully completed the vendor's training curriculum. The assessor training is an important component of ensuring the consistency and validity of the tool. The assessment tool is a series of more than 300 questions that might be asked during an in-person interview. The interview may include family members and friends as well as the Medicaid beneficiary. How a question is answered may trigger another question. Responses are weighted based on the service needs being assessed. The MnChoices assessment is computerized and uses computer program language based on logic (an algorithm) to generate a tier assignment for each individual. An algorithm is simply a sequence of instructions that will produce the exact same result to ensure consistency and eliminate interviewer bias. Reassessments may be conducted in person or through the use of telehealth. In order to comply with Arkansas Code § 20-77-2710, reassessments for Behavioral Health and Developmental Disabilities Assessments will have an abbreviated option. The focused assessment will utilize the same Tier logic as the standard assessment. The abbreviated process will be available to those individuals who have previously been approved for services through an independent assessment. The abbreviated assessment option for Behavioral Health shall not be effective until the date that the Centers for Medicare & Medicaid approve an amendment to Arkansas's 1915(i) State plan for Home and Community-Based Services (HCBS).

The results of the assessment are provided to the individual and program staff at DHS. The results packet includes the individual's tier result, scores, and answers to all questions asked

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during the assessment. **Click here to see an example results packet**. Individuals can review those results and may contact the appropriate division for more information on their individual results, including any explanations for how their scores were determined. Depending upon which program the individual participates in, the results also may be given to service providers. The results will assign an individual into a tier which subsequently is used to develop the individual's PCSP. The tiers and tiering logic are defined by DHS and are specific to the population served. DHS and the vendor provide internal quality review of the assessment results as part of the overall process. The tier definitions for each population group/waiver group are available in the respective section of this Manual. In the case of an individual whose services are delivered through the Provider-led Arkansas Shared Savings Entity (PASSE); the tier is used in the determination of the actuarially sound global payment made to the PASSE. ~~Beginning January 1, 2019, e~~Each PASSE is responsible for its network of providers and payments to providers are based on the negotiated payment arrangements.

~~For beneficiaries receiving state plan personal care, the assessment results determine initial eligibility for services, then are used to inform the amount of services the beneficiary is to receive.~~

For beneficiaries who receive HCBS services, the assessment results are used to develop the PCSP with the individual Medicaid beneficiary. ~~and establishes the per member per month payment to a managed care entity. The Medicaid beneficiary (or a parent or guardian on the individual's behalf) will sign the PCSP. Depending upon which program the individual participates in, department staff or a provider is responsible for ensuring the PCSP is implemented.~~ The DHS ARIA vendor does not participate in the development of the PCSP, nor in the provision of services under the approved plan.

There are four key features of every HCBS waiver:

A. It is an alternative to care in an institutional setting (hospital, nursing home, intermediate care facility for individuals with developmental disabilities), therefore the individual must require a level of services and supports that would otherwise require that the individual be admitted to an institutional setting;

B. The state must assure that the individual's health and safety can be met in a non-institutional setting;

C. The cost of services and supports is cost effective in comparison to the cost of care in an institutional setting; and~~,~~

D. The PCSP should reflect the preferences of the individual and must be signed by the individual or the individual's designee.

~~The PCSP, as agreed to by the Medicaid beneficiary, therefore represents the final decision for setting the amount, duration, and scope of HCBSs for that individual.~~

~~**201.100 Developmental Screen Overview** 1-1-24~~

~~Additionally, the vendor will perform developmental screens for children seeking admission into an Early Intervention Day Treatment (EIDT) program, the successor program to Developmental Day Treatment Clinic Services (DDTCS) and Child Health Management Services (CHMS) described in Act 1017 of 2013. Ark. Code Ann. § 20-48-1102.~~

~~The developmental screen is the Battelle Developmental Inventory screening tool, which is a norm-referenced tool commonly used in the field to screen children for possible developmental delays. The state has established a broad baseline and will use this tool to screen children to determine if further evaluation for services is warranted. The screening results can also be used by the EIDT provider to further determine what evaluations for services a child should receive.~~

~~The developmental disabilities screening process will sunset April 1, 2024.~~

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210.100 Referral Process 1-1-247

Independent ~~a~~Assessment (IA) referrals are initiated by the Division of Aging, Adult, and Behavioral Services (DAABHS) and Behavioral Health (BH) ~~s~~Service providers identifying an ~~beneficiary~~ individual who may require services in addition to behavioral health counseling services and medication management. ~~-~~Requests for functional assessment shall be transmitted to the Department of Human Services (DHS) or its designee. ~~-~~Supporting documentation related to treatment services necessary to address functional deficits may be provided.

DHS or its designee will review the request and make a determination to either:

A. Finalize a referral and send it to the vendor for a BH independent assessment

B. Provide notification to the requesting BH service provider that more information is needed

C. Provide notification to the requesting entity

Reassessments will occur annually unless a change in circumstances requires a new assessment. A reassessment will be completed by staff employed by the independent assessment contractor utilizing the current approved assessment instrument (ARIA), which was approved prior to April 1, 2021, to assess functional need. An interview will be conducted in person for initial assessments, with the option of using telemedicine to complete Behavioral Health reassessments. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

210.300 Tiering 1-1-274

A. Tier Definitions:

1. Tier 1 ~~means~~ indicates the score reflected that the individual can continue Counseling and Medication Management services but is not eligible for the additional array of services available in Tier 2 ~~or~~ and Tier 3.
2. Tier 2 ~~means~~ indicates the score reflected difficulties with certain functional behaviors allowing eligibility for a full array of ~~non-residential~~ services to help the ~~beneficiary~~ individual function in home and community settings and move towards recovery.
3. Tier 3 ~~means~~indicates the score reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the individual move towards reintegrating back into the community, function in home and community settings, and~~including 24 hours a day/7 days a week residential services, to help the beneficiary~~ move toward~~s~~ recovery~~eintegrating back into the community~~.

B. Tier Logic

1. Beneficiaries aged 18 and over

	Tier 1 – Counseling and Medication Management Services	Tier 2 – Counseling, Medication Management, and Support Services	Tier 3 – Counseling, Medication Management, Support, and Residential Services
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score of 4 **AND**	Mental Health Diagnosis Score of 4 **AND**

		Intervention Score of 1 or 2 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA	Intervention Score of 3 or 4 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 4 or 5 in any ONE of the following Psychosocial Subdomains: Difficulties Regulating Emotions Susceptibility to Victimization Withdrawal Agitation Impulsivity Intrusiveness	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 1, 2, 3 or 4 **AND** Frequency Score of 1, 2, 3, 4 or 5 in the following Psychosocial Subdomain: Psychotic Behaviors	
		OR	
		Mental Health Diagnosis Score of 4 **AND**	

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		Intervention Score of 4 **AND** Frequency Score of 4 or 5 in the following Psychosocial Subdomain: Manic Behaviors	
		OR	
		Mental Health Diagnosis Score of 4 **AND** PHQ-9 Score of 3 or 4 (Moderately Severe or Severe Depression) **OR** Geriatric Depression Score of 3 ~~(>=~~(≥ 10)	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Substance Abuse or Alcohol Use Score of 3	

When you see "**AND"**, this ~~means~~ indicates you must have a score in this area **AND** a score in another area. When you see "**OR**", this indicates~~means~~ you must have a score in this area **OR** a score in another area.

2. Beneficiaries Under Age 18

	Tier 1 – Counseling and Medication Management Services	**Tier 2 – Counseling, Medication Management, and Support Services**	**Tier 3 – Counseling, Medication Management, Support, and Residential Services**
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score ~~>=~~ ≥ 2 **AND** Injurious to Self: Intervention Score of 1, 2 or 3 **AND** Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score ~~>=~~ ≥ 2 **AND** Injurious to Self: Intervention Score of 4 **AND** Frequency Score of 1, 2, 3, 4 or 5
		OR	
		Mental Health Diagnosis Score ~~>=~~ ≥ 2	Mental Health Diagnosis Score ~~>=~~ ≥ 2

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		AND Aggressive Toward Others, Physical: Intervention Score of 1, 2 or 3 **AND** Frequency Score of 1, 2, 3, 4 or 5	**AND** Aggressive Toward Others, Physical: Intervention Score of 4 **AND** Frequency Score of 2, 3, 4 or 5
		OR	
		Mental Health Diagnosis Score ~~>=~~ ≥ 2 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Aggressive Toward Others, Verbal/Gestural Wandering/Elopement	Mental Health Diagnosis Score ~~>=~~ ≥ 2 **AND** Psychotic Behaviors: Intervention Score of 3 or 4 **AND** Frequency Score of 3, 4 or 5
		OR	
		Mental Health Diagnosis Score ~~>=~~ ≥ 2 **AND** Intervention Score of 2, 3 or 4 **AND** Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Socially Unacceptable Behavior Property Destruction	
		OR	
		Mental Health Diagnosis Score ~~>=~~ ≥ 2 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 3, 4, or 5 in any ONE of the following Psychosocial Subdomains:	

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		Agitation Anxiety Difficulties Regulating Emotions Impulsivity Injury to Others, Unintentional Manic Behaviors Susceptibility to Victimization Withdrawal	
		OR	
		Mental Health Diagnosis Score ~~>=~~≥ 2 **AND** **PICA**: Intervention Score of 4	
		OR	
		Mental Health Diagnosis Score ~~>=~~≥ 2 **AND** **Intrusiveness**: Intervention Score of 3 or 4 **AND** Frequency Score of 4 or 5	
		OR	
		Mental Health Diagnosis Score ~~>=~~≥ 2 **AND** **Psychotic Behaviors**: Intervention Score of 1 or 2 **AND** Frequency Score of 1 or 2	
		OR	
		Mental Health Diagnosis Score ~~>=~~≥ 2 **AND** Psychosocial Subdomain Score ~~>=~~≥ 5 and ~~<=~~≤ 7 **AND** Pediatric Symptom Checklist Score > 15	

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210.400 Possible Outcomes 1-1-247

A. For a beneficiary receiving a Tier 1 determination:

1. Eligible for Counseling and Medication Management services and may continue Tier 1 services with a certified behavioral health service provider or Independently Licensed Practitioner (ILP).
2. Not eligible for Tier 2 or Tier 3 services.
3. Not eligible for ~~auto-~~assignment to a Provider-led Arkansas Shared Savings Entity (PASSE) or to continue participation with a PASSE.

B. For a beneficiary receiving a Tier 2 or Tier 3 determination:

1. Eligible for services contained in Tier 1 and ~~Tier 2~~higher.

~~2. Not eligible for Tier 3 services.~~

2~~3~~. Eligible for ~~auto-~~assignment to a PASSE or to continue participation with a PASSE.

a. ~~On January 1, 2019, t~~The PASSE ~~began~~ will receive~~ing~~ a PMPM that corresponds to the determined rate for the assigned tier.

b. The PASSE ~~is~~will be responsible for providing care coordination ~~and~~ assisting the beneficiary in accessing all needed services and~~, after January 1, 2019, for~~ providing those services.

~~C. For a beneficiary receiving a Tier 3 determination:~~

~~1. Eligible for services contained in Tier 1, Tier 2 and Tier 3.~~

~~2. Eligible for auto-assignment to a PASSE or to continue participation with a PASSE.~~

~~a. On January 1, 2019, the PASSE began receiving a PMPM that corresponds to the determined rate for the assigned tier.~~

~~b. The PASSE is responsible for providing care coordination and assisting the beneficiary in accessing all needed services and, after January 1, 2019, for ensuring those services are provided.~~

220.300 Tiering 1-1-274

A. Tier Definitions:

1. Tier 2 ~~means~~ indicates that the ~~beneficiary~~ score~~d high enough in certain areas to be eligible for paid services and supports.~~ reflected difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings.
2. Tier 3 ~~means~~ indicates that the ~~beneficiary~~ score~~d~~ reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings.~~high enough in certain areas to be eligible for the most intensive level of services, **including 24 hours a day/7 days a week** paid supports and services.~~

B. Tiering Logic:

1. DDS tier logic is organized by categories of need, as follows:
   a. Safety: Your ability to remain safe and out of harm's way
   b. Behavior: Behaviors that could place you or others in harm's way
   c. Self-Care: Your ability to take care of yourself, such as bathing yourself, getting dressed, preparing your meals, shopping, or going to the bathroom

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Tier 2: Institutional Level of Care	Tier 3: Institutional Level of Care and may need 24 hours a day/7 days a week paid supports and services to maintain current placement
Safety Level High A. Self-Preservation Score ~~>=~~≥ 4 **AND** B. Caregiving Capacity/Risk Score ~~>=~~≥ 6 **AND** C. Caregiving/Natural Supports Score ~~>=~~≥ 6 **AND** D. Mental Status Evaluation Score (in the home) = 3 or 4 **AND** E. Mental Status Evaluation Score (in the community) = 2	A. Self-Preservation Score ~~>=~~≥ 16 **AND** B. Caregiving Capacity/Risk Score = 11 **AND** C. Caregiving/Natural Supports Score of = 7 **AND** D. Mental Status Evaluation Score (in the home) Score = 5 **AND** E. Mental Status Evaluation Score (in the community) Score = 3
Safety Level Medium A. Self-Preservation Score ~~>=~~≥ 4 **AND** B. Caregiving Capacity/Risk Score ~~>=~~≥ 6 **AND** C. Caregiving/Natural Supports Score ~~>=~~≥ 6 **AND** D. Mental Status Evaluation Score (in the home) = 2 **AND** E. Mental Status Evaluation Score (in the community) = 2	
Safety Level Low A. Self-Preservation Score ~~>=~~≥ 4 **AND** B. Caregiving Capacity/Risk Score ~~>=~~≥ 6 **AND** C. Caregiving/Natural Supports Score ~~>=~~≥ 6 **AND** D. Mental Status Evaluation Score (in the home) = 1 **AND**	

E. Mental Status Evaluation Score (in the community) Score = 1	
Behavior Level High A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ~~>=~~≥ 5 - ~~<=~~≤ 7 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement; **AND** C. Caregiving Capacity/Risk Score of ~~>=~~≥ 6 **AND** D. Caregiving/Natural Supports Score of ~~>=~~≥ 5] **OR** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ~~>=~~≥ 5 - ~~<=~~≤ 7 in at least THREE of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. **AND** at least one of the following scores:	**Behavior Level High** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ~~>=~~≥ 8 - ~~<=~~≤ 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement **OR** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ~~>=~~≥ 8 - ~~<=~~≤ 9 in at least THREE of the following Subdomains: Aggressive Toward Others Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Verbal/Gestural; Withdrawal

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Caregiving Capacity/Risk Score of ~~>=~~≥ 9 Caregiving/Natural Supports Score of ~~>=~~≥ 5	
Behavior Level Low A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ~~>=~~≥ 3 - ~~<=~~≤ 4 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of ~~<=~~≤ 8 Caregiving/Natural Supports Score of ~~<=~~≤ 3 **OR** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ~~>=~~≥ 5 ~~<=~~≤ 7 in at least one of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. **AND** at least one of the following scores:	**Behavior Level Low** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ~~>=~~≥ 8 - ~~<=~~≤ 9 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement] **OR** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ~~>=~~≥ 8 - ~~<=~~≤ 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal

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Caregiving Capacity/Risk Score of <~~=~~≤ 8 Caregiving/Natural Supports Score of <~~=~~≤ 3	
Self-Care Level High A. Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following: *1. ADL's:* Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers 2. *Functional Communication:* Score of 2 or 3 in Functional Communication *3. IADLs:* Score of 3 in any of the following IADLs (Meal Preparation, Housekeeping, Finances, Shopping) *4. Safety:* Self-Preservation Score of >~~=~~≥ 4 **AND** a score in at least one of the following areas: Caregiving Capacity/Risk Score of >~~=~~≥ 9 Caregiving/Natural Supports Score of >~~=~~≥ 4 Treatment/Monitoring Score of at least 2	**Self-Care Level High** A. Neurodevelopmental Score of 2 **AND** B. Treatments/Monitoring Score of at least 2 C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score >~~=~~≥ 10 Caregiving/Natural Supports Score of = 7
Self-Care Level Medium A. Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following: *1. ADLs:* Score of 1-11 in Eating Score of 1-11 in Bathing	

Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers 2. *Functional Communication:* Score of 1 in Functional Communication 3. *IADLs* Score of 3 in any of the following IADLs: (Meal Preparation, Housekeeping, Finances, Shopping) 4. *Safety:* Self-Preservation Score of ~~>=~~≥ 2 **AND** a score in at least one of the following areas: Caregiving Capacity/Risk Score of ~~>=~~≥ 9 Caregiving/Natural Supports Score of ~~>=~~≥ 4	
Self-Care Level Low A. Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following combinations: Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers] **OR** Neurodevelopmental Score of 2 **AND** Score of ~~>=~~≥ 1 in any of the following: IADLs (Meal Preparation, Housekeeping, Finances, Shopping)	**Self-Care Level Low** A. Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following combinations: Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of ~~>=~~≥ 10 Caregiving/Natural Supports Score of 7

When you see "**AND"**, this indicates~~means~~ you must have a score in this area **AND** a score in another area. When you see "**OR**", this indicates~~means~~ you must have a score in this area **OR** a score in another area.

~~220.410 Battelle Developmental Inventory Screen~~ ~~1-1-24~~

~~A. The screening tool that will be used by the vendor is the most recent edition of the Battelle Developmental Inventory (BDI) Screening Tool. The BDI screens children in the following five domains: adaptive, personal/social, communication, motor, and cognitive.~~

~~B. Definitions used for the screening process:~~

~~1. Cut Score - The lowest score a beneficiary could have for that age range and standard deviation to pass a particular domain.~~

~~2. Pass - The child's raw score is higher than the cut score, and the child is not referred for further evaluation~~

~~3. Refer – The child's raw score is lower than the cut score, and the child is referred for further evaluation of service need~~

~~4. Age Equivalent Score - The age at which the raw score for a subdomain is typical~~

~~5. Raw Score – Is the score the child received on that domain. It is compared to the cut score to determine if the child receives a pass or refer.~~

~~6. Standard Deviation - A measurement used to quantify the amount of variation; the standard deviation will be applied to the child's raw score so that their score can be compared to the score of a child with typical development.~~

~~C. The standard deviation of -1.5 will be applied to all raw scores. Any score that is more than 1.5 standard deviations below that of a child with typical development will be referred for further evaluation for EIDT services.~~

~~D. Assessors who administer the Battelle Developmental Inventory screen must meet the qualifications of a DD assessor, listed in Section 220.200 and undergo training specific to administering the tool.~~

230.000 ~~PERSONAL CARE SERVICES~~ ARCHOICES

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 Division of County Operations DCO are not eligible for the ARChoices Program.

230.100 Referral Process 1-1-247

Independent ~~a~~Assessment (IA) referrals are initiated by ~~Personal Care (PC) service providers identifying a beneficiary who may require PC services. After January 1, 2019, individuals who are enrolled in a PASSE do not require a personal care assessment to continue services. Requests for functional assessment shall be transmitted to DHS or its designee, and will require supporting documentation. Supporting documentation that must be provided include:~~

~~A. A provider completed form that has been provided by DHS; and~~

~~B. A referral form if it is an initial referral.~~

~~DHS or its designee will review the request and make a determination to:~~

~~A. Finalize a referral and send it to the vendor for a PC independent assessment, or~~

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~~B. Provide notification to the requesting entity that more information is needed, and that the PC provider may resubmit the request with the additional information, or~~

~~C. Provide notification to the requesting entity that the request is denied, for example, if a functional assessment has been performed within the previous ten (10) months and there is no change of circumstances to justify reassessment.~~

~~Reassessments must be conducted in person or by telemedicine and occur annually but may occur more frequently if a change of circumstances necessitates such.~~the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. -The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

230.200 Assessor Qualifications 1-1-247

In addition to the qualifications listed in Section 202.000, ~~PC~~ARChoices assessors must be a Registered Nurse licensed in the State of Arkansas.

230.300 Tiering 1-1-274

A. Tier Definitions:

1. ~~Tier 0 means you did not score high enough in any of the activities of daily living (ADLs) such as eating, bathing, or toileting to meet the state's eligibility criteria for personal care services. A Tier 0 means that you did not need any "hands on assistance" in being able to bathe yourself, feed yourself and dress yourself as examples.~~Tier 0 and~~&~~ Tier 1 ~~mean~~indicate the individual's assessed needs, if any, do not support the need for either ARChoices waiver services or nursing facility services.
2. ~~Tier 1 means you scored high enough in at least one of the ADLs such as eating, bathing, toileting, to be eligible for the state's Personal Care services. A Tier 1 means that you need "hands on assistance" to be able to bathe yourself, dress yourself, or feed yourself, as examples~~Tier 2 ~~means~~indicates the individual's assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.

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

B. Tiering Logic:

	~~Tier 0~~	~~Tier 1~~
~~Functional Status (ADLs)~~	~~Score < 3 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning~~	~~Score of > = 3 in at least ONE of the following ADLs:~~ ~~Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning~~

DAAS Approved Tier Logic STATE APPROVED				
	Tier 0	Tier 1	Tier 2	Tier 3

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Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ≥~~>=~~ 2
	AND	**AND**	**AND**	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Physical Assistance Score of ~~>=~~≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 **OR** Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 **OR** Mobility Physical Assistance Score = 2	
			OR	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score ~~>=~~≥ 2 **AND** Types of supports in home Score ~~>=~~≥ 3 **OR**	

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			Types of supports in community Score >=≥ 2 **AND** [Score in at least ONE of the following: Injurious to Self Score >=≥ 8 Aggressive Toward Others, Physical Score >=≥ 8 Aggressive Toward Others, Verbal/Gestural Score >=≥ 8 Socially Unacceptable Behavior Score >=≥ 8 Wandering/ Elopement Score >=≥ 8 Susceptibility to Victimization Score >=≥ 8 Eating Cuing/Supervision Score >=≥ 1] **OR** Life Threatening Condition Score = 1	

Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED **Applies to Tier 2 Results ONLY**			
	Intensive	**Intermediate**	**Preventative**

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Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND** Category 2: Eating Eating Physical Assistance Score = 3 **AND** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/ Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND/OR** Category 2: Eating Eating Physical Assistance Score = 3 **AND/OR** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.

230.400 Possible Outcomes 1-1-247

~~Upon successful completion of an assessment, the tier determination will determine eligibility of service levels. Possible outcomes include:~~

~~A. Tier 0 Determination~~

~~1. Not currently eligible for Personal Care services.~~

~~2. May be reassessed when a change in circumstances necessitates a re-assessment.~~

~~B. Tier 1 Determination~~

~~1. Currently eligible for up to 256 units (64 hours) per month of Personal Care services.~~

~~2. The PC assessment is submitted to DHS or its designee who reviews it, along with any information submitted by the provider to authorize the set amount of service time per month.~~

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~~The PC assessment is not used to assign clients to a PASSE.~~ These indications notwithstanding, the final determination of Level of Care and waiver eligibility is made by DCO.

240.000 LIVING CHOICES

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

240.100 Referral Process 1-1-27

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

240.200 Assessor Qualifications 1-1-27

In addition to the qualifications listed in Section 202.000, Living Choices assessors must be a Registered Nurse licensed in the State of Arkansas.

240.300 Tiering 1-1-27

A. Tier definitions:

1. Tier 0 and~~&~~ Tier 1 indicate~~mean~~ 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 indicates~~means~~ 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 indicates~~means~~ 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 waiver eligibility is made by DCO.

B. Tiering logic:

DAAS Approved Tier Logic STATE APPROVED				
	Tier 0	Tier 1	Tier 2	Tier 3

MARKUP

Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score >=≥ 2
	AND	**AND**	**AND**	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Physical Assistance Score of >=≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 **OR** Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 **OR** Mobility Physical Assistance Score = 2	
			OR	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score >=≥ 2 **AND** Types of supports in home Score >=≥ 3 **OR** Types of supports in community Score >=≥ 2	

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			AND [Score in at least ONE of the following: Injurious to Self Score ~~>=~~≥ 8 Aggressive Toward Others, Physical Score ~~>=~~≥ 8 Aggressive Toward Others, Verbal/Gestural Score ~~>=~~≥ 8 Socially Unacceptable Behavior Score ~~>=~~≥ 8 Wandering/Elopement Score ~~>=~~≥ 8 Susceptibility to Victimization Score ~~>=~~≥ 8 Eating Cuing/Supervision Score ~~>=~~≥ 1]	
			OR	
Life Threatening Condition			Life Threatening Condition Score = 1	

Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED **Applies to Tier 2 Results ONLY**			
	Intensive	**Intermediate**	**Preventative**
Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR**	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR**	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.

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	Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND** Category 2: Eating Eating Physical Assistance Score = 3 **AND** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/ Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND/OR** Category 2: Eating Eating Physical Assistance Score = 3 **AND/OR** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	

240.400 Possible Outcomes 1-1-27

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

250.000 PACE

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model that enables individuals who are fifty-five (55) years of age or older and certified by the state to need nursing facility care, to live as independently as possible. -Through PACE, fragmented health care financing and delivery system comes together to serve the unique needs of the enrolled individual with chronic care needs. -The population served by PACE is historically very frail. -The PACE organization must provide all needed services to the PACE participant.

250.100 Referral Process 1-1-27

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. -The referral is transmitted to the IA vendor.

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Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

250.200 Assessor Qualifications 1-1-27

In addition to the qualifications listed in Section 202.000, PACE assessors must be a Registered Nurse licensed in the State of Arkansas.

250.300 Tiering 1-1-27

A. Tier definitions:

1. Tier 0 ~~&~~and Tier 1 ~~mean~~indicate the individual's assessed needs, if any, do not support the need for either PACE services or nursing facility services.
2. Tier 2 indicates~~means~~ the individual's assessed needs are consistent with services available through either the PACE program or a licensed nursing facility.
3. Tier 3 indicates~~means~~ the individual needs skilled care available through a licensed nursing facility and therefore is not eligible for the PACE program.

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

B. Tiering logic:

DAAS Approved Tier Logic STATE APPROVED				
	Tier 0	**Tier 1**	**Tier 2**	**Tier 3**
Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ~~>=~~≥ 2
	AND	**AND**	**AND**	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Physical Assistance Score of ~~>=~~≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 **OR**	

			Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 **OR** Mobility Physical Assistance Score = 2	
			OR	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score ~~>=~~≥ 2 **AND** Types of supports in home Score ~~>=~~≥ 3 **OR** Types of supports in community Score ~~>=~~≥ 2 **AND** [Score in at least ONE of the following: Injurious to Self Score ~~>=~~≥ 8 Aggressive Toward Others, Physical Score ~~>=~~≥ 8 Aggressive Toward Others, Verbal/Gestural Score ~~>=~~≥ 8 Socially Unacceptable Behavior Score ~~>=~~≥ 8 Wandering/ Elopement Score ~~>=~~≥ 8	

MARKUP

			Susceptibility to Victimization Score >=≥ 8 Eating Cuing/Supervision Score >=≥ 1] **OR** Life Threatening Condition Score = 1	

Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED **Applies to Tier 2 Results ONLY**			
	Intensive	**Intermediate**	**Preventative**
Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND** Category 2: Eating Eating Physical Assistance Score = 3 **AND** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/ Continence Support Challenge = Cannot change incontinence pads.	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND/OR** Category 2: Eating Eating Physical Assistance Score = 3 **AND/OR** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/Continence Support Challenge = Cannot change incontinence pads.	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.

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	Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	

250.400 Possible Outcomes **1-1-27**

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

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201.000 Arkansas Independent Assessment (ARIA) System Overview 1-1-27

The Arkansas Independent Assessment (ARIA) system is comprised of several parts that are administered through separate steps for each eligible Medicaid individual served through one of the state's waiver programs. The purpose of the ARIA system is to perform a functional-needs assessment to assist in the development of an individual's Person-Centered Service Plan (PCSP), and for certain populations to establish the per member per month payment to a managed care entity. As such, it assesses an individual's capabilities and limitations in performing activities of daily living, including bathing, toileting, and dressing. It is not a medical diagnosis, although the medical history of an individual is an important component of the assessment as a functional deficiency may be caused by an underlying medical condition. In the case of an individual in need of behavioral health services, or waiver services, the independent assessment does not determine whether an individual is Medicaid eligible. That determination is made prior to and separately from the assessment of an individual.

Federal statutes and regulations require states to use an independent assessment for determining eligibility for certain services offered though Home and Community-Based Services (HCBS) waivers. It also is important to Medicaid beneficiaries and their families that any type of assessment is based on tested and validated instruments that are objective and fair to everyone. In 2017, Arkansas selected the ARIA system. It has been phased in over time for different population groups. When implemented for a population, the ARIA system replaces and voids any previous IA systems.

The ARIA system is administered by a vendor under contract with the Arkansas Department of Human Services (DHS). The basic foundation of the ARIA system is MnCHOICES, a comprehensive functional assessment tool originally developed by state and local officials in Minnesota for use in assessing the long-term services and supports (LTSS) needs of elderly individuals. Many individuals with developmental disabilities (DD)/intellectual disabilities (ID) and individuals with severe behavioral health needs also have LTSS needs. Therefore, the basic MnCHOICES tool has common elements across the different population groups. DHS and its vendor further customized MnCHOICES to reflect the Arkansas populations.

The assessment is administered by professional assessors who have successfully completed the vendor's training curriculum. The assessor training is an important component of ensuring the consistency and validity of the tool. The assessment tool is a series of more than 300 questions that might be asked during an in-person interview. The interview may include family members and friends as well as the Medicaid beneficiary. How a question is answered may trigger another question. Responses are weighted based on the service needs being assessed. The MnChoices assessment is computerized and uses computer program language based on logic (an algorithm) to generate a tier assignment for each individual. An algorithm is simply a sequence of instructions that will produce the exact same result to ensure consistency and eliminate interviewer bias. Reassessments may be conducted in person or through the use of telehealth. In order to comply with Arkansas Code § 20-77-2710, reassessments for Behavioral Health and Developmental Disabilities Assessments will have an abbreviated option. The focused assessment will utilize the same Tier logic as the standard assessment. The abbreviated process will be available to those individuals who have previously been approved for services through an independent assessment. The abbreviated assessment option for Behavioral Health shall not be effective until the date that the Centers for Medicare & Medicaid approve an amendment to Arkansas's 1915(i) State plan for Home and Community-Based Services (HCBS).

The results of the assessment are provided to the individual and program staff at DHS. The results packet includes the individual's tier result, scores, and answers to all questions asked during the assessment. **Click here to see an example results packet**. Individuals can review

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those results and may contact the appropriate division for more information on their individual results, including any explanations for how their scores were determined. Depending upon which program the individual participates in, the results also may be given to service providers. The results will assign an individual into a tier which subsequently is used to develop the individual's PCSP. The tiers and tiering logic are defined by DHS and are specific to the population served. DHS and the vendor provide internal quality review of the assessment results as part of the overall process. The tier definitions for each population group/waiver group are available in the respective section of this Manual. In the case of an individual whose services are delivered through the Provider-led Arkansas Shared Savings Entity (PASSE); the tier is used in the determination of the actuarially sound global payment made to the PASSE. Each PASSE is responsible for its network of providers and payments to providers are based on the negotiated payment arrangements.

For beneficiaries who receive HCBS services, the assessment results are used to develop the PCSP with the individual Medicaid beneficiary. The DHS ARIA vendor does not participate in the development of the PCSP, nor in the provision of services under the approved plan.

There are four key features of every HCBS waiver:

A. It is an alternative to care in an institutional setting (hospital, nursing home, intermediate care facility for individuals with developmental disabilities), therefore the individual must require a level of services and supports that would otherwise require that the individual be admitted to an institutional setting;

B. The state must assure that the individual's health and safety can be met in a non-institutional setting;

C. The cost of services and supports is cost effective in comparison to the cost of care in an institutional setting; and

D. The PCSP should reflect the preferences of the individual and must be signed by the individual or the individual's designee.

210.100 Referral Process 1-1-27

Independent Assessment (IA) referrals are initiated by the Division of Aging, Adult, and Behavioral Services (DAABHS) and Behavioral Health (BH) Service providers identifying an individual who may require services in addition to behavioral health counseling services and medication management. Requests for functional assessment shall be transmitted to the Department of Human Services (DHS) or its designee. Supporting documentation related to treatment services necessary to address functional deficits may be provided.

DHS or its designee will review the request and make a determination to either:

A. Finalize a referral and send it to the vendor for a BH independent assessment

B. Provide notification to the requesting BH service provider that more information is needed

C. Provide notification to the requesting entity

Reassessments will occur annually unless a change in circumstances requires a new assessment. A reassessment will be completed by staff employed by the independent assessment contractor utilizing the current approved assessment instrument (ARIA), which was approved prior to April 1, 2021, to assess functional need. An interview will be conducted in person for initial assessments, with the option of using telemedicine to complete Behavioral Health reassessments. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

210.300 Tiering 1-1-27

A. Tier Definitions:

PROPOSED

1. Tier 1 indicates the score reflected that the individual can continue Counseling and Medication Management services but is not eligible for the additional array of services available in Tier 2 and Tier 3.
2. Tier 2 indicates the score reflected difficulties with certain functional behaviors allowing eligibility for a full array of services to help the individual function in home and community settings and move towards recovery.
3. Tier 3 indicates the score reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the individual move towards reintegrating back into the community, function in home and community settings, and move toward recovery.

B. Tier Logic

1. Beneficiaries aged 18 and over

	Tier 1 – Counseling and Medication Management Services	**Tier 2 – Counseling, Medication Management, and Support Services**	**Tier 3 – Counseling, Medication Management, Support, and Residential Services**
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score of 4 **AND** Intervention Score of 1 or 2 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA	Mental Health Diagnosis Score of 4 **AND** Intervention Score of 3 or 4 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 4 or 5 in any ONE of the following Psychosocial Subdomains: Difficulties Regulating Emotions Susceptibility to Victimization	

PROPOSED

		Withdrawal Agitation Impulsivity Intrusiveness	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 1, 2, 3 or 4 **AND** Frequency Score of 1, 2, 3, 4 or 5 in the following Psychosocial Subdomain: Psychotic Behaviors	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 4 **AND** Frequency Score of 4 or 5 in the following Psychosocial Subdomain: Manic Behaviors	
		OR	
		Mental Health Diagnosis Score of 4 **AND** PHQ-9 Score of 3 or 4 (Moderately Severe or Severe Depression) **OR** Geriatric Depression Score of 3 (≥ 10)	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Substance Abuse or Alcohol Use Score of 3	

PROPOSED

When you see "**AND"**, this indicates you must have a score in this area **AND** a score in another area. When you see "**OR**", this indicates you must have a score in this area **OR** a score in another area.

2. Beneficiaries Under Age 18

	Tier 1 – Counseling and Medication Management Services	**Tier 2 – Counseling, Medication Management, and Support Services**	**Tier 3 – Counseling, Medication Management, Support, and Residential Services**
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score ≥ 2 **AND** Injurious to Self: Intervention Score of 1, 2 or 3 **AND** Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score ≥ 2 **AND** Injurious to Self: Intervention Score of 4 **AND** Frequency Score of 1, 2, 3, 4 or 5
		OR	
		Mental Health Diagnosis Score ≥ 2 **AND** Aggressive Toward Others, Physical: Intervention Score of 1, 2 or 3 **AND** Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score ≥ 2 **AND** Aggressive Toward Others, Physical: Intervention Score of 4 **AND** Frequency Score of 2, 3, 4 or 5
		OR	
		Mental Health Diagnosis Score ≥ 2 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Aggressive Toward Others, Verbal/Gestural Wandering/Elopement	Mental Health Diagnosis Score ≥ 2 **AND** Psychotic Behaviors: Intervention Score of 3 or 4 **AND** Frequency Score of 3, 4 or 5
		OR	
		Mental Health Diagnosis Score ≥ 2	

PROPOSED

		AND Intervention Score of 2, 3 or 4 **AND** Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Socially Unacceptable Behavior Property Destruction	
		OR	
		Mental Health Diagnosis Score ≥ 2 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Agitation Anxiety Difficulties Regulating Emotions Impulsivity Injury to Others, Unintentional Manic Behaviors Susceptibility to Victimization Withdrawal	
		OR	
		Mental Health Diagnosis Score ≥ 2 **AND** **PICA**: Intervention Score of 4	
		OR	
		Mental Health Diagnosis Score ≥ 2 **AND** **Intrusiveness**: Intervention Score of 3 or 4 **AND**	

PROPOSED

		Frequency Score of 4 or 5	
		OR	
		Mental Health Diagnosis Score ≥ 2 **AND** **Psychotic Behaviors**: Intervention Score of 1 or 2 **AND** Frequency Score of 1 or 2	
		OR	
		Mental Health Diagnosis Score ≥ 2 **AND** Psychosocial Subdomain Score ≥ 5 and ≤ 7 **AND** Pediatric Symptom Checklist Score > 15	

210.400 Possible Outcomes 1-1-27

A. For a beneficiary receiving a Tier 1 determination:

1. Eligible for Counseling and Medication Management services and may continue Tier 1 services with a certified behavioral health service provider or Independently Licensed Practitioner (ILP).
2. Not eligible for Tier 2 or Tier 3 services.
3. Not eligible for assignment to a Provider-led Arkansas Shared Savings Entity (PASSE) or to continue participation with a PASSE.

B. For a beneficiary receiving a Tier 2 or Tier 3 determination:

1. Eligible for services contained in Tier 1 and higher.
2. Eligible for assignment to a PASSE or to continue participation with a PASSE.
   a. The PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.
   b. The PASSE will be responsible for providing care coordination assisting the beneficiary in accessing all needed services and providing those services.

220.300 Tiering 1-1-27

A. Tier Definitions:

1. Tier 2 indicates that the score reflected difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings.
2. Tier 3 indicates that the score reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings.

PROPOSED

B. Tiering Logic:

1. DDS tier logic is organized by categories of need, as follows:
   a. Safety: Your ability to remain safe and out of harm's way
   b. Behavior: Behaviors that could place you or others in harm's way
   c. Self-Care: Your ability to take care of yourself, such as bathing yourself, getting dressed, preparing your meals, shopping, or going to the bathroom

Tier 2: Institutional Level of Care	**Tier 3: Institutional Level of Care and may need 24 hours a day/7 days a week paid supports and services to maintain current placement**
Safety Level High A. Self-Preservation Score ≥ 4 **AND** B. Caregiving Capacity/Risk Score ≥ 6 **AND** C. Caregiving/Natural Supports Score ≥ 6 **AND** D. Mental Status Evaluation Score (in the home) = 3 or 4 **AND** E. Mental Status Evaluation Score (in the community) = 2	A. Self-Preservation Score ≥ 16 **AND** B. Caregiving Capacity/Risk Score = 11 **AND** C. Caregiving/Natural Supports Score of = 7 **AND** D. Mental Status Evaluation Score (in the home) Score = 5 **AND** E. Mental Status Evaluation Score (in the community) Score = 3
Safety Level Medium A. Self-Preservation Score ≥ 4 **AND** B. Caregiving Capacity/Risk Score ≥ 6 **AND** C. Caregiving/Natural Supports Score ≥ 6 **AND** D. Mental Status Evaluation Score (in the home) = 2 **AND** E. Mental Status Evaluation Score (in the community) = 2	
Safety Level Low A. Self-Preservation Score ≥ 4 **AND** B. Caregiving Capacity/Risk Score ≥ 6 **AND** C. Caregiving/Natural Supports Score ≥ 6 **AND**	

D. Mental Status Evaluation Score (in the home) = 1 **AND** E. Mental Status Evaluation Score (in the community) Score = 1	
Behavior Level High A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ≥ 5 - ≤ 7 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement; **AND** C. Caregiving Capacity/Risk Score of ≥ 6 **AND** D. Caregiving/Natural Supports Score of ≥ 5] **OR** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ≥ 5 - ≤ 7 in at least THREE of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal	**Behavior Level High** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement **OR** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 in at least THREE of the following Subdomains: Aggressive Toward Others Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Verbal/Gestural; Withdrawal

PROPOSED

C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 5	
Behavior Level Low A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ≥ 3 - ≤ 4 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of ≤ 8 Caregiving/Natural Supports Score of ≤ 3 **OR** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ≥ 5 -≤ 7 in at least one of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of ≤ 8	**Behavior Level Low** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement] **OR** A. Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal

PROPOSED

Caregiving/Natural Supports Score of ≤ 3	
Self-Care Level High A. Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following: *1. ADLs:* Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers 2. *Functional Communication:* Score of 2 or 3 in Functional Communication *3. IADLs:* Score of 3 in any of the following IADLs (Meal Preparation, Housekeeping, Finances, Shopping) *4. Safety:* Self-Preservation Score of ≥ 4 **AND** a score in at least one of the following areas: Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 4 Treatment/Monitoring Score of at least 2	**Self-Care Level High** A. Neurodevelopmental Score of 2 **AND** B. Treatments/Monitoring Score of at least 2 C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score ≥ 10 Caregiving/Natural Supports Score of = 7
Self-Care Level Medium A. Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following: *1. ADLs:* Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting	

Score of 1-10 in Mobility Score of 1-10 in Transfers 2. *Functional Communication:* Score of 1 in Functional Communication 3. *IADLs* Score of 3 in any of the following IADLs: (Meal Preparation, Housekeeping, Finances, Shopping) 4. *Safety:* Self-Preservation Score of ≥ 2 **AND** a score in at least one of the following areas: Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 4	
Self-Care Level Low A. Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following combinations: Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers] **OR** Neurodevelopmental Score of 2 **AND** Score of ≥ 1 in any of the following: IADLs (Meal Preparation, Housekeeping, Finances, Shopping)	**Self-Care Level Low** A. Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following combinations: Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of ≥ 10 Caregiving/Natural Supports Score of 7

When you see "**AND"**, this indicates you must have a score in this area **AND** a score in another area. When you see "**OR**", this indicates you must have a score in this area **OR** a score in another area.

230.000 ARCHOICES

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 Division of County Operations DCO are not eligible for the ARChoices Program.

230.100 Referral Process 1-1-27

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

230.200 Assessor Qualifications 1-1-27

In addition to the qualifications listed in Section 202.000, ARChoices assessors must be a Registered Nurse licensed in the State of Arkansas.

230.300 Tiering 1-1-27

A. Tier Definitions:

1. Tier 0 and Tier 1 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 indicates the individual's assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.

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

B. Tiering Logic:

DAAS Approved Tier Logic STATE APPROVED				
	Tier 0	**Tier 1**	**Tier 2**	**Tier 3**
Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ≥ 2
	AND	**AND**	**AND**	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence	Physical Assistance Score of ≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3	

PROPOSED

	Support, Positioning	Use/Continence Support, Positioning	3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 **OR** Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 **OR** Mobility Physical Assistance Score = 2	
			OR	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score ≥ 2 **AND** Types of supports in home Score ≥ 3 **OR** Types of supports in community Score ≥ 2 **AND** [Score in at least ONE of the following: Injurious to Self Score ≥ 8 Aggressive Toward Others, Physical Score ≥ 8	

PROPOSED

			Aggressive Toward Others, Verbal/Gestural Score ≥ 8 Socially Unacceptable Behavior Score ≥ 8 Wandering/ Elopement Score ≥ 8 Susceptibility to Victimization Score ≥ 8 Eating Cuing/Supervision Score ≥ 1] **OR** Life Threatening Condition Score = 1	

Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED **Applies to Tier 2 Results ONLY**			
	Intensive	**Intermediate**	**Preventative**
Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND** Category 2: Eating Eating Physical Assistance Score = 3	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND/OR** Category 2: Eating Eating Physical Assistance Score = 3	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.

PROPOSED

	AND Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/ Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	**AND/OR** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	

230.400 Possible Outcomes 1-1-27

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

240.000 LIVING CHOICES

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

240.100 Referral Process 1-1-27

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

240.200 Assessor Qualifications 1-1-27

In addition to the qualifications listed in Section 202.000, Living Choices assessors must be a Registered Nurse licensed in the State of Arkansas.

240.300 Tiering 1-1-27

PROPOSED

A. Tier definitions:

1. Tier 0 and Tier 1 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 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 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 waiver eligibility is made by DCO.

B. Tiering logic:

DAAS Approved Tier Logic STATE APPROVED				
	Tier 0	**Tier 1**	**Tier 2**	**Tier 3**
Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ≥ 2
	AND	**AND**	**AND**	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Physical Assistance Score of ≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 **OR** Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2	

PROPOSED

			3. Transfers Physical Assistance Score = 2 **OR** Mobility Physical Assistance Score = 2	
			OR	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score ≥ 2 **AND** Types of supports in home Score ≥ 3 **OR** Types of supports in community Score ≥ 2 **AND** [Score in at least ONE of the following: Injurious to Self Score ≥ 8 Aggressive Toward Others, Physical Score ≥ 8 Aggressive Toward Others, Verbal/Gestural Score ≥ 8 Socially Unacceptable Behavior Score ≥ 8 Wandering/Elopement Score ≥ 8 Susceptibility to Victimization Score ≥ 8 Eating Cuing/Supervision Score ≥ 1]	
			OR	
Life Threatening Condition			Life Threatening Condition Score = 1	

PROPOSED

Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED Applies to Tier 2 Results ONLY			
	Intensive	**Intermediate**	**Preventative**
Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND** Category 2: Eating Eating Physical Assistance Score = 3 **AND** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/ Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3 **AND/OR** Category 2: Eating Eating Physical Assistance Score = 3 **AND/OR** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.

PROPOSED

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

250.000 PACE

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model that enables individuals who are fifty-five (55) years of age or older and certified by the state to need nursing facility care, to live as independently as possible. Through PACE, fragmented health care financing and delivery system comes together to serve the unique needs of the enrolled individual with chronic care needs. The population served by PACE is historically very frail. The PACE organization must provide all needed services to the PACE participant.

250.100 Referral Process 1-1-27

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

250.200 Assessor Qualifications 1-1-27

In addition to the qualifications listed in Section 202.000, PACE assessors must be a Registered Nurse licensed in the State of Arkansas.

250.300 Tiering 1-1-27

A. Tier definitions:

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

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

B. Tiering logic:

DAAS Approved Tier Logic STATE APPROVED				
	Tier 0	**Tier 1**	**Tier 2**	**Tier 3**
Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ≥ 2
	AND	**AND**	**AND**	
Functional	Physical Assistance Score < 2 in all of the following ADLs:	Physical Assistance Score of ≥ 2 in at	Must meet scores in at least ONE ADL listed:	

PROPOSED

	Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 **OR** Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 **OR** Mobility Physical Assistance Score = 2	
			OR	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score ≥ 2 **AND** Types of supports in home Score ≥ 3 **OR** Types of supports in community Score ≥ 2 **AND** [Score in at least ONE of the following:	

PROPOSED

			Injurious to Self Score ≥ 8 Aggressive Toward Others, Physical Score ≥ 8 Aggressive Toward Others, Verbal/Gestural Score ≥ 8 Socially Unacceptable Behavior Score ≥ 8 Wandering/ Elopement Score ≥ 8 Susceptibility to Victimization Score ≥ 8 Eating Cuing/Supervision Score ≥ 1] **OR** Life Threatening Condition Score = 1	

Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED **Applies to Tier 2 Results ONLY**			
	Intensive	**Intermediate**	**Preventative**
Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 **OR** Transfers Physical Assistance Score = 3 **OR** Positioning Physical Assistance Score = 3	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.

PROPOSED

	AND Category 2: Eating Eating Physical Assistance Score = 3 **AND** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/ Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	**AND/OR** Category 2: Eating Eating Physical Assistance Score = 3 **AND/OR** Category 3: Toileting Toileting Physical Assistance Score = 3 **OR** Toileting/Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 **OR** Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	

250.400 Possible Outcomes 1-1-27

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

PROPOSED

SECTION II - PERSONAL CARE

CONTENTS

200.000 PERSONAL CARE GENERAL INFORMATION
- 200.100 Arkansas Medicaid Participation Requirements for Personal Care Providers
- 200.110 Class A Home Health Agencies
- 200.120 Class B Home Health Agencies
- 200.130 Private Care Agencies
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200.000 PERSONAL CARE GENERAL INFORMATION

200.100 Arkansas Medicaid Participation Requirements for Personal Care Providers 1-1-19

REPEAL

Numerous agencies, organizations and other entities may qualify for enrollment in the Arkansas Medicaid Personal Care Program. Participation requirements vary among these different types of providers. Sections 200.110 through 200.130 outline the participation requirements specific to each type of personal care provider. Section 201.000 describes the procedures required to enroll in the Medicaid Program. Sections 201.010 through 201.030 set forth the licensing, certification and other requirements specific to each type of personal care provider.

All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 *et seq*. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

200.110 Class A Home Health Agencies 3-1-05

The Division of Health Facility Services, Arkansas Department of Health, must license a Class A Home Health agency before the agency may apply to enroll as a personal care provider.

200.120 Class B Home Health Agencies 8-1-04

A. A Class B Home Health agency applying for enrollment as a personal care provider must be licensed as a Class B Home Health agency by the Arkansas Department of Health.

B. The Class B Home Health license must state that the provider is licensed to perform personal care services only.

200.130 Private Care Agencies 1-1-18

A. A private care agency applying to enroll as a personal care provider must be licensed by the Arkansas Department of Health.

B. Private care agencies must be enrolled in the Arkansas Medicaid ARChoices Program.

C. Private care agencies must have liability insurance coverage of not less than one million dollars ($1,000,000.00) covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.

200.140 Assisted Living Facilities 1-1-19

A. Only one type of assisted living facility, a Level 1 Assisted Living Facility (ALF), may enroll as a personal care provider.

B. The Division of Provider Services and Quality Assurance (DPSQA) certifies, licenses and regulates certain institutions, including ALFs.

C. Each ALF has a separate license, regardless of which type it is and regardless of its location or proprietorship.

D. Each ALF that provides personal care for Medicaid beneficiaries and that desires Medicaid reimbursement for those services must enroll separately in the Arkansas Medicaid Personal Care Program, effective for dates of service on and after March 1, 2005.

1. Some providers operate multiple ALF facilities, sometimes on the same property or in the same complex and sometimes in multiple locations.

a. Effective for dates of service before March 1, 2005, Medicaid covers personal care services provided by enrolled RCFs for residents of Level I ALFs under the same proprietorship as the enrolled RCF.

b. Level I ALFs that are not under the same proprietorship as a Medicaid-enrolled RCF may not contract for Medicaid-covered personal care with an enrolled RCF owned by another entity.

c. Except under the conditions described in part a above, personal care in any assisted living facility may be provided only by the facility itself, if it is enrolled in the Arkansas Medicaid Personal Care Program, or by

(1). A private care agency that is enrolled as a Personal Care provider or

(2). A Class A or Class B home health agency that is enrolled as a Personal Care provider.

2. Several provider files may share the same Federal Employer Identification Number (FEIN). For example: A corporate entity that has one FEIN owns an RCF and a Level I ALF and enrolls them as Personal Care Program providers.

a. Each facility is assigned a unique Arkansas Medicaid provider number.

b. Each facility's Arkansas Medicaid Personal Care provider number is linked to its unique license number.

c. Each facility's Arkansas Medicaid Personal Care provider number is linked to the corporate entity's single FEIN.

E. Sections 200.141 and 200.142outline Arkansas Medicaid Personal Care Program participation requirements for RCFs, and Level I ALFs.

F. Level II ALFs may participate in the Living Choices Assisted Living Program.

1. Living Choices is a home- and community-based program established for certain nursing home-eligible individuals who, without a program like Living Choices, would not be able to live in a dwelling of their own or would be able to do so only with great difficulty and with significant risk to their health and safety.

2. Providers may obtain Living Choices Program participation requirements by downloading the Living Choices Assisted Living Provider Manual from the Arkansas Medicaid website, https://medicaid.mmis.arkansas.gov.

REPEAL

3. Living Choices services are not covered for beneficiaries receiving services through the Personal Care Program, and Personal Care Program services are not covered for beneficiaries in the Living Choices Program.

200.141 Residential Care Facilities 1-1-19

A residential care facility applying for enrollment as a personal care provider must be licensed as a residential care facility by the Division of Provider Services and Quality Assurance (DPSQA).

200.142 Level I Assisted Living Facilities 1-1-19

A Level I ALF applying for enrollment as a personal care provider must be licensed as a Level I ALF by the Division of Provider Services and Quality Assurance (DPSQA)..

200.160 School Districts and Education Service Cooperatives 8-1-04

A school district or education service cooperative must be certified as a Local Educational Agency (LEA) by the Arkansas Department of Education. The Arkansas Department of Education will provide verification of LEA certification to the Provider Enrollment Unit of the Division of Medical Services (DMS).

201.000 Reserved 11-1-09

201.100 Provider Enrollment Procedures 7-22-10

Personal care providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of the manual as well as the following criteria to be eligible for the Arkansas Medicaid Program.

REPEAL

Sections 201.100 through 201.140 list the documentation required of each type of applicant for enrollment as a provider in the Personal Care program.

201.110 Class A and Class B Home Health Agencies 1-1-19

Class A and Class B Home Health Agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current Class A or Class B license. In addition, certification by DPSQA is required for Medicaid provider enrollment.

201.120 Private Care Agencies 1-1-19

A. Private care agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current license from the Arkansas Department of Health. In addition, certification by DPSQA is required for Medicaid provider enrollment.

B. Private care agencies must ensure that there is on file with the Provider Enrollment Unit proof of liability insurance coverage of not less than one million dollars ($1,000,000.00), covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.

C. Annually, private care agency providers must ensure that there is on file with the Provider Enrollment Unit proof that the agency's required liability insurance remains in force and has remained in force at a level of coverage no less than the required minimum since the provider's previous report.

~~201.130 Assisted Living Facilities~~

~~201.131 Residential Care Facilities~~ ~~1-1-19~~

~~A residential care facility applying for enrollment as a personal care provider must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of its current license from the Division of Provider Services and Quality Assurance (DPSQA). In addition, certification by DPSQA is required for Medicaid provider enrollment.~~

~~201.132 Level I Assisted Living Facilities~~ ~~1-1-19~~

~~A Level I Assisted Living Facility (ALF) applying to enroll as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the Division of Provider Services and Quality Assurance (DPSQA).. In addition, certification by DPSQA is required for Medicaid provider enrollment.~~

~~202.000 Routine Services Providers and Limited Services Providers Not Licensed in Arkansas~~

~~202.100 Routine Services Providers~~ ~~3-1-05~~

~~Routine services providers in the Arkansas Medicaid Personal Care Program are enrolled Medicaid providers who, in accordance with the regulations of the Arkansas Medicaid Program, may provide medically necessary services to eligible and qualified individuals who choose to receive their services.~~

REPEAL

~~202.110 Personal Care Providers in Arkansas~~ ~~3-1-05~~

~~Enrolled Personal Care providers in Arkansas qualify as routine service providers. However, some personal care providers are limited to providing services only in certain places of service. See Section 213.000, part F.~~

~~202.210 Out-of-State Limited Services Personal Care Providers~~ ~~1-1-19~~

~~A. Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and they have a claim or claims to file with Arkansas Medicaid.~~

~~1. To enroll, providers must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet). View Medicaid Provider Enrollment Unit contact information.**~~

~~2. Out of sate providers must also be certified by DPSQA.~~

~~3. Enrollment as a limited services provider automatically expires after a year unless the provider provides and bills for subsequent services for Arkansas Medicaid beneficiaries during the year. See part B below.~~

~~B. Out-of-state limited services providers remain enrolled for one year.~~

~~1. If an out-of-state limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.~~

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.

3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

203.000 IndependentChoices 1-1-13

IndependentChoices began as a Cash and Counseling Demonstration and Evaluation Project. IndependentChoices seeks to increase the opportunity for consumer direction and control for Medicaid beneficiaries receiving or needing personal care by offering a cash allowance and counseling services in place of traditionally provided personal care. IndependentChoices and how it related to the Personal Care State Plan program is referenced in this manual and the IndependentChoices provider manual.

204.000 Record Maintenance and Availability 11-1-09

A. Personal Care providers are required to keep documentation and records as described in Section 140.000, in Section 221.000 and in officially promulgated, approved and published rules that may be incorporated into this manual.

205.000 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

REPEAL

210.000 PROGRAM COVERAGE

211.000 Program Authority 10-13-03

A. Title XIX of the Social Security Act authorizes personal care services as an optional State Plan benefit.

B. The Arkansas Medicaid Program has elected to offer personal care services benefits in conformity with the rules set out in this manual.

212.000 Program Purpose 1-1-18

A. The purpose of Personal Care Program services is to supplement, not to supplant, other resources available to the beneficiary.

B. Personal care services are medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS and individually designed to assist beneficiaries with their physical dependency needs as described in Section 213.200 and Sections 216.100 through 216.140.

213.000 Scope of the Program 1-1-19

A. Personal care services are primarily based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Hands-on assistance in at least one of these areas, based on the ARIA assessment results, is required. This type of assistance is provided by a personal care aide based on a beneficiary's physical dependency needs (as opposed to purely housekeeping services). An individualized plan of care is developed based on the ARIA assessment results and information in the form designated by DHS that is submitted by the provider, and is based on a beneficiary's assessed dependency in at least one of the above-listed activities of daily living. While not

a part of the eligibility criteria, the need for assistance with other tasks and IADLs (Instrumental Activities of Daily Living) are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized. Routines or IADLs include meal preparation, incidental housekeeping, laundry, medication assistance, etc. These tasks are also defined and described in this section of this provider manual and are defined in the Arkansas State Board of Nursing Position Statement 97-2.

B. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the beneficiary were in a hospital or nursing facility.

C. Personal care services may be similar to or overlap some services that home health aides furnish.

1. Home health aides may provide personal care services in the home under the home health benefit.

2. Skilled services that only a health professional may perform are not considered personal care services.

D. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, Level II assisted living facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State, e.g., ARChoices, IndependentChoices;

2. Furnished in the beneficiary's home, and at the State's option, in another location.

3. Provided by an individual trained to provide such services and who is not a member of the beneficiary's family. See Section 222.100, Part A, for the definition of "a member of the beneficiary's family".

REPEAL

E. Personal care for Medicaid-eligible individuals requires prior authorization. See Sections 240.000 through 246.000.

F. Only Class A Home Health agencies, Class B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, and education service cooperatives may provide personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the beneficiary's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

213.100 Individuals Eligible for Personal Care

213.110 Categorically Needy Medicaid Eligibility 10-13-03

A. Only Categorically Needy Medicaid beneficiaries are eligible for personal care services. Beneficiaries in Medically Needy categories are not eligible for personal care services.

B. See Section I of this manual for the Beneficiary Aid Categories, including the category codes and abbreviated category descriptions. The suffix "MN" indicates a "Medically Needy" aid category.

1. An Eligibility Verification Transaction Response identifies an Aid Category Code and an Aid Category Description for each eligibility segment it lists.

2. The headings, "AID CATEGORY CODE" and "AID CAT DESCRIPTION," appear beneath each eligibility segment.

3. The Aid Category description of a Medically Needy category ends with "EC" (Exceptional Category) or "SD" (Spend Down), as it appears on the Eligibility Verification Transaction Response.

213.120 Non-Inpatient, Non-Institutionalized Status 1-1-19

A. Personal care services are services furnished to an individual who is not an inpatient or a resident of:

1. A hospital,

2. A nursing facility,

3. A Level II assisted living facility,

4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or

5. An institution for mental diseases (IMD).

B. Individuals who are inpatients or residents of the foregoing institutions or facilities are ineligible for Personal Care Program services.

1. Under applicable federal statutory and regulatory provisions, the institutional status of an individual controls the individual's exclusion from service eligibility.

2. The location of the personal care service delivery site is not a determinant of the institutionalized individual's ineligibility for services.

213.200 Physical Dependency Need Criteria for Service Eligibility 1-1-19

REPEAL

A. The terms "routines," "activities of daily living" and "service" have particular definitions that apply to the Personal Care Program. See Sections 216.000 through 216.140 for definitions of these and other terms employed in this manual.

B. Personal care services, described in Sections 216.000 through 216.330, must be medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS.

C. Personal care services are individually designed to assist with a beneficiary's assessed physical dependency needs related to the following routine activities of daily living and instrumental activities of daily living:

1. Bathing

2. Bladder and bowel requirements

3. Dressing

4. Eating

5. Incidental housekeeping

6. Laundry

7. Personal hygiene

8. Shopping for personal maintenance items

9. Taking medications*

10. Mobility and Ambulation

* Assistance with medications is a personal care service only to the extent that it is permitted by the Arkansas Nurse Practice Act, implementing regulations permit a personal care aide to perform the service, and Arkansas State Board of Nursing Position Statement 97-2.

D. A number of conditions may cause "physical dependency needs."

1. Particular disabilities or conditions may or may not be pertinent to specific needs for individual assistance.

2. In assessing an individual's need for personal care, the question to pursue is whether the individual is unable to perform tasks covered by this program without assistance from someone else.

3. The need for individual assistance indicates whether to consider personal care.

213.300 Beneficiary's Consent and Freedom of Choice 10-13-03

A. A Medicaid beneficiary has freedom of choice in selecting a personal care provider.

B. Provision of personal care services is contingent upon the written consent of the beneficiary or the beneficiary's representative.

213.310 IndependentChoices Program, Title XIX State Plan Program 1-1-19

IndependentChoices is operated by the Division of Provider Services and Quality Assurance (DPSQA) and operates under the authority of the Title XIX State Plan with the Division of Medical Services responsible for administrative and financial authority.

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly (age 65 and older) to direct their personal care. The beneficiary chooses a cash allowance in lieu of agency personal care services. IndependentChoices provides qualifying beneficiaries with counseling and training to assist them with information to fulfill their role as an employer. The beneficiary as the employer will hire, train, supervise and, if necessary, terminate the services of their employee. In addition to hiring an employee, the beneficiary may use part of their budget to purchase goods and services that lessen their physical dependency needs. In addition to counseling support services, beneficiaries may receive Financial Management Services (FMS) from a DMS contracted provider. The FMS provider will assist the participant by processing timesheets, withholding and reporting State and Federal taxes, issuing a W-2 to all employees who meet the tax threshold and refunding taxes to the participant and the employee when the threshold was not met. The FMS provider also coordinates the accuracy and coordination of the forms used to establish the Medicaid beneficiary as an employer and to employ a worker. The FMS provider representing the Medicaid beneficiary will obtain permissions and execute an IRS Form 2678 to act as the beneficiary's agent.

REPEAL

NOTE: The IndependentChoices Program is required to follow the rules and regulations of the State Plan approved Personal Care Program, unless stated otherwise in this manual.

213.500 Personal Care Service Locations 1-1-19

A. Arkansas Medicaid covers personal care in a beneficiary's home and, at the state's option, in another location, for beneficiaries of all ages.

1. A beneficiary's home is the beneficiary's residence, subject to the exclusions in part B, below.

2. Service locations outside the beneficiary's home must be included in the service plan. (If shopping or assistance with shopping is included in the service plan, it is understood that the actual activity occurs at a store. The place of service—for billing purposes—remains the beneficiary's home.)

3. The beneficiary's assessment and service plan must justify the medical necessity for personal care in a location other than the beneficiary's residence. For example: A beneficiary's service plan includes assistance with dressing. This particular

beneficiary regularly (by PCP referral or a physician's order) goes to a clinic or other site for a therapy, such as aqua therapy, that involves changing clothes. If, at the therapy site, assistance with dressing and/or changing is not included with the therapy service, the personal care service plan may include an aide's assistance. However, in such a situation, only the time the aide spends performing the service is covered.

B. Medicaid does not cover personal care services in the following locations:

1. A hospital,

2. A nursing facility,

3. A Level II assisted living facility,

4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or

5. An institution for mental diseases (IMD).

C. All individuals residing in locations listed above in part B are ineligible for Medicaid-covered personal care.

D. Individuals who are inpatients or residents of the facilities and institutions listed in part B are not eligible for Medicaid-covered personal care services in any location.

213.520 Personal Care in Public Schools- Beneficiaries under Age 21 7-1-09

A. Personal care in public schools is available to eligible beneficiaries under the age of 21.

1. School may be on campus or off site based on accessibility for the beneficiary.

2. When a beneficiary's education is the responsibility of the school district in which that individual resides, "public school" as a place of service for Medicaid-covered services is any location, on site or away from the site of an actual school building or campus.

a. When a beneficiary is attending school at a DDS community provider facility because the school district has contracted with the facility to provide educational services, the place of service for Medicaid Program purposes is "public school."

b. When the home is the educational setting for a beneficiary who is enrolled in the public school system, "public school" is considered the place of service.

c. The beneficiary's home is not considered a "public school" place of service when a parent elects to home school a child.

B. Medicaid Program requirements are the same as for services delivered in the beneficiary's home.

C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the beneficiary receives services.

D. Beneficiaries receiving personal care in public schools may receive a number of services in accordance with an Individualized Education Program (IEP).

1. The IEP may not supersede or substitute for the personal care service plan.

2. The Personal Care Program requires a distinct and separate assessment and service plan.

E. Refer to Section 262.103 for billing instructions regarding personal care in public schools.

213.530 Personal Care in Residential Care Facilities (RCFs) 3-1-08

REPEAL

A. Residential Care Facilities (RCFs) enrolled as Personal Care providers may furnish Medicaid-covered personal care services, on their own RCF-licensed premises, to their own beneficiaries (i.e. personal care qualified Medicaid beneficiaries whose residence is the RCF).

B. RCF Personal Care providers may not provide Medicaid-covered Personal Care services at any other locations or for any other Medicaid beneficiaries.

C. RCF Personal Care providers are subject to the same requirements as all other Personal Care providers unless this manual, other official documents or jurisdictional court or consent decrees explicitly state otherwise as, for instance, in parts A and B above.

213.540 Employment-related Personal Care Outside the Home 1-1-19

No condition of this section alters or adversely affects the status of individuals who are furnished personal care in sheltered workshops or similarly authorized habilitative environments. There may be a few beneficiaries working in sheltered workshops solely or primarily because they have access to personal care in that setting. This expansion of personal care outside the home may enable some of those individuals to move or attempt to move into an integrated work setting.

A. Personal care may be provided outside the home when the requirements in subparts A1 through A5 are met and the services are necessary to assist an individual with a disability to obtain or retain employment.

1. The beneficiary must have an authorized, individualized personal care service plan that includes the covered personal care services necessary to and appropriate for an employed individual or for an individual seeking employment.

2. The beneficiary must be aged 16 or older.

3. The beneficiary's disability must meet the Social Security/SSI disability definition.

a. A beneficiary's disability may be confirmed by verifying his or her eligibility for SSI, Social Security disability benefits or a Medicaid disability aid category, such as Working Disabled or DDS Alternative Community Services waiver.

b. If uncertain whether a beneficiary qualifies under this disability provision, contact the Department of Human Services local office in the county in which the beneficiary resides.

4. One of the following two conditions must be met.

a. The beneficiary must work at least 40 hours per month in an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability).

b. Alternatively, the beneficiary must be actively seeking employment that requires a minimum of 40 hours of work per month in an integrated setting.

5. The beneficiary must earn at least minimum wage or be actively seeking employment that pays at least minimum wage.

B. Personal care aides may assist beneficiaries with personal care needs in a beneficiary's workplace and at employment-related locations, such as human resource offices, employment agencies or job interview sites.

C. Employment-related personal care associated with transportation is covered as follows.

1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking.

2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; see Section 215.300, part F) in the service plan and all pertinent service documentation.

REPEAL

3. Medicaid does not cover mileage associated with any personal care service.

4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is included in the 64-hour per month personal care benefit limit for beneficiaries aged 21 and older.

D. All personal care for beneficiaries requires prior authorization.

E. Providers furnishing both employment-related personal care outside the home and non-employment related personal care at home or elsewhere for the same beneficiary must comply with the applicable rules at Sections 215.350, 215.351 and 262.100.

213.600 In-State and Out-of-State Limited Services Secondary Personal Care Providers 1-1-19

On rare occasions, a personal care beneficiary might have urgent cause to travel to a locality outside his or her personal care provider's service area. If DHS professional staff or contractor(s) designated by DHS authorizes personal care during the beneficiary's stay in that locality, the beneficiary may choose a personal care provider agency in the service area to which he or she is traveling.

A. In-State and Out-of-State Limited Services Secondary Personal Care Provider

If the selected provider is an in-state provider, the selected provider's services may be covered if all the following requirements are met:

1. The beneficiary's personal care provider (the "primary" provider) must request in writing that the selected provider (the "secondary" provider) assume the beneficiary's service for the specified duration of the beneficiary's stay.

2. The primary provider must forward to the secondary provider a copy of the beneficiary's current service plan and service documentation, including logs, for a minimum service period of sixty days prior to the request.

3. If the secondary provider requests additional information or documentation, the primary provider must forward the requested materials immediately.

4. The secondary provider must execute a written agreement to assume the beneficiary's care on behalf of the primary provider.

5. The secondary provider must submit its service documentation to the primary provider within ten working days of the beneficiary's departure from the temporary locality.

B. Out-of-State Limited Services Secondary Personal Care Provider

If the provider is an out-of-state provider, the provider must also download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application and contract to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).**

The selected provider must also submit to contractor designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff a written request for prior authorization accompanied with copies of the provider's license, Medicare certification, beneficiary's identifying information and the beneficiary's service plan.

C. All documentation exchanged between the primary and secondary providers must satisfy all Medicaid requirements.

213.610 Personal Care/Hospice Policy Clarification 1-1-19

REPEAL

Medicaid beneficiaries are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice and homemaker services.

A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in-home providers.

B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aid and homemaker services necessary for the treatment of the terminal condition.

C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the IndependentChoices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

REPEAL

NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice-care in the home that provides the amount of services required to meet the needs of the beneficiary, the amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the hospice and personal care records must explain the need for both and be supported by the policy in this section.

214.200 Service Plan Review and Renewal 7-1-20

A. A personal care service plan is effective for up to one (1) year from the date of the beneficiary's last independent assessment.

B. Personal care services may not continue past the one-year anniversary of the last independent assessment until DHS professional staff or contractor(s) designated by DHS authorizes a revised service plan, or renews, or extends the authorization of an existing service plan.

214.300 Authorization of ARChoices Person Centered Service Plan and Personal Care Individual Service Plan 1-1-21

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.

The ARChoices PCSP is effective for one (1) year from the date of the beneficiary's most recent assessment, reassessment, or evaluation. The authorization for personal care services, when included on the ARChoices PCSP, will be for one (1) year from the date of the beneficiary's most recent assessment, reassessment, or evaluation unless revised by the DHS RN or the personal care individualized service plan needs to be revised, whichever occurs first.

NOTE: For ARChoices beneficiaries who receive personal care through traditional agency services or have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a DHS RN, will serve as the authorization for personal care services for one year from the date of the beneficiary's most recent assessment, reassessment, or evaluation as described above.

The responsibility of developing a personal care individualized service plan is not placed with the DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

The Arkansas Medicaid Program waives no other Personal Care Program requirements with regard to personal care individualized service plan authorizations obtained by DHS RNs.

REPEAL

214.310 Development of ARChoices Person-Centered Service Plan 1-1-19

If personal care services are not currently being provided when the DHS RN develops the ARChoices Person-Centered Service Plan (PCSP), the DHS RN will determine if personal care services are needed. If so, the service, amount, frequency, duration and the beneficiary's provider of choice will be included on the ARChoices PCSP. A copy of the ARChoices PCSP and a Start of Care form (AAS-9510) will be forwarded to the personal care provider, as is current practice for waiver services. The Start of Care form must be returned to the DHS RN within 10 working days from mailing or action may be taken by the DHS RN to secure another personal care provider or modify the ARChoices PCSP. (The ARChoices PCSP is dated the date it is mailed.) Before taking action to secure another provider or modifying the PCSP, the applicant and/or family members will be contacted to discuss possible alternatives.

This PCSP supersedes any other care plan that may have been previously developed by another Medicaid provider for the applicant. The ARChoices PCSP must include all appropriate ARChoices services and certain non-waiver services appropriate for the applicant, such as Personal Care.

An agency providing services to an ARChoices beneficiary must report these services to the DHS RN. The services being provided to the ARChoices beneficiary must be included on the ARChoices PCSP. Prior to beginning services or revising services provided to an ARChoices beneficiary, contact the DHS RN so the PCSP is properly revised and approved. Please report all changes in services and changes in the ARChoices beneficiary's circumstances to the DHS RN immediately upon learning of the change. Certain services provided to an ARChoices beneficiary that are not included on the ARChoices PCSP may be subject to recoupment by the Medicaid Program.

NOTE: It is the IndependentChoices employer or personal care provider's responsibility to place information regarding their presence in the home in a prominent location so that the DHS RN will be aware that they are serving the beneficiary. Preferably, the provider will place the information on the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will

place the information in a location satisfactory to the applicant, as long as it is readily available and easily accessible by the DHS RN.

The personal care individualized service plan developed by the personal care provider must meet all requirements as detailed in the personal care provider manual. This includes, but is not limited to, the amount of personal care services, personal care tasks, frequency and duration. The ARChoices PCSP and the required justification for each service remains the responsibility of the DHS RN. Therefore, final decisions regarding services included on the ARChoices PCSP rest with the DHS RN.

NOTE: For ARChoices waiver beneficiaries participating in the IndependentChoices program, services are effective on the date of the DHS RN's signature on the ARChoices waiver PCSP.

214.330 Medicaid Audit Requirements for the ARChoices Person-Centered Service Plan 1-1-19

When the Medicaid Program, as authorized by the ARChoices Person-Centered Service Plan (PCSP), reimburses for Personal Care services, all Medicaid audits will be performed based on that authorization. Therefore, all documentation by the Personal Care provider must tie services rendered to services authorized as reflected on the ARChoices PCSP.

215.000 Personal Care Assessment and Individualized Service Plan

215.100 IndependentChoices Assessment and Service Plan Formats 1-1-19

REPEAL

A.

For IndependentChoices beneficiaries who are also active waiver beneficiaries in the ARChoices Program, the assessment tool used for waiver level of care determination and the waiver Person Centered Service Plan (PCSP) will suffice to support authorization for personal care services, if signed by theDHS RN. Eligibility for personal care services is based on the same criteria as state plan personal care services. Services are effective on the date of the waiver PCSP. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver PCSP must include, at least, the information designated by DHS that is utilized to support the medical necessity, eligibility and amount of personal care services provided through IndependentChoices or agency personal care services. This information is required in documentation for each beneficiary. As with all required documentation, this information must be available in the participant's chart or electronic record and available for audit and Quality Management Strategy reviews.

215.200 Personal Care Provider's Prior Authorization Request 7-1-20

A. As part of each prior authorization request, each provider shall submit a complete and accurate form designated by DHS. The provider is not required to submit a proposed Individualized Service Plan to DHS.

B. The completed form designed by DHS shall include all information applicable to the individual beneficiary, including:

1. Beneficiary and provider information;

2. Certification that the beneficiary's service plan will not duplicate any other in-home services of which the provider is aware;

3. The total number of hours per month the provider seeks to offer the beneficiary;

4. Detailed information on all personal assistance available to the beneficiary through other sources, including informal caregivers (e.g., family, friends), community

organizations (e.g., Meals on Wheels), Medicare (e.g., Medicare home health aide services), or the beneficiary's Medicare Advantage health plan;

5. The frequency of in-person supervisory visits to be made by an agency supervisor based on the specific needs of the beneficiary and the recommendations of an agency-designated registered nurse; and,

6. The signed approval of the beneficiary or the beneficiary's legal representative.

C. When a beneficiary has two or more personal care providers, the providers should cooperate in the required nursing evaluation and the preparation and submission of the prior authorization request and completed form designated by DHS on behalf of the beneficiary.

D. When an individual will receive some or all of his or her services in a congregate setting, the assessment must reflect the RN's determination that the individual is an appropriate candidate for services delivered in that setting. See Section 216.201 and Sections 220.110 through 220.112.

E. Before furnishing any personal care services to an individual, the provider must prepare a complete and accurate Individualized Service Plan with proposed hours/minutes and frequency of needed tasks consistent with the aggregate number of hours authorized under the Task and Hour Standards (as described in Section 240.100). The service plan must be prepared, certified, and signed by a supervisor or registered nurse. The service plan and all subsequent revisions must be kept by the personal care provider as Documentation under Section 221.000.

215.210 Alternative Resources for Assistance 1-1-19

REPEAL

A. The following requirements regarding alternative resources for assistance do not apply, or apply only insofar as they are legal, practical and practicable when the identifiable resource(s) are prohibited from assisting the beneficiary by law or by a facility's or organization's rules or bylaws. For example, a relative of the beneficiary is an alternative resource in the beneficiary's home or the relative's home but not in the public school.

B. The form designated by DHS that is submitted by the provider to DHS or the contractor designated by DHS must include written evidence that the beneficiary or the beneficiary's representative and the provider have considered alternative resources available to assist or partially assist the beneficiary with physical dependency needs identified in the assessment.

1. The provider must determine whether voluntary third-party resources are available and if so, the extent of the third party's willingness to devote time to the benefit of the beneficiary. The provider must:

a. Consider other members of the beneficiary's household as well as nearby relatives and friends,

b. Indicate the usual times of their availability to assist the beneficiary and the frequency and duration of their assistance, and

c. Explain the circumstances of any individual household member's inability to provide any assistance or to provide less than complete assistance with the beneficiary's physical dependency needs.

2. The provider must also consider such alternative community resources as public and private community agencies and organizations, whether secular or religious, paid or volunteer.

a. Consider entities that provide not only in-home services, but also such services as adult day care or caregiver respite.

b. List the approximate number of hours per week the beneficiary receives (or will receive) services from each such community resource.

C. The provider must make reasonable efforts to determine the nature, scope, frequency and duration of other services the individual receives, particularly in-home services.

D. The provider's case record documentation must include the certification that the beneficiary's individualized service plan does not duplicate any other in-home services of which the provider is aware.

215.300 Individualized Service Plan 1-1-19

A beneficiary must receive services in accordance with an individualized service plan.

A. The plan must be acceptable to the beneficiary or the beneficiary's representative.

B. A registered nurse and other appropriate personnel of the personal care provider agency, in concert with the beneficiary or the beneficiary's representative, must design the individualized service plan to correlate with the physical dependency needs identified in the assessment.

C. The individualized service plan must be limited to assistance with the beneficiary's individual physical dependency needs.

D. The service plan must clearly identify which of the beneficiary's physical dependency needs will be met by each task performed by a personal care aide.

1. This requirement does not necessarily mandate writing a unique statement for each task or task component. Indexing the assessment may expedite documentation by permitting one to reference the relevant section of the assessment for the exp[illegible] def[illegible] For example:

a. "Task 4 (c[illegible]) to Physical Dependency 2"

b. "Task 6 (c[illegible]) to Physical Dependency 3."

2. In addition to establishing its correspondence to the assessment (e.g., designing individualized services for a beneficiary's physical dependency needs), the service plan must describe for each routine or activity listed:

a. The individual tasks the aide is to perform for the beneficiary,

b. The individual tasks with which the aide is to assist the beneficiary and

c. The frequency and duration of service of each routine and activity, including:

(1). The number of days per week each routine or activity will be accomplished and

(2). The maximum and minimum estimated aggregate minutes the aide should spend on all authorized tasks each service day.

E. The service plan must include written instructions for the personal care aide specifying how and when to execute or assist with the beneficiary's routines or activities including:

1. The number of days per week to accomplish each routine or activity (as well as which days when relevant) and

2. The time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.

F. The service plan must include written instructions describing whether and to what extent the aide's function in individual task components of each routine or activity is:

1. To assist the beneficiary to perform the task,

2. To perform the task for the beneficiary or

3. To observe the beneficiary perform the task.

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G. The service plan must require the beneficiary to perform all tasks within the beneficiary's capability. Medicaid does not cover assistance with any task a beneficiary can perform unless DHS professional staff or contractor(s) designated by DHS have authorized the assistance. For example:

1. A beneficiary can manage his own laundry but he cannot extract wet items from the washer while leaning over the machine.

a. The assessment notes that he needs assistance with the task of removing wet items from the washing machine.

b. The service plan describes the assistance designed for his individual physical dependency need with his laundry.

c. The registered nurse instructs the aide to perform the task(s) constituting the service.

2. Loading the washer, emptying the dryer, folding and ironing clothing and linens are not covered tasks for this particular beneficiary.

3. Removing laundry from the washer and loading it in the dryer are covered tasks for this beneficiary if those tasks are described in his service plan and authorized by DHS professional staff or contractor(s) designated by DHS.

H. The form designated by DHS that is submitted by the provider must support the service plan and the provider's RN's instructions to the aide(s) regarding the delivery of services. The plan must reflect whether the individual is receiving services in more than one setting. If a beneficiary is receiving services in more than one setting, it must be clear in which setting a beneficiary receives a particular service or assistance. See part G of Section 215.200, Section 216.201 and Sections 220.110 through 220.112.

See Section 215.230 for information about service plan revision requirements.

REPEAL

215.310 Identifying Individual Physical Dependency Needs 1-1-19

A. A personal care provider must identify and describe (*assess*) a beneficiary's need for assistance (*physical dependency need*) with individual task components of routines and activities of daily living in the form designated by DHS.

B. The provider must describe the type, amount, frequency and duration of assistance required for each task thus identified (*individualized service plan*) in the form designated by DHS.

C. A personal care aide furnishes assistance (*service*) with the individual task components of routines and activities of daily living, in accordance with the individualized service plan authorized by DHS professional staff or contractor(s) designated by DHS.

D. The following examples illustrate how to facilitate service plan development and service documentation by assessing the beneficiary at the level of individual task performance:

E. A beneficiary is unable to pick up slender items, such as spoons and toothbrushes, and sometimes loses his grip on those objects.

1. This condition causes similar physical dependency needs in different routines.

Sample Assessment Entry	
Eating:	The beneficiary needs someone to place eating utensils in his grasp and to retrieve them when he drops them.
Oral hygiene:	The beneficiary needs someone to place his toothbrush in his grasp and to retrieve it when he drops it.

2. The service plan will contain instructions to the aide similar to this Sample Service Plan Entry.

Sample Service Plan Entry	
Eating:	Place the (*object*) in (*beneficiary's name*)'s grasp.
Oral hygiene:	Retrieve the (*object*) when *(beneficiary's name)* drops it and replace the (*object*) in his grasp.

F. Medicaid Program staff reviewing a personal care provider's records must be able to readily observe that the service plan logically follows the assessment, which is possible only if the provider assesses the beneficiary at the individual task performance level.

1. Additionally, the aide's daily service documentation and the registered nurse's case notes must address the requirements and objectives of the service plan.

2. There must be a clear and logical relationship of each component of this documentation to each other component and to the service continuum.

215.320 Identifying Frequency of In-Person Supervisory Visits 7-1-20

A. A registered nurse designated by the personal care provider must identify and recommend the frequency for in-person visits to be made by the supervisor of the personal care aide, based on the specific needs of the beneficiary.

B. The frequency of in-person visits shall be at least every 365 days and shall be determined jointly by the personal care provider and the beneficiary or the beneficiary's legal representative, based on the recommendations of the registered nurse.

C. The individualized service plan must identify the agreed frequency, the risk factors that are specific to that beneficiary, and a justification for the agreed frequency. The risk factors identified by the service plan must include without limitation any relevant medical diagnoses; the beneficiary's mental status; the presence of family or other residents in the beneficiary's home, and the frequency of their presence; and the beneficiary's physical dependency needs, including the activities of daily living (ADL) with which the beneficiary needs assistance.

D. If the frequency identified in the service plan is less than the frequency recommended by the registered nurse, the service plan shall identify the medical justification for the reduced frequency.

E. If the beneficiary has a significant change of condition affecting a risk factor, the registered nurse shall review the frequency of in-person visits and recommend changes as appropriate.

REPEAL

215.330 Service Plan Revisions 7-1-20

NOTE: Subsections (A) (3) and (B) are not applicable to IndependentChoices program.

A. A personal care provider must amend a beneficiary's individualized service plan to document any permanent service plan changes before the provider amends service delivery.

1. For purposes of this requirement, a **permanent** service plan change is one expected to last thirty (30) days or more.

2. Service plan revisions must be made if a beneficiary's condition changes to the extent that the personal care provider must modify, add or delete tasks.

3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.

a. Changes in the amount, frequency or duration of a service must be documented in the medical record,

b. The reasons for the service variances must be written daily in the service documentation.

4. A service plan revision must be authorized by DHS professional staff or contractor(s) designated by DHS only if the provider requests to increase or decrease the total monthly hours. DHS professional staff or the DHS contractor will review the request and determine, based on application of the Task and Hour Standards described in Section 240.100, the amount of adjustment to make in prior authorized minutes. DHS professional staff or the DHS contractor will revise the number of minutes in Interchange.

B. Providers may not reduce a beneficiary's services without prior authorization by DHS professional staff or contractor(s) designated by DHS

C. The personal care provider must document medical reasons for service plan revisions.

D. The new beginning date of service is the date authorized by DHS professional staff or contractor(s) designated by DHS.

E. Service plan revisions and updates since the previous assessment must remain with the service plan. Updates since the previous assessment must include documentation of when and why the change occurred.

REPEAL

215.350 Service Plan Requirements for a Single Provider with a Single Beneficiary at Multiple Service Locations 10-1-07

A. Only one service plan for personal care services is necessary when a single provider is delivering services to a beneficiary in more than one authorized location.

B. The service plan must identify which tasks the aide performs at each location.

1. When the aide performs the same or similar tasks at each location, the service plan must separately identify the tasks at each location in accordance with the criteria in Sections 215.300 and 215.310.

2. The aide's service documentation must reflect the service location distinctions.

215.351 Service Plan Requirements for Multiple Providers 7-1-20

When a beneficiary receives services from more than one personal care provider, each provider must comply with the following requirements.

A. Each provider must create an individualized service plan and collaborate with the beneficiary's other personal care provider(s) to create a comprehensive service plan.

1. Each comprehensive service plan must clearly state which provider provides which services, where and on which day(s) they do so, which time(s) of day they furnish services and the maximum and minimum amount of time per day and per week that the provider will take to perform those services.

2. Each comprehensive service plan must be authorized, signed and dated by the provider.

B. Each time a personal care provider intends to revise or renew a comprehensive service plan, that provider must notify the beneficiary's other personal care provider(s) to agree on the revision or renewal.

C. If the providers cannot agree on a comprehensive service plan, plan revision or plan renewal, the providers shall submit the various alternatives to DHS professional staff or contractor(s) designated by DHS, who shall determine the terms of the final comprehensive service plan.

D. Any Medicaid provider having knowledge that another Medicaid provider has failed to comply with a service plan, including a comprehensive service plan, shall notify the DMS Director of such failure within ten (10) business days of the occurrence, or sooner if the beneficiary's life or health is threatened.

215.360 Changes of Condition 7-1-20

A. The individualized service plan must identify individualized, beneficiary-specific standards, based on the identified risk factors, for when a caregiver or supervisor must document and report any significant change in the beneficiary's condition. A significant change is one that exhibits a major decline or improvement in the physical or mental health status of the beneficiary.

B. If a caregiver or supervisor observes a significant change of condition, the caregiver or supervisor must document and report the change of condition as required by the change-reporting standards contained in the beneficiary's individualized service plan. Documentation must include the time and date the change was identified by the caregiver and a full description of the change.

C. Within twenty-four (24) hours of a significant change of condition being reported, a registered nurse must evaluate and document an assessment of the beneficiary, including without limitation the potential changes of condition.

D. A change of condition under this section may result in a change to the service plan or to the frequency of supervisory visits, but it does not automatically result in a new Independent Assessment by the DHS Independent Assessment Contractor. Independent Assessments or Reassessments are governed by the provisions of the Arkansas Independent Assessment Medicaid Provider Manual.

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216.000 Coverage 7-1-20

A. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, Level II assisted living facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State
2. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family"
3. Prior authorized by DHS professional staff or contractor(s) designated by DHS
4. Provided by an individual who is
   a. Qualified to provide the services;
   b. Supervised by an individual meeting the qualification set forth in Section 220.100; and,
   c. Not a member of the beneficiary's family; OR
   d. Qualified to provide the service according to approved policy in the IndependentChoices Program.
5. Furnished in the beneficiary's home or, at the State's option, in another location

B. Medicaid restricts coverage of personal care to services directly helping a beneficiary with certain specified routines and activities, regardless of the beneficiary's ability or inability to execute other non-covered routines and activities. Personal care services may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in this section.

C. Travel Time of Personal Care Aide Accompanying Beneficiary:

1. Personal care only covers personal care aide travel time when all of the following apply:

   a. The personal care aide accompanies the beneficiary in the same vehicle as the beneficiary travels to and returns from a community location for medical appointment or community activity;

   b. The travel time billed is solely for necessary time in transit from the beneficiary's home to the community location and the return travel from the community location to the beneficiary's home;

   c. The beneficiary's participation in the local community activity is for the benefit of the beneficiary and to meet the beneficiary's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the personal care aide, a family member, the driver, or other passengers);

   d. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;

   e. The beneficiary's Individualized Service Plan includes Personal Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;

   f. While in transit to and from the community location the beneficiary requires, or is likely to require given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility/ambulating; and

   g. The travel time is reasonable given driving distances, traffic conditions, and weather, with time and locations documented.

2. Travel time is not reimbursable if any other adult person accompanying (or driving) the beneficiary is a family member and is reasonably able to assist the beneficiary in transit if needed.

3. Travel time accompanying a beneficiary will count against the total number of Personal Care hours per month authorized in the participant's Individualized Service Plan and prior authorization.

4. Requesting Hours for Travel Time of Attendant Accompanying Participant:

   Beneficiaries vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of a personal care aide accompanying a beneficiary is incident to but itself not the ADL task of toileting or the ADL task of mobility/ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Personal Care hours, if any, associated solely with travel time of a personal care aide accompanying a beneficiary to a medical visit or community activity.

   For an ARChoices beneficiary, the number of hours allowed for travel time of a personal care aide will be determined by the DHS nurse in the beneficiary's Person-Centered Service Plan.

   For other beneficiaries, the provider may include in the prior authorization request justification for travel time, based on the beneficiary's community activities, need for

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a personal care aide to accompany them, and the distances and roundtrip travel times typically involved. Based on this information and consistent with the above requirements, the contractor designated by DHS to process prior authorization requests, or if there is no contractor designated by DHS, DHS professional staff, may increase the number of Personal Care hours per month covered in the Individualized Service Plan and prior authorization to reasonably accommodate the travel time of a personal care aide accompanying the beneficiary.

216.100 Definitions of Terms

216.110 Routines and Activities of Daily Living 7-22-10

In the Arkansas Medicaid Personal Care Program, essential chores are referred to as "routines." Beneficiaries must eat, dress, void the bladder and bowels, bathe and perform other personal hygiene chores.

216.120 Instrumental Activities of Daily Living 7-22-10

In the Arkansas Medicaid Personal Care Program, certain chores are referred to as "instrumental activities of daily living" or "activities." For example, beneficiaries need to wash their clothes and linens (laundry), clean their immediate living area (incidental housekeeping) and purchase the items necessary to maintain themselves (shopping).

216.130 Tasks 7-22-10

A. "Tasks" are components of routines and instrumental activities of daily living. For example:

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1. Meal preparation is a routine that involves a number of tasks: removing food from the refrigerator or pantry, opening food containers and packages, processing meats or vegetables, mixing ingredients, setting oven temperatures and adjusting stovetop settings; setting out, using, washing and putting away cooking and eating utensils, etc.

2. Laundry is an activity of daily living. Some tasks associated with the laundry activity are: sorting items to be washed, measuring detergent and additives, adjusting machine settings, extracting wet items from the washer and dry items from a dryer, hanging wet items on a line to dry, etc.

B. "Individual task component" and "task component" have the same meaning as "task." The words "routine," "activity" and "task," retain their meaning regardless of whether the person performing them is the beneficiary, the aide or any other person.

216.140 Service 1-1-19

A. A "personal care service" is a covered task or a related group of covered tasks.

B. A "personal care aide service" is a personal care service.

1. "Personal care services" and "personal care aide services" are interchangeable expressions that mean "covered tasks."

2. Only a certified personal care aide, or an individual who meets or exceeds the qualifications of a personal care aide, as defined in Section 222.100, who is also in the employ of a Medicaid-enrolled personal care provider, may provide covered personal care services or personal care aide services as defined in this manual.

C. As a condition of coverage and reimbursement, all personal care services must be:

1. Reasonable and medically necessary, supported by the individual's latest nursing evaluation, and consistent with the individual's service plan;

2. Expressly authorized in the individual's approved personal care services prior authorization;

3. Not available from another source (including, but not limited to, family members, a member of the beneficiary's household, or other unpaid caregivers; another Medicaid State Plan covered service; the Medicare program; the beneficiary's Medicare Advantage plan or Medicare prescription drug plan; or the beneficiary's private long-term care, disability, or supplemental insurance coverage);

4. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services, including without limitation the aggregate weekly or monthly limits calculated by DHS for the beneficiary in accordance with the Arkansas Medicaid Task and Hours Standards;

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

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

D. Personal care services exclude all of the following:

1. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including, but not limited to, aseptic or sterile procedures, application of dressings, medications administration, injections, observation and assessment of health conditions, insertion, removal, or irrigation of catheters, tube or other enteral feedings, tracheostomy care, oxygen administration, ventilator care, drawing blood, and care and maintenance of any medical equipment;

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

3. Services provided for a person other than the beneficiary, including but limited to a provider, family member, household resident, or neighbor;

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

5. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and

6. Mental health counseling or services.

REPEAL

216.200 Tasks Associated with Covered Routines **10-1-12**

Effective for dates of service on and after March 1, 2008, all regulations regarding personal care aides' logging beginning and ending times (i.e., time of day) of individual services, and all references to any such regulations, do not apply to RCF and ALF Personal Care providers.

216.201 Simultaneous Services and Congregate Settings **10-13-03**

Simultaneous services to two beneficiaries or to more than two beneficiaries in a congregate setting may be covered provided the service plan and the scope, duration and frequency of each individual's services are directly related to the needs of the individual as reflected in the RN's assessment of the individual's physical dependency needs. Part H of Section 215.300, Sections 216.211 and Sections 220.110 through 220.112 provide additional information and include instructions for determining the relative amount of coverage available per beneficiary for tasks performed for multiple beneficiaries.

~~216.210 Eating~~

~~See Section 216.212, Consuming Meats, below~~

~~216.211 Meal Preparation~~ ~~10-13-03~~

~~A. Meal preparation is a covered personal care service if the aide's logged service time meets certain conditions:~~

~~1. The aide must make reasonable efforts to prepare servings of a size or an amount commensurate with the beneficiary's nutritional needs and normal appetite. For the purpose of these rules a provider will be presumed to have made a reasonable effort unless the quantity of food prepared exceeds by more than 100% the beneficiary's need for a meal or meals. An example follows.~~

~~a. An aide prepares soup for a beneficiary.~~

~~b. The beneficiary typically consumes 8 oz. of soup per meal.~~

~~c. If the aide prepares 16 oz. or less per meal, the provider will be presumed to have made reasonable efforts to limit the service to the beneficiary's needs.~~

~~d. However, if the aide prepares 3 quarts of soup per meal, the time required is presumed unreasonable and the provider is not entitled to reimbursement. Refer to part E of this section for rules regarding simultaneous services for two or more beneficiaries.~~

~~2. Medicaid does not cover an aide's time at meal preparation tasks or assisting at meal preparation tasks for individuals who are not personal care beneficiaries or whose personal care service plan does not include meal preparation tasks or assistance with meal preparation tasks.~~

~~a. The aide must document the meal preparation tasks in the beneficiary's personal care service record.~~

~~b. Refer to part E of this section for rules regarding simultaneous services for two or more beneficiaries.~~

~~B. This routine includes the tasks involved in:~~

~~1. Preparing and serving a meal and~~

~~2. Cleaning articles and utensils used in the preparation of the meal.~~

~~C. To be eligible to receive personal care assistance with meal preparation, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to perform meal preparation tasks or to clean up the utensils and preparation area.~~

~~D. The aide's service in the beneficiary's meal preparation routine is hands-on assistance with meal preparation tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.~~

~~E. Simultaneous services to two beneficiaries or to more than two beneficiaries in a congregate setting may be covered if the rules below and the regulations stated at Section 216.201 and Sections 220.110 through 220.112 are followed.~~

~~1. Medicaid will cover the actual time attributable to the individual beneficiary when services, such as meal preparation, are delivered simultaneously.~~

~~2. Refer to Section 220.111 for the methodologies required to determine the amount of time attributable to the individual beneficiary.~~

~~F. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following example.~~

REPEAL

1. A beneficiary is able to remove items from the refrigerator and pantry and to perform most tasks related to meal preparation.

2. The assessment states, "Beneficiary's arthritic condition prevents him from opening bottles and jars with small tops and from gripping eating utensils."

3. A related entry in the service plan would be similar to:

Meal preparation:

a. The aide will open bottles and jars with lids too small for the beneficiary to negotiate.

b. The aide will operate cooking and serving utensils the beneficiary cannot grip or pick up.

G. The complete meal-preparation routine might include additional instructions. These examples are simply to illustrate that instructions at the task level facilitate correlation of physical dependency needs with individualized services.

216.212 Consuming Meals 1-1-19

A. The service related to this routine includes the tasks involved in giving the beneficiary hands-on assistance to consume a meal and fluids. It does not include meal preparation.

B. To receive personal care assistance with this routine, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to execute tasks such as cutting food in bite-size pieces or negotiating food from plate to mouth.

C. The related service is hands-on assistance with the beneficiary's physical dependency needs to accomplish eating. The aide may only assist with or perform functional tasks the beneficiary cannot physically perform in accordance with the beneficiary's physical dependency needs described in the assessment.

REPEAL

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following examples.

1. An assessment states, "Beneficiary's arthritis prevents him from gripping slender objects such as eating utensils with either hand." The related task in the service plan is for the aide to "cut items into bite-size pieces and deliver them from plate to mouth for the beneficiary."

2. The same assessment also states, "Effects of a recent stroke cause the beneficiary to choke or to risk choking unless food is pureed."

a. The related task in the service plan is for the aide to "puree food items for the beneficiary."

b. A separate statement, "The aide will deliver spoonfuls from plate to mouth for the beneficiary," addresses the arthritic condition.

E. Observing a beneficiary eat is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the beneficiary's eating places the beneficiary at risk of injury or harm.

216.240 Personal Hygiene 1-1-19

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's personal hygiene. "Personal hygiene" means grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene.

1. An aide's time spent reminding a beneficiary to perform personal hygiene tasks is not a covered service unless the beneficiary's service plan includes hands-on assistance with personal hygiene.

2. An aide's time spent observing a beneficiary perform personal hygiene tasks is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the activity places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency preventing or substantially impairing their ability to perform hair and skin care and grooming, oral hygiene, shaving and nail care.

C. The aide's service in regard to this routine is hands-on assistance with personal hygiene tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.250 Bladder and Bowel Requirements 10-13-03

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's elimination routines.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To safely enter and exit the bathroom, or

2. To properly complete elimination routines without assistance.

C. The aide's service in this routine is hands-on assistance with bladder-and-bowel-voiding tasks the beneficiary cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

REPEAL

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.260 Medication 1-1-19

A. Personal care aide services regarding medication routines are covered only to the extent that they are permitted by the Arkansas Nurse Practice Act and implementing rules and regulations.

B. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's medications.

C. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability to safely and correctly dispense and ingest orally administered prescription medications.

D. The aide's service in regard to the beneficiary's medication routines is hands-on assistance with tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment, as described in the Arkansas State Board of Nursing Position Statement 97.2.

E. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.270 Mobility and Ambulation 1-1-19

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's mobility and ambulation. "Mobility and ambulation" mean functional mobility

(moving from seated to standing, getting in and out of bed) and mastering the use of adaptive equipment.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To turn themselves in bed,

2. To move from bed to chair (including wheelchair or motorized chair),

3. To walk (alone or with a device) or

4. To operate a push wheelchair or a motorized chair.

C. The aide's service in this routine is hands-on assistance with ambulation and mobility tasks the beneficiary cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.300 Tasks Associated with Covered Activities of Daily Living 10-13-03

A. The tasks constituting this group of services are those involved in hands-on assistance with the beneficiary's incidental housekeeping, laundry and shopping. Tasks associated with activities of daily living are not covered if the aide is also performing the tasks for other individuals of the same household, home or facility

1. Who are not Personal Care Program beneficiaries, or

2. Who are Personal Care Program beneficiaries whose service plans do not require the [illegible] tasks.

REPEAL

B. To be eligible for services associated with activities of daily living:

1. A beneficiary must exhibit one or more physical dependency need(s) related to his or her impaired ambulation, mobility or functional capability within the service delivery location;

2. The personal care assessment must describe the impairments that prevent or impede the beneficiary's ability to move freely and safely about the living area and to perform necessary tasks and

3. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.310 Incidental Housekeeping 1-1-19

A. "Incidental housekeeping" means cleaning of the floor, furniture, and areas that are directly used by the beneficiary.

B. The aide's service in regard to incidental housekeeping is hands-on assistance with covered tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

C. The assessment must describe the impairments that prevent or impede the beneficiary's ability to move freely and safely about their living area and clean the floor and furniture in the area they occupy.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.320 Laundry 10-13-03

A. "Laundry" means laundering only items incidental to the care of the beneficiary. Laundry is not a covered service if it includes laundry services for the convenience of non-Medicaid eligible individuals residing in the same service delivery location. For example,

1. A spouse requires assistance with laundry. The remaining cohabiting spouse is not a Medicaid beneficiary.

a. The cohabiting spouse is usually considered an alternative resource.

b. It is presumed that the cohabiting spouse will perform routine laundry services for the household.

2. If, however, the Medicaid-eligible spouse is incontinent of bowel or bladder:

a. Laundry may be a covered service to the extent that it is a service designed to address the beneficiary's immediate needs, e.g., cleaning soiled bedding or clothing.

b. If the laundry service is designed to address the beneficiary's immediate needs, the aide may top up an incomplete washer-load by including items used by the remaining cohabiting spouse and the service will still be covered.

B. The aide's service in regard to laundry is hands-on assistance with covered laundry tasks the beneficiary cannot physically perform, according to the beneficiary's physical dependency needs detailed in the assessment.

C. The assessment must also describe the impairment(s) that prevent or impede the beneficiary's ability to move freely and safely about his or her living area and to perform some or all of the laundry tasks involved in maintaining his or her own clothing and bed and bath linens.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

REPEAL

216.330 Shopping 1-1-19

"Shopping" means services to address the beneficiary's physical dependency need by assisting the beneficiary with shopping or by shopping for the beneficiary.

A. Assisting a beneficiary with shopping is a covered service only when the beneficiary is purchasing items that are necessary for the beneficiary's health and maintenance in the home (such as food, clothing, and other essential items) and that are used primarily by the beneficiary or, are used primarily by the beneficiary and other Personal Care Program beneficiaries who reside in the same service delivery location, and whose service plans include assistance with shopping.

1. The aide's service in regard to shopping is hands-on assistance with covered shopping tasks the beneficiary cannot physically perform, according to the beneficiary's physical dependency needs detailed in the assessment.

2. The assessment must describe the impairment(s) that prevent or impede the beneficiary's ability to move freely and safely in stores and perform some or all of the shopping tasks necessary to maintain his or her health and comfort.

3. The service plan must correlate each required task with the beneficiary's corresponding physical dependency need. See Sections 215.300 and 215.310.

B. If the service plan requires the aide to shop for the beneficiary:

1. The beneficiary, or the beneficiary's representative, has freedom of choice to describe the items to be purchased (within the constraints stated herein) for the beneficiary's maintenance in the home.

2. The beneficiary has freedom of choice to designate the individual stores at which to purchase the items.

a. If the designated stores are within the beneficiary's normal retail service area the service plan need not identify the specific stores.

b. If the designated stores are outside the normal retail service area for residents of the beneficiary's locale, the service plan must include the stores' names and locations.

C. If there are other members of the beneficiary's household, the service plan must not include shopping, or assistance with shopping, unless the assessment fully documents all reasons each household member can neither:

1. Assist with or do the beneficiary's shopping, nor

2. Arrange for someone else to assist with or to do the beneficiary's shopping.

D. Medicaid provides no additional coverage for an aide's mileage incurred performing shopping tasks.

216.400 Personal Care Aide Service and Documentation Responsibility 1-1-19

NOTE: This section is not applicable to the IndependentChoices program.

It is the responsibility of the personal care aide to accomplish the following:

A. Perform authorized tasks as instructed by the supervising RN or QIDP.

B. Maintain a service log.

1. The service log must be completed at the time services are delivered. In the service log it is necessary to itemize the time spent on each individual ADL or IADL task for a given beneficiary, provided those tasks were performed by the same personal care aide in the same visit on the same day and at the same location.

2. If the service log is not completed concurrently with service delivery, coverage may be denied.

3. Refer to Sections 220.110 through 220.112 for service log requirements.

C. Provide necessary documentation showing the date, time, location, nature and scope of authorized services delivered.

D. Provide necessary documentation showing the date, time, location, nature and scope of emergency services delivered.

1. If an emergency requires the personal care aide to perform a personal care service task not included on the personal care service plan, the personal care aide must receive when possible, prior approval from the supervising registered nurse or QIDP to perform the task.

2. When prior approval is not possible, the personal care aide may perform the emergency service task, but she or he must receive post-service approval from the supervising registered nurse or QIDP.

3. Document the circumstances in detail, describing:

a. The nature of the emergency,

b. The action or task required to resolve the emergency and

c. The justification for the unscheduled service.

E. If a personal care aide does not perform a particular task scheduled on the service plan, the personal care aide must document why she or he did not perform the task that day.

217.000 Benefit Limits 1-1-19

REPEAL

A. Medicaid imposes a 64-hour benefit limit, per month, per beneficiary, on personal care aide services for beneficiaries aged 21 and older.

B. The 64-hour limitation applies to the monthly aggregated hours of personal care aide services.

C. This 64-hour limit on personal care services for beneficiaries aged 21 and older is a firm cap for which there will be no extensions or exceptions.

D. The hour limit does not apply to beneficiaries under age 21.

220.000 Service Administration 10-1-12

Effective for dates of service on and after March 1, 2008, RCF and ALF Personal Care providers are exempt from all requirements of Sections 220.000 through 221.000—whether by explicit statement or reference—to record or log the time of day (clock time) when a service begins or ends.

220.100 Service Supervision 7-1-20

A. The provider must assure that the delivery of personal care services by personal care aides is supervised.

1. A supervisor must be a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.

2. Alternatively, a Qualified Intellectual Disabilities Professional (QIDP) may fulfill the supervision requirement for personal care services to beneficiaries residing in alternative living situations or alternative family homes, licensed and certified by DPSQA as personal care providers.

3. An individual who personally provides personal care services to a beneficiary may not supervise another personal care aide providing personal care services to that same beneficiary.

B. The supervisor has the following responsibilities.

1. The supervisor must instruct the personal care aide in

a. Which routines, activities and tasks to perform in executing a beneficiary's service plan;

b. The minimum frequency of each routine or activity; and

c. The maximum number of hours per month of personal care service delivery, as authorized in the service plan.

2. At least once a month, the supervisor must

a. Review the aide's records;

b. Document the record review; and

c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

3. At least annually, the supervisor must visit the beneficiary at the service delivery location to conduct on-site evaluation.

a. Medicaid requires that at least one of these supervisory visits annually must be when the aide is not present.

b. If the frequency of in-home supervisory visits for a beneficiary is greater than

REPEAL

one annually, at least one visit must be while the aide is present and furnishing services.

4. When the aide is present during the visit the supervising RN or QIDP must

a. Observe and document;

(1). The condition of the beneficiary;

(2). The type and quality of the personal care aide's service provision;

(3). The interaction and relationship between the beneficiary and the aide; and

(4). Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.

b. Consult with the agency-designated registered nurse regarding modifications to the service plan, if necessary, based on the observations and findings from the visit and document the consultation in the beneficiary's records; and,

c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

5. When the aide is not present during the visit, the supervisor must

a. Observe and document the condition of the beneficiary;

b. Observe and document, from available evidence, the type and quality of the personal care aide's service provision;

c. Observe, document, and report any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits;

d. Query the beneficiary or the beneficiary's representative and document pertinent information regarding the beneficiary's opinion of:

(1). The type and quality of the aide's service;

(2). The aide's conduct; and

(3). The adequacy of the working relationship of the beneficiary and the aide.

e. Consult with the agency-designated registered nurse regarding modifications to the service plan, if necessary, based on observations and findings from the visit and document the consultation in the beneficiary's records; and

f. Further instruct the aide, if necessary, and document the nature of and the reasons for further instructions.

C. The provider must review the service plan and the aide's records as necessary. The review will ensure that the daily aggregate time estimate in the service plan accurately reflects the actual average time the aide spends delivering personal care aide services to a beneficiary.

REPEAL

220.110 Service Log **1-1-13**

NOTE: This section is not applicable to the IndependentChoices program.

Instructions in this section apply to all beneficiaries' service logs, with one exception. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers maintain their service logs by means of the format and instructions of form DMS-873, *"Arkansas Department of Human Services Division of Medical Services Instructions for completing the Service Log & Aide Notes For Personal Care Services in a Residential Care Facility"*. Effective for dates of service on and after March 1, 2008, form DMS-873 is found in Section V of this manual and DMS requires that RCF Personal Care providers use it exclusively for its designated purposes. See Section 220.111 for special documentation requirements regarding multiple beneficiaries who are attended by one aide. Those instructions at Section 220.111 do not apply to RCF Personal Care providers, effective for dates of service on and after March 1, 2008. See Section 220.112 for special documentation requirements regarding multiple aides attending one beneficiary. Those instructions at Section 220.112 do not apply to RCF Personal Care providers, effective for dates

of service on and after March 1, 2008. The examples in these sections and in Section 220.110 are related to food preparation, but personal care beneficiaries may receive other services in congregate settings if their individual assessments support their receiving assistance in that fashion.

A. Medicaid covers only service time that is supported by an aide's service log.

B. Service time in excess of the maximum service time estimates in the authorized service plan is covered only when the provider complies with the rules in Sections 215.330 and 220.110 through 220.112.

C. The time estimate in the service plan is not service documentation. It is an estimate of the anticipated minimum and maximum daily duration of medically necessary personal care aide service for an individual beneficiary.

D. For each service date, for each beneficiary, the personal care aide must record the following:

1. The time of day the aide begins the beneficiary's services.

2. The time of day the aide ends a beneficiary's services. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.

3. Notes regarding the beneficiary's condition as instructed by the service supervisor.

4. Task performance difficulties.

5. The justification for any emergency unscheduled tasks and documentation of the prior approval or post approval of the unscheduled tasks.

6. The justification for not performing any scheduled service plan required tasks.

7. Any other observations the aide believes are of note or that should be reported to the supervisor.

REPEAL

E. If the aide discontinues performing service-plan-required tasks at any time before completing all of the required tasks for the day, the aide will record:

1. The beginning time of the non-service-plan-required activities,

2. The ending time of the non-service-plan-required activities,

3. The beginning time of the aide's resumption of service-plan-required activities and

4. The beginning and ending times of any subsequent breaks in service-plan-required aide activities.

5. If the aide discontinues or interrupts the beneficiary's service-plan required activities at one location to begin service-plan-required activities at another location, the aide must record the beginning and ending times of service at each location.

220.111 Service Log for Multiple Beneficiaries 1-1-19

Effective for dates of service on and after March 1, 2008, the rules in this section do not apply to RCF and ALF Personal Care providers.

An aide delivering services to two or more beneficiaries at the same service location, during the same period (discontinuing or interrupting a beneficiary's service plan required tasks to begin or resume service plan required tasks for another beneficiary, or performing an authorized service simultaneously for two or more beneficiaries. For example, cleaning a living space used by more than one beneficiary or preparing a meal that will be eaten by more than one beneficiary), must comply with the applicable instructions in parts A or B below:

A. If providing services for only two beneficiaries, the aide must record in each beneficiary's service log

1. The name of each individual for whom they are simultaneously performing personal care service;

2. The beginning and ending times of service for each beneficiary and the beginning and ending times of each interruption and of each resumption of service; and

3. Which services or services were performed simultaneously for more than one beneficiary.

B. If services are performed in a congregate setting (more than two beneficiaries) the service log must state

1. The actual time of day (clock time) that the congregate services begin and end;

2. The number of individuals, and the name of each individual, both Medicaid-eligible and non-Medicaid-eligible, who received the documented congregate services during that period; and.

3. Which services or services were performed simultaneously for more than one beneficiary.

C. For services performed simultaneously for more than one beneficiary, the provider must split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took 20 minutes, the aide would document only half of that time - 10 minutes - for each beneficiary for the task).

D. If the beneficiaries have different providers and different aides, both providers may not bill for cleaning a shared living space (e.g., a bathroom) or performing another task that benefits both beneficiaries (e.g., preparing a meal for both). The providers must determine which of their aides will be responsible for performing the task. The provider whose aide did not perform the task may not bill for it.

REPEAL

E. A provider who knowingly bills twice for the same service or for a service that has been billed by another provider is committing a fraudulent act and may be referred by DHS to the Medicaid Fraud Control Unit.

220.112 Service Log for Multiple Aides with One Beneficiary **10-1-12**

Effective for dates of service on and after March 1, 2008, the rules in this section do not apply to RCF and ALF Personal Care providers.

When two or more aides attend a single beneficiary, each aide must record the beginning and ending times of each service plan required routine or activity of daily living that she or he performs for the beneficiary, regardless of whether another aide is performing a service plan required routine or activity of daily living at the same time.

220.113 Service Logging by Electronic Media **3-1-05**

A. Personal care aides may log the times that they begin and end services, as well as the services themselves, by electronic media, such as telephony.

B. Electronic signatures, as permitted under Arkansas law and as defined in Section IV of this manual, are allowed in the Personal Care Program.

C. All Arkansas Medicaid documentation requirements must be met, regardless of documentation media.

221.000 Documentation **7-1-20**

REPEAL

NOTE: This section is not applicable to the IndependentChoices program.

The personal care provider must keep and make available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Human Services and its authorized agents or officials; records including:

A. If applicable, certification by the Home Health State Survey Agency as a participant in the Title XVIII Program. Agencies that provided Medicaid personal care services before July 1, 1986 are exempt from this requirement.

B. When applicable, copies of pertinent residential care facility license(s) issued by the Office of Long Term Care.

C. Medicaid contract.

D. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers will be required, when requested by DHS, to provide payroll records to validate service plans and service logs.

E. Documents signed by the supervisor or, Qualified Intellectual Disabilities Professional (QIDP), or agency-designated registered nurse including without limitation:

1. The initial and all subsequent assessments.

2. Instructions to the personal care aide regarding:

a. The tasks the aide is to perform;

b. The frequency of each task; and

c. The maximum number of hours and minutes per month of aide service authorized by DHS professional staff or contractor(s) designated by DHS.

3. Notes arising from the supervisor's visit to the service delivery location, regarding:

a. The condition of the beneficiary;

b. Evaluation of the aide's service performance;

c. The beneficiary's evaluation of the aide's service performance; and,

d. Difficulties the aide encounters performing any tasks.

4. The service plan and service plan revisions:

a. The justifications for service plan revisions;

b. Justification for emergency, unscheduled tasks;

c. Documentation of prior or post approval of unscheduled tasks; and

d. Recommendation or justification for the frequency needed for in-person supervisory visits.

F. Any additional or special documentation required to satisfy or to resolve questions arising during, from or out of an investigation or audit. "Additional or special documentation," refers to notes, correspondence, written or transcribed consultations with or by other healthcare professionals (i.e., material in the beneficiary's or provider's records relevant to the beneficiary's personal care services, but not necessarily specifically mentioned in the foregoing requirements). "Additional or special documentation," is not a generic designation for inadvertent omissions from program policy. It does not imply and one should not infer from it that, the State may arbitrarily demand media, material, records or documentation irrelevant or unrelated to Medicaid Program policy as stated in this manual and in official program correspondence.

G. The personal care aide's training records, including:

1. Examination results;

2. Skills test results; and

3. Personal care aide certification.

H. The personal care aide's daily service notes for each beneficiary, reflecting:

1. The date of service;

2. The routines performed on that date of service, noted to affirm completion of each task;

3. The time of day the aide began performing the first service-plan-required task for the beneficiary;

4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function;

5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks; and,

6. The time of day the aide completed the last service-plan-required task for the day for that beneficiary.

I. Notes, orders and records reflecting the activities of the physician, the agency-designated registered nurse, the supervisor or QIDP, the aide and the beneficiary or the beneficiary's representative; as those activities affect delivering personal care services.

222.000 Personal Care Aide Qualifications and Certification

222.100 Personal Care Aide Selection, Training and Continuing Education 1-1-13

REPEAL

NOTE: This section is not applicable to the Independent Choices program.

A. The beneficiary must receive Medicaid Personal Care services from a certified personal care aide who is not a member of the beneficiary's family. The Medicaid agency defines, "a member of the beneficiary's family" as:

1. A spouse.

2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent.

3. Legal guardian of the person.

4. Attorney-in-fact granted authority to direct the beneficiary's care.

B. Personal care aides must be selected on the basis of such factors as:

1. A sympathetic attitude toward the care of the sick,

2. An ability to read, write and carry out directions and

3. Maturity and ability to deal effectively with the demands of the job.

C. The personal care provider is responsible for ensuring that personal care aides in its employ are:

1. Certified as personal care aides,

2. Participate in all required in-service training and

3. Maintain at least "satisfactory" competency evaluations from their supervisors in all personal care tasks they perform.

D. DMS will deem valid the Certified Personal Care Aide status of an individual with

1. Personal Care Aide Certification conferred before April 1, 1998, and

2. Documentation of ongoing compliance with Personal Care Program policies in effect before April 1, 1998, regarding continuing education and competency requirements.

3. The deemed status will be effective for dates of service on and after April 1, 1998, conditional upon the certified aide's continuing compliance with program policies.

E. A qualified training program (see Section 222.110) may waive the training component of personal care aide certification requirements for individuals who can document previous experience as personal care aides, nurse's aides or similar occupations requiring the same skills needed by personal care aides.

1. The qualified training program must verify the individual's previous experience.

2. The individual must pass the personal care aide examinations and skills tests.

F. Certified Nursing Assistants with current valid credentials are deemed qualified personal care aides.

G. Certified Home Health Aides with current valid credentials are deemed qualified personal care aides.

222.110 Conduct of Training 7-1-20

NOTE: This section is not applicable to the IndependentChoices program.

A. A personal care aide training program may be offered by any organization meeting the standards in this section for:

1. Instructor qualifications;

2. Content and duration of personal care aide training; and,

3. Documentation of personal care aide training and verification.

REPEAL

B. Personal Care provider agencies conducting personal care aide training must maintain their training program documentation.

C. Personal Care providers hiring or contracting with individuals or organizations to conduct personal care aide training must maintain the individual's or organization's training program documentation. The provider is responsible for maintaining the training program documentation file.

D. Required training program documentation includes:

1. The number of hours each of classroom instruction and supervised practical training;

2. Names and qualifications of instructors and copies of licenses of supervising registered nurses;

3. Street addresses and physical locations of training sites, including facility names when applicable;

4. Maintaining samples of the forms used to document the beneficiary's consent to the training in their home, if the training includes supervised practical training in the home;

5. The course outline;

6. Lesson plans;

7. The instructor's methods of supervising trainees during practical training;

8. The training program's methods and standards for, determining whether a trainee can read and write well enough to perform satisfactorily the duties of a personal care aide;

9. The training program's method of evaluating written tests, oral exams (if any) and skills tests, including the relative weights of each in the minimum standard for successful completion of the course;

10. The training program's minimum standard for successful completion of the course; and

11. Evidence and documentation of successful completions (Certificates supported by internal records).

E. Personal Care providers are responsible for the upkeep of all required training program documentation.

F. A qualified personal care aide training and certification program must include instruction in each of the subject areas listed in Section 222.120.

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

1. Minimum classroom training time is twenty-four (24) hours.

2. Minimum time for supervised practical training is sixteen (16) hours.

a. "Supervised practical training" means training in a laboratory or other setting in which:

(1). The trainee demonstrates knowledge by performing tasks on an individual while

(2). The trainee is under supervision as defined in Section 220.100.

b. Trainees must complete at least sixteen (16) hours of classroom training before beginning any supervised practical training.

3. Supervised practical training may occur at locations other than the site of the classroom training.

a. However, trainees must complete at least twenty four (24) hours of classroom training before undertaking any supervised practical training at an actual service delivery site.

b. The training program must have the written consent of the beneficiary or the beneficiary's representative if aide trainees furnish any of the beneficiary's services at the beneficiary's service delivery location.

(1). A copy of the beneficiary's consent must be maintained in the file of each aide trainee receiving supervised practical training at the beneficiary's service delivery location.

(2). The beneficiary's daily service documentation must include the names of the supervisor or QIDP and the personal care aide trainees.

4. The training of personal care aides and the supervision of personal care aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse whose current credentials are on file with the provider.

a. The qualified registered nurse must possess a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of in-home health care.

b. Other individuals may provide instruction under the supervision of the qualified registered nurse.

c. Supervised practical training with a consenting personal care beneficiary for a subject must be personally supervised by:

(1). The qualified registered nurse; or

(2). By a licensed practical nurse under the general supervision of the qualified registered nurse.

REPEAL

H. Providers must maintain documentation demonstrating that aide training meets the requirements set forth herein.

222.120 Personal Care Aide Training Subject Areas 7-1-20

NOTE: This section is not applicable to the IndependentChoices program.

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

B. Understanding and following spoken and written instructions.

C. Communications skills, especially the skills needed to:

1. Interact with beneficiaries;
2. Report relevant and required information to supervisors; and,
3. Report events accurately to public safety personnel and to emergency and medical personnel.

D. Record-keeping, including:

1. The role and importance of record keeping and documentation;
2. Service documentation requirements and procedures, especially all documentation Medicaid requires of personal care aides, as described in Medicaid Personal Care Program policy statements current at the time of the aide's training;
3. Reporting and documenting non-medical observations of beneficiary status; and
4. Reporting and documenting, when pertinent, the beneficiary's observations regarding the beneficiary's own status.

REPEAL

E. Recognizing and reporting to the supervising Qualified Intellectual Disabilities Professional (QIDP), when changes in the beneficiary's condition or status require the aide to perform tasks differently than instructed.

F. State law regarding delegation of nursing tasks to unlicensed personnel as designated by the Arkansas State Board of Nursing.

G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.

H. Safe transfer techniques and ambulation.

I. Normal range of motion and positioning.

J. Recognizing emergencies and knowledge of emergency procedures.

K. Basic household safety and fire prevention.

L. Maintaining a clean, safe and healthy environment.

M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the beneficiary with:

1. Bed bath;
2. Sponge, tub or shower bath;
3. Shampoo; sink, tub or bed;
4. Nail and skin care;
5. Oral hygiene;

6. Toileting and elimination;

7. Shaving;

8. Assistance with eating;

9. Assistance with dressing;

10. Efficient, safe and sanitary meal preparation;

11. Dishwashing;

12. Basic housekeeping procedures; and

13. Laundry skills.

N. Early recognition and reporting of changes in client condition.

222.130 Personal Care Aide Certification 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

A. A personal care aide trainee must pass an examination based on the curriculum of the personal care aide training course.

1. Some of the examination may be oral.

2. Examinations must include written questions requiring written answers, in sufficient number for instructors or other qualified training program personnel to determine that trainees meet or surpass a minimum standard for reading and writing.

B. The personal care aide candidate must demonstrate the ability to perform all tasks required of personal care aides, by meeting or exceeding minimum standards in a personal care services skills test.

C. An aide trainee successfully completing training must receive a certificate confirming that the individual is a Certified Personal Care Aide qualified for employment in that capacity.

1. The certificate must contain the name of the training entity.

2. The certificate must contain the signature of an individual authorized by the training program to certify the qualifications of personal care aides.

REPEAL

222.140 In-Service Training 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

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

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

1. When appropriate, in-service training may occur at a personal care service delivery location when the aide is furnishing personal care services.

2. In-service training at a service delivery site may occur only if the beneficiary or the beneficiary's representative has given prior written consent for training activities to occur concurrently with the beneficiary's care.

B. The Personal Care Program provider agency and the personal care aide must maintain documentation that they are meeting the in-service training requirement.

240.000 PRIOR AUTHORIZATION 1-1-19

A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries, including beneficiaries participating in the IndependentChoices Program.

B. Prior authorization does not guarantee payment for the service.

1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.

2. The provider must follow the billing procedures in this manual.

C. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the DHS Independent Assessment Contractor to collect information used in determining the beneficiary's physical dependency needs for "hands-on" services with activities of daily living (ADL), and in calculating the number of personal care hours that can be authorized for the beneficiary. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each beneficiary is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment.

1. Tier 0 (zero) indicates the individual's assessed needs, if any, do not support the need for personal care services.

2. Tiers 1 (one), 2 (two), or 3 (three) indicate the individual's assessed needs do support the need for personal care services.

D. The Task and Hour Standards will be used by DHS RNs and DHS contractors to calculate the number of personal care hours that can be authorized for the beneficiary.

240.100 Task and Hour Standards (THS) 1-1-19

REPEAL

A. Background of THS

The Arkansas Medicaid Task and Hour Standards (THS) is the written methodology used by the DHS RNs and DHS contractor RNs to calculate the number of personal care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

The current DAABHS approved THS is located on the web at **https://medicaid.mmis.arkansas.gov/Download/provider/provdocs/Manuals/ARCHOICES/THS.doc**

The THS includes the following four components, described in a grid format:

1. The beneficiary's Needs Intensity Score (0, 1, 2, or 3) for each task;

2. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;

3. The frequency with which a task is necessary and reasonably performed; and

4. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary personal care services hours, with the minute ranges and frequencies, providing the ability to adjust service plans based on unique factors related to a given beneficiary's needs, preferences, and risks.

The number of personal care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN or by the contractor(s) designated by DHS consistent with the THS grid and based on:

1. Responses by the beneficiary and their representatives to certain relevant questions in the ARIA assessment instrument, and

2. As appropriate, information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representatives or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

B. Needs Intensity Score:

For each task, the DHS RN or the contractor(s) designated by DHS will assign a Needs Intensity Score to the beneficiary based on the beneficiary's and/or representative's responses to questions during the ARIA assessment and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS. The four Needs Intensity Scores are defined as follows:

REPEAL

Impairment Score 0 - The beneficiary has no functional impairment with regard to the task and can perform it without assistance.

Impairment Score 1 (Mild): Minimal/mild functional impairment. The beneficiary is able to conduct activities with minimal difficulty and needs minimal assistance.

Impairment Score 2 (Severe): Extensive/severe functional impairment. The beneficiary has extensive difficulty carrying out activities and needs extensive assistance.

Impairment Score 3 (Total): The beneficiary is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

C. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN or contractor(s) designated by DHS will determine the number of minutes within the range that are appropriate for the beneficiary based on conditions specific to the beneficiary. For example, if a beneficiary has cognitive or behavioral issues, the maximum number of minutes in the range for bathing may be warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a beneficiary who is bald.

If the beneficiary has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN or designated contractor RN must obtain supervisory approval. For supervisory approval, the RN must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed

medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the personal care prior authorization or ARChoices PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the personal care prior authorization or PCSP.

D. The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

E. The amount of assistance with ADLs and IADLs provided by other sources

Personal care services are not available for assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then personal care services are not necessary and no time for that task is included. When another source is available to provide some instances of a needed ADL or IADL task, the frequency and time associated with these other sources are adjusted to correspond with the remaining assessed needs.

REPEAL

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task (e.g., the beneficiary's daughter bathes her mother once a week and prepares all meals on weekends). For example, where a needed meal is supplied by Meals on Wheels, minutes for meal preparation may not be necessary and should be adjusted.

F. Calculation of total hours of personal care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of personal care hours approved for the beneficiary for a month.

241.000 Personal Care Program Prior Authorization (PA) Responsibility 1-1-19

A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization of personal care services for beneficiaries.

B. DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's completed form designated by DHS and submitted documentation for personal

care services. Based on the information in the ARIA assessment and the form designated by DHS, they authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.

C. DHS professional staff or contractor(s) designated by DHS have a right to review the beneficiary's medical information.

242.000 Personal Care PA Request Procedure 1-1-19

A. Providers must use the form designated by DHS to request PA. **View or print the form designated by DHS (English). View or print the form designated by DHS (Spanish).**

B. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals for beneficiaries who are assessed at Tier 1, 2, or 3 will be retroactive to the beginning date of service if the request is received within the 30-day time frame. There will be no prior authorization, including any retroactive prior authorization, if the beneficiary is assessed at Tier 0.

C. Providers should submit prior authorization forms to the contractor(s) designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff

243.000 Provider Notification Procedure 1-1-19

Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

REPEAL

A. For approved cases, an approval letter will be mailed to the requesting provider, detailing the procedures approved, total number of service time increments, beginning and ending dates and the authorization number.

B. For denied or partially denied cases, a denial letter with reason for denial will be mailed to the beneficiary and the requesting provider. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation. The letter shall specify why the prior authorization request was denied or partially denied and shall give the beneficiary notice of the right to file a request for a fair hearing and where to file the request. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation.

244.000 Duration of PA 7-1-20

Personal Care PAs are generally assigned for twelve (12) months from the date of the last independent assessment or for the life of the service plan, whichever is shorter, unless the beneficiary has a change in condition.

245.000 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

~~246.000 Reserved~~ ~~6-1-25~~

~~250.000 REIMBURSEMENT~~

~~250.100 Reimbursement Methods~~ ~~1-1-19~~

~~A. Reimbursement for personal care services is the lesser of the billed amount per unit of service or Medicaid's maximum allowable fee (herein also referred to as "rate" or "the rate") per unit.~~

~~B. Reimbursement for Arkansas Medicaid Personal Care services is based on a 15-minute unit of service.~~

~~C. RCF Personal Care provider reimbursement is in accordance with a multi-hour daily service rate system, employing Medicaid maximum allowable fees (Daily Service Rates) determined by individual beneficiaries' Payment Levels.~~

~~D. ALF Personal Care provider reimbursement is in accordance with a multi-hour daily service rate system, employing Medicaid maximum allowable fees (Daily Service Rates) determined by individual beneficiaries' Payment Levels. This excludes the Living Choices Assisted Living waiver beneficiaries.~~

~~250.200 RCF and ALF Personal Care Reimbursement Methodology~~ ~~1-1-19~~

~~A. The RCF and ALF Personal Care reimbursement methodology is designed with the intent that reimbursement under the multi-hour Daily Service Rate system closely approximates what reimbursement would have been if the providers were to have billed by units of service furnished.~~

REPEAL

~~B. Whenever the unit rate (i.e., the maximum allowable amount per fifteen minutes service) for personal care services changes, Daily Service Rates under the RCF and ALF methodology are correspondingly adjusted in accordance with the initial methodology by which they were established and which is described in detail in the following sections.~~

~~C. The Daily Service Rate paid for personal care services is based on a Payment Level determined from the resident's service plan.~~

~~250.210 Payment Level~~ ~~1-1-19~~

~~There are 10 Payment Levels, each based on the average number of 15-minute units of service per month required to fulfill a beneficiary's service plan.~~

~~A. Level 1 includes RCF and ALF Personal Care beneficiaries whose service plans comprise 100 units or less per month of medically necessary personal care.~~

~~B. Level 10 includes RCF and ALF Personal Care beneficiaries whose service plans comprise 256 or more units per month of medically necessary personal care.~~

~~C. Level 2 through Level 9 were established in equal increments between 101 and 255 units per month.~~

~~250.211 Payment Level Determination~~ ~~1-1-19~~

~~A. The average of a service plan's monthly units of service is used to determine each beneficiary's Payment Level.~~

~~B. Calculate a beneficiary's average number of monthly units of personal care as follows.~~

1. Add the Weekly Minute Totals from the prior authorization approved by DHS using the Task and Hour Standards.

2. Divide the minutes by **15** (*15 minutes equals one unit of service*) to calculate weekly average units of service.

3. Multiply the weekly average units from step 2 by **52** (*Weeks in a year*) and divide the product by **12** (*Months in a year*) to calculate monthly average units of service.

4. Consult the "RCF and ALF Personal Care Service Rate Schedule" on the Arkansas Medicaid Personal Care Fee Schedule to find the applicable Daily Multi-Hour Service Rate for each Payment Level. Procedure code T1020 is the applicable code for RCF and ALF Personal Care providers.

250.212 Rate Development 1-1-19

A. The Level 1 Daily Service Rate was calculated as follows.

1. Multiplied **100** (*15-minute units*) by **12** (*Months in a year*)

2. Divided units per year calculated in step 1 by **365** (*The average number of days in a year*) to calculate average units per day

3. Multiplied average units (*Unrounded*) per day obtained in step 2 by the current Personal Care maximum allowable fee per unit and rounded the product to the nearest 100th to calculate the Level I Daily Service Rate

B. The Level 10 Daily Service Rate was calculated as follows.

1. Multiplied **256** (*Maximum monthly units*) by **12** (*Months per year*)

2. Divided the product calculated in step 1 by **365** (*The average number of days in a year*) to calculate average maximum units per day

3. Multiplied average maximum units per day from step 2 by the current Personal Care maximum allowable fee per unit and rounded the product to the nearest 100th to calculate the Level 10 Daily Service Rate

C. The Daily Service Rates for Level 2 through Level 9 were calculated as follows.

1. The difference between 255 and 101 (154) was divided into eight equal increments that then were designated Payment Levels ("Levels") 2 through 9.

2. The sum of the beginning and ending values within each Payment Level was divided by **2** to calculate the Level's average units per month.

3. The average units per month was multiplied by **12** (*Months per year*) to calculate average annual units.

4. The average annual units calculated in step 3 was divided by **365** (*The average number of days in a year*) to arrive at average units per day.

5. The average units per day calculated in step 4 was multiplied by the current Personal Care maximum allowable fee per unit and the product was rounded to the nearest 100th.

251.100 Individuals with Disabilities Education Act (IDEA) and Beneficiary Free Choice

251.120 IDEA Responsibilities of School Districts and Education Service Cooperatives 8-1-04

Arkansas public school districts and education service cooperatives (ESCs), when enrolled as Arkansas Medicaid Personal Care providers, are deemed the provider of service.

REPEAL

A. As such, the school districts and ESCs must provide services, under the guidelines of the Arkansas Medicaid Personal Care Provider Manual, to the following groups of children.

1. Medicaid-eligible school-aged children with disabilities, whose Individualized Education Programs (IEPs) call for personal care as a "Related Service" in accordance with the Individuals with Disabilities Education Act (IDEA).

2. Medicaid-eligible preschool children (aged 3 through 4 years) with disabilities, who are enrolled in special education programs, and whose IEPs include personal care.

B. Under the IDEA, the student's parent or guardian may independently select an enrolled Medicaid provider, ("other provider") other than the school district or ESC. This exception requires the existence of each of the following conditions:

1. Neither the school district or ESC nor anyone acting on behalf of the school district or ESC may refer the beneficiary, or the beneficiary's parent or guardian, to the other provider.

2. There is no arrangement by the school district or ESC, or persons or entities in privity with the school district or ESC, for the other provider to furnish the services.

3. The other provider does not, either directly or through another person or entity, have a contract with the school district or ESC or with persons or entities in privity with the school district or ESC, for referrals, consulting or the provision of Medicaid-covered services.

4. The other provider is not under control or supervision of the school district or ESC or persons or entities in privity with the school district or ESC.

C. For purposes of this rule, "privity" means a direct or indirect interest growing out of a contract, mutuality of interest, or common ownership or control.

REPEAL

251.121 Fee Schedules 1-1-19

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

252.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a Program decision affecting reimbursement by writing to the Assistant Director, Division of Medical Services (DMS).

A. The Program must receive the request within twenty (20) calendar days of the latest of the following events:

1. The implementation date of the new or revised policy, or

2. The effective date of the new or revised billing or coding instructions, or

3. The date of official provider notification of

a. New or revised policy or of

b. New or revised billing or coding instructions;

B. The Assistant Director, DMS, will review the request and will arrange a Program/Provider conference if needed or if the provider so requests.

1. The Assistant Director will advise the provider of the Program decision on the matter within twenty (20) calendar days following receipt of the request.

2. If there is a Program/Provider conference, the Assistant Director will notify the provider within twenty (20) calendar days following the date of that conference.

C. If the decision of the Assistant Director, DMS, is unsatisfactory to the provider, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the DMS.

1. A member of DHS management staff will chair the Rate Review Panel, which will include a member of the DMS and a representative of the medical professional community.

2. The written request for review by the Rate Review Panel must be postmarked by the fifteenth (15th) calendar day following the date of notification of the initial decision by the Assistant Director, DMS.

3. The Rate Review Panel will meet within fifteen (15) calendar days following receipt of the appeal request. The panel will submit its recommendation to the Director of the DMS.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 7-1-20

A. Personal Care providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries.

B. Providers submitting claims electronically through the provider portal use the Professional claim format.

C. A claim may contain charges for only one (1) beneficiary.

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

REPEAL

261.100 Electronic Visit Verification (EVV) 1-1-24

Refer to Provider Manual Section 1, General Policy, subsection 145.000 for EVV requirements regarding personal care services.

262.000 CMS-1500 Billing Procedures

262.100 Personal Care Billing 3-1-08

A. Providers must use applicable HCPCS procedure codes and modifiers listed in the following section.

B. All billing by any media requires the correct national standard place of service code.

262.101 Personal Care for a Beneficiary Aged 21 or Older (Non-RCF) 1-1-19

Procedure Code	Modifier	Service Description
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older, per 15 minutes (requires prior authorization)

262.102 Personal Care for a Beneficiary Under 21 (Non-RCF) 3-1-08

Procedure Code	Modifier	Service Description
T1019		Personal Care for a (non-RCF) Beneficiary Under 21, per 15 minutes (requires prior authorization)

262.103 Personal Care in a Public School 8-1-04

Procedure Code	Modifier	Service Description
T1019	U4	Personal Care for a Beneficiary Under 21, provided by a school district or education service cooperative, per 15 minutes (requires prior authorization).

262.104 Personal Care in an RCF or ALF 1-1-19

A. To bill for RCF or ALF Personal Care, use HCPCS procedure code **T1020** and the modifier corresponding to the beneficiary's Payment Level in effect for the date(s) of service being billed.

B. The Payment Level that a provider bills must be consistent with the beneficiary's service plan in effect on the day that the provider furnished the personal care services billed.

Payment Level Specifications and Modifiers for Procedure Code T1020

REPEAL

Payment Levels	Minimum Service Units	Maximum Service Units	Modifier
Level 1	Less than 101	100	U1
Level 2	101	119	U2
Level 3	120	139	U3
Level 4	140	158	U4
Level 5	159	177	U5
Level 6	178	196	U6
Level 7	197	216	U7
Level 8	217	235	U8
Level 9	236	255	U9
Level 10	256	256	UA

262.105 Employment-Related Personal Care Outside the Home 1-1-19

Procedure Code	Modifier	Service Description
T1019	U5	Employment-related personal care outside the home, beneficiary aged 16 or older, per 15 minutes. All personal care services require prior authorization.

262.106 Billing RCF and ALF Personal Care Services 10-1-12

A. RCF and ALF Personal Care providers may not bill for days during which a beneficiary received no personal care services (for instance, he or she was away for a day or more); therefore, do not include in the billed dates of service any days the beneficiary was absent.

B. For each unbroken span of days of service, multiply the days of service by the applicable Daily Service Rate and bill that amount on the corresponding claim detail.

C. Documentation requirements outlined in the Medicaid Personal Care Policy Section 216.400 (Personal Care Aide Service and Documentation Responsibility) must be adhered to when providing Personal Care services at all ALF facilities.

262.110 Coding Home and DDS Facility Places of Service 3-1-08

A. The beneficiary's home is the beneficiary's residence, subject to the exclusions in Section 213.500, part B. For example, if a beneficiary lives in a residential care facility (RCF) or an assisted living facility (ALF), then the RCF or ALF is the beneficiary's home and is so indicated on a claim by place of service code **12**.

B. Section 213.520, part A, explains and describes special circumstances under which the place of service is deemed "public school."

1. The Arkansas Department of Education (ADE) sometimes deems a student's home a "public school," coded **03.**

2. Under certain circumstances, the ADE deems a Division of Developmental Disabilities Services community provider facility ("DDS facility") a "public school," also coded **03**.

C. When beneficiaries receiving personal care in a DDS facility are not in the charge of their school district, the place of service code is 99, "Other Place of Service," because there is no national code for a DDS clinic or facility.

REPEAL

262.300 Calculating Individual Service Times for Services Delivered in a Congregate Setting 3-1-08

Rules in this section and its subsections regard calculation and determination of service-time to convert into billing units (Fifteen-minute units). Effective for dates of service on and after March 1, 2008, those rules do not apply to RCF Personal Care providers' billing. Rules in this section and its subsections that are applicable to assessments and service plan development continue to apply to RCFs.

If services, such as meal preparation in a congregate setting, are delivered simultaneously, only the actual proportionate service time attributable to each individual beneficiary is covered.

A. The provider shall compute the covered time by dividing the actual aide clock-hours, attributing a proportionate share to each individual and multiplying each individual's proportionate share by a percentage arrived at from the individual's assessment. For example:

1. If an individual is totally dependent and cannot prepare a meal, the provider would be eligible for 100 percent of the beneficiary's proportionate share.

2. If a resident is totally capable of preparing a meal, the provider is not eligible for any reimbursement for any of the beneficiary's proportionate share.

3. If the beneficiary has an impairment that limits but does not totally prevent meal preparation the provider will be eligible for reimbursement of 50 percent of the individual's proportionate share of the aide's time.

B. The beneficiary's assessment must describe, in narrative form, his or her level of impairment with respect to each physical dependency with which the beneficiary receives assistance in a congregate setting.

262.310 Unit Billing 7-1-04

A. Fifteen minutes of authorized, documented and logged personal care equals one unit of personal care aide service.

B. Providers may not bill for less than fifteen minutes of service; however personal care aides' time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day, and the sum – in minutes – divided by 15 to calculate the number of units of service provided during that day.

C. The estimated daily maximum service time in the beneficiary's service plan is the upper limit for daily billing.

D. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary.

E. There is no "carryover" of time from one day to another or from one beneficiary to another.

F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

262.311 Calculating Units 07-01-04

REPEAL

A. Personal Care providers must bill Medicaid by 15-minute units.

B. Total the daily personal care service time for a single beneficiary in minutes, using the beginning and ending service times from the service logs.

C. Set your calculator to compute to three decimal places.

D. Divide the total time (expressed in minutes) by fifteen and

E. Bill for the lesser of:

1. The rounded, whole-number quotient of the division or

2. The maximum time estimate in the service plan.

262.312 Rounding 07-01-04

When a quotient contains decimals, look at the numbers after the decimal point.

A. If the number after the decimal point is 500 (e.g., 3.500) or less (e.g., 3.495) round downward to the whole number displayed before the decimal point (3, in this example)

B. If the number after the decimal is 501 (e.g., 3.501) or greater (e.g., 3.576) round upward to the whole number one greater than the whole number displayed before the decimal point (4 in this example, because it is a whole number one greater than 3).

262.400 Billing Instructions—Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

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

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

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

262.410 Completing a CMS-1500 Claim Form for Personal Care 1-1-19

When a provider must bill on a paper claim, the fiscal agent accepts only red-lined, sensor-coded CMS-1500 claim forms. Claim photocopies and claim forms that are not sensor-coded cannot be processed.

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid or ARKids First-A identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the individual's Medicaid or ARKids First-A identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary resides.
STATE	Two-letter postal code for the state in which the beneficiary resides.
ZIP CODE	Five-digit ZIP code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/ emergency telephone
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if the insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.

REPEAL

Field Name and Number	Instructions for Completion
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9a and d are required. Name of the insured individual's employer and/or school.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a, 9c and 9d.Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

REPEAL

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness ; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of the referral source.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not applicable.
19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER	Insert LEA number.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

REPEAL

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization number.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. A provider may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the date sequence. 3. RCFs may bill for a date span of any length within the same calendar month, provided the beneficiary was present every day of the date span and all services provided within the date span were at the same Payment Level.
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) when applicable.

REPEAL

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the services totaled in the detail. This charge must be the usual charge to any beneficiary patient, or other recipient of the provider's services. RCFs' charges should equal no less than the product of the number of units (days) times the beneficiary's Daily Service Rate. If the charge is less, Medicaid will pay the billed charge.
G. DAYS OR UNITS	The units (in whole numbers) of service provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening and referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9 digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, advise Provider Enrollment so that the year-end 1099 will be correct and reported correctly.
26. PATIENT'S ACCOUNT NO.	Optional entry for providers' accounting and account retrieval purposes. Enter up to 16 numeric, alphabetic or alpha-numeric characters. This character set appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F – the sum of all charges on the claim.
29. AMOUNT PAID	Enter the total of payments received from other sources on this claim. Do not include amounts previously paid by Medicaid.
30. RESERVED	Reserved for NUCC use.

REPEAL

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PROVIDER	The performing provider or an individual authorized by the performing provider or by an institutional, corporate, business or other provider organization, must sign and date the claim, certifying that the services were furnished by the provider, under (when applicable) the direction of the individual provider or other qualified individual, and in strict and verifiable accordance with all applicable rules of the Medicaid program in which the provider participates. A "provider's signature" is the provider's or authorized individual's personally written signature, a rubber stamp of the signature, an automated signature or a typed signature. The name of a group practice, a facility or institution, a corporation, a business or any other organization will prevent the claim from being processed.
32. SERVICE FACILITY LOCATION INFORMATION	If services were not performed at the beneficiary's home or at the provider's facility (*e.g.*, school, etc.) enter the name, street address, city, state and zip code of the facility, workplace etc. where services were performed. If services were furnished at multiple sites (for instance, when job seeking), indicate "multiple locations" or leave blank.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

REPEAL

State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

HOUSE BILL 1439

By: Representative Ladyman
By: Senator Flippo

For An Act To Be Entitled

AN ACT TO REMOVE THE CERTIFICATION PROCESS OF THE DEPARTMENT OF HUMAN SERVICES FROM LICENSURE AS A PRIVATE CARE AGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO REMOVE THE CERTIFICATION PROCESS OF THE DEPARTMENT OF HUMAN SERVICES FROM LICENSURE AS A PRIVATE CARE AGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 20-10-2301(b), concerning the purpose and intent of the licensure of private care agencies, is amended to read as follows:

(b) It is the purpose of this subchapter to:

(1) Allow a licensed private care agency to provide in-home personal care services twenty-four (24) hours a day and seven (7) days a week to eligible recipients;

(2) Provide for the reimbursement of the personal care services through Medicaid; and

(3) Authorize the Department of Human Services in its administration of the Arkansas Medicaid Program to set forth Medicaid provider participation requirements for a private care agency that will ensure sufficient available personal care service providers in order to meet the needs of all eligible recipients, including available in-home personal care services twenty-four (24) hours a day and seven (7) days a week.

SECTION 2. Arkansas Code § 20-10-2302 is amended to read as follows:

20-10-2302. Definitions.

As used in this subchapter, "private care agency" means a provider that is ~~certified by the Division of Provider Services and Quality Assurance as a provider of home- and community-based health services~~ licensed by the Department of Health as a private care agency and that:

(1) Furnishes in-home staffing services for personal and attendant care services for which the provider seeks reimbursement through the Arkansas Medicaid Program; and

(2) Retains liability insurance of not less than one million dollars ($1,000,000) to cover its employees and independent contractors while its employees and independent contractors are engaged in providing personal and attendant care services.

SECTION 3. Arkansas Code § 20-10-2304(c)(3)(B), concerning the rules for private care agencies, is amended to read as follows:

(B) A private care agency maintain a primary location in Arkansas ~~and a sufficient number of regional offices~~ to adequately service the administrative needs of the private care agency and the patients of the private care agency; and

APPROVED: 4/17/25

State of Arkansas *As Engrossed: H2/4/25 H2/18/25*
95th General Assembly **A Bill**
Regular Session, 2025 HOUSE BILL 1171

By: Representatives K. Moore, L. Johnson
By: Senator Irvin

For An Act To Be Entitled

AN ACT TO MODIFY THE MEDICAID PROVIDER-LED ORGANIZED CARE ACT; TO AUTHORIZE AN ABBREVIATED INDEPENDENT ASSESSMENT FOR CERTAIN BENEFICIARIES ENROLLED IN A RISK-BASED PROVIDER ORGANIZATION; AND FOR OTHER PURPOSES.

Subtitle

TO MODIFY THE MEDICAID PROVIDER-LED ORGANIZED CARE ACT; AND TO AUTHORIZE AN ABBREVIATED INDEPENDENT ASSESSMENT FOR CERTAIN BENEFICIARIES ENROLLED IN A RISK-BASED PROVIDER ORGANIZATION.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 27, is amended to add an additional section to read as follows:

20-77-2709. Independent assessments for home- and community-based services.

(a) The Department of Human Services shall implement an abbreviated *independent assessment process for beneficiaries who have been previously approved for services through an independent assessment, including without limitation a desk review, for beneficiaries who have chronic, long-term conditions and receive services through enrollment in a risk-based provider organization.*

(b) The department shall apply for any federal waiver, Medicaid state plan amendment, or other authorization necessary to implement this section.

/s/K.Moore

APPROVED: 4/16/25