Arkansas Medicaid Task and Hour Standards (THS)
For Use in Calculating Medically Necessary Hours of Services for Adult Beneficiaries
ARChoices Attendant Care & Respite Care, Personal Care Services, and IndependentChoices Self-Directed Personal Assistance

1 Task / Activity	2 Needs Intensity Score 1 Needs and Minute Ranges	3 Minutes Assigned within Range	4 Needs Intensity Score 2 Needs and Minute Ranges	5 Minutes Assigned within Range	6 Needs Intensity Score 3 Needs and Minute Ranges	7 Minutes Assigned within Range	8 Frequency	9 Total Minutes per week	10 Minutes of Assistance with Task Per Week from Another Source	11 Total Minutes/ Hours Per Week Net of Assistance from Another Source	12 Total Net Hours per Month
Bathing	• Laying out supplies • Drawing water • Standby assistance for safety • Minimal assistance in/out of tub or shower • Reminding, monitoring Minute range: 5-10		• Tub/shower bathing • Sponge bathing • Bed bathing • Drying • Extensive assistance in/out of tub or shower Minute range: 15-30		Total assistance with bathing Minute range: 35-45						
Dressing	• Laying out clothing • May require occasional help with zippers, buttons, putting on socks or shoes • Reminding or monitoring Minute range: 5-10		• Always requires assistance with zippers, buttons, socks, or shoes • Requires assistance getting into and out of garments Minute range: 15-20		Total assistance with dressing Minute range: 25-30						
Feeding	• Verbal reminders & encouragement • Standby assistance • Applying adaptive devices Note: feeding is calculated by # of meals per week, not # of days Minute range: 5-10		• Spoon feeding • Bottle feeding Minute range: 15-20		Total assistance with feeding Minute range: 25-30						

Grooming/Routine hair and skin care	• Laying out supplies • Verbal reminders • Combing/brushing hair • Applying non-prescription lotion to skin Minute range: 10-20		• Shaving • Brushing teeth • Shaving legs, underarms • Caring for nails • Washing hair • Drying hair • Setting/rolling/braiding hair • Washing hands and face • Applying makeup Minute range: 30-50		Total assistance with grooming and routine hair and skin care Minute range: 60-75						
Toileting	• Preparing toileting supplies / equipment • Assisting with clothing during toileting • Occasional help with Cleaning self • Occasional help with catheter or colostomy care • Standby assistance Minute range: 5-10		• Assisting on/off bedpan • Assisting with the use of urinal • Assisting with toileting hygiene • Assisting with feminine hygiene needs • Changing diapers Changing external catheter • Emptying catheter bag • Changing colostomy bag Minute range: 15-20		Total assistance with toileting Minute range: 25-30						
Transferring	• Helping with positioning (adjusting/changing position) • Minimal assistance in rising • Standby assistance Minute range: 5-10		• Non-ambulatory movement from one stationary position to another • Hands-on assistance with rising from a sitting to a standing position • Extensive assistance with positioning or turning Minute range: 15-20		Total assistance with positioning or transferring from bed to chair Minute range: 25-30						

Walking	• Standby assistance with walking • Assistance with putting on and removing leg braces Minute range: 5-10		• Steadying in walking/using steps • Assistance with wheelchair ambulation Minute range: 15-20		Total assistance with wheelchair ambulation Minute range: 25-30						
Cleaning	• Minimal assistance with cleaning • Make bed • Straightening areas Minute range: 60-90		• Cleaning up after personal care tasks • Cleaning floors of living area used by individual • Dusting • Cleaning bathroom • Changing bed linens • Cleaning stove top, counters, washing dishes • Cleaning refrigerator and stove • Emptying and cleaning bedside commode • Carrying out trash, setting out garbage for pickup Minute range: 95-235		Total assistance with cleaning Minute range: 240-300						
Laundry	Individual requires at least minimal assistance but has no special laundry needs: Minute range: 30-120		Individual has special laundry needs: Minute range: 120-240								

Arkansas Medicaid Task and Hour Standards (THS)
For Use in Calculating Medically Necessary Hours of Services for Adult Beneficiaries
ARChoices Attendant Care & Respite Care, Personal Care Services, and IndependentChoices Self-Directed Personal Assistance

Meal preparation	• Warming, cutting, serving prepared food
	• Meal planning
	• Helping prepare meals Light Breakfast
	• Snacks
	• Cooking full meal. Indicate meals to be cooked. The maximum time per meal is 30 minutes.
	  ○ Breakfast
	  ○ Lunch
	  ○ Supper
	• Additional time for leftovers. Allow an extra 15 minutes per day for cooking enough for leftovers for the next meal, if needed.
	• Grinding and pureeing food
	
	Minute range: 10-90										

Shopping	• Preparing a shopping list • Picking up extra items Minute range: 10-30		• Going to the store; shopping for all items • Picking up medications • Putting items away Minute range: 35-90		Total assistance with shopping Minute range: 35-90						
Employment-related personal care associated with travel											
										TOTAL Minutes/Hours for All Tasks Per Week	
										TOTAL Minutes/Hours for All Tasks Per Month	

Arkansas Medicaid Task and Hour Standards (THS)
For Use in Calculating Medically Necessary Hours of Services for Adult Beneficiaries
ARChoices Attendant Care & Respite Care, Personal Care Services, and IndependentChoices Self-Directed Personal Assistance

Instructions for Completing the Above Task and Hour Standards Grid

The Task and Hour Standards (THS) grid is used to provide the basis for calculating the number of approved and authorized minutes and hours of attendant care, respite care, personal care, and self-directed personal assistance that are medically necessary for an adult beneficiary aged 21 or older.

Whenever there is a change in condition for the beneficiary or a change in assistance from other sources, the DHS RN or contractor will update the THS grid for the beneficiary. The updated THS grid may result in a change the minutes/hours of attendant care, respite care, personal care, or self-directed personal assistance approved for the beneficiary.

The DHS nurse/contractor will assign a Needs Intensity Score to the beneficiary for each task based on the beneficiary's and/or representative's responses to questions during the ARIA assessment conducted by an RN from the Independent Assessment Contractor. A Needs Intensity Score is required for completion of the THS grid.

Steps for completing the THS grid to calculate the number of medically necessary and reasonable minutes/hours of attendant care, respite care, personal care, or personal assistance for the beneficiary per week/month:

1. Identify the beneficiary's Needs Intensity Score (0, 1, 2, or 3) for each task from the ARIA assessment results and from information collected by the DHS RN during the PCSP meeting with the participant. If the Needs Intensity Score for the task is 0, the beneficiary will not be approved for any minutes for that task and THS grid would not be completed for the task. If the beneficiary's Needs Intensity Score is 1, 2, or 3, the grid will be completed for the task and the Needs Intensity Score will determine which minute range (Columns 2, 4, and 6) is applicable for the task.

2. Columns 3, 5, and 7: (Complete only one of these three.) The DHS nurse/contractor will calculate the number of minutes within the minute range for that Needs Intensity Score that are appropriate for the beneficiary based on conditions specific to the beneficiary. For example, if a beneficiary has cognitive or behavioral issues, the nurse may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming for a beneficiary who is bald would probably not be appropriate.

    - In exceptional circumstances and based on documented need, the DHS nurse/contractor may approve minutes in excess of the minute range for the task, so long as the justification of need is documented in writing, the justification is based on the beneficiary's assessed or

observed medical needs, the justification is not for the convenience of the provider or attendant, and the DHS nurse/contractor obtains written supervisory approval.

3. Column 8: Insert the frequency with which the task is performed based on the reasonable needs and preferences of the beneficiary. The frequency with which a given task is performed for a beneficiary will be calculated by the DHS nurse or contractor, drawing upon information from the ARIA assessment results and, as applicable, the information collected by DHS nurses during the PCSP meeting with the beneficiary and/or information submitted by the beneficiary's provider.

4. Column 9: Multiply the total minutes assigned for the task in Columns 3, 5, or 7 by the frequency with which the task is performed (Column 8) to arrive at the total minutes per week. Insert that product in Column 9.

5. Column 10: If the beneficiary is receiving assistance with the task from another source such as (a) informal caregivers (e.g., relatives, neighbors, and friends), (b) community-based agencies such as Meals on Wheels, and/or (c) Medicare or a Medicare Advantage health plan), calculate approximately how many of the assigned minutes for the task are being performed by the other source (e.g., 45 minutes for bathing because the beneficiary's mother needs total assistance and the daughter performs the entire bathing task once a week) and insert in Column 10. The amount of support with ADLs and IADLs provided by other sources is primarily calculated by the DHS nurse or contractor based on ARIA assessment results, during PCSP meetings with the participant, and from information supplied by providers.

6. Column 11: Subtract the number of Minutes of Assistance Per Week from Another Source in Column 10 from the number of Total Minutes Per Week in Column 9. Divide that number by 60 to arrive at the number of hours per week. Enter both minutes and hours per week in this column.

7. Column 12: Multiply the number of hours per week in Column 11 by 4.334 to arrive at the number of hours per month.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

I. Request Information

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

B. Waiver Title (*optional*): ARChoices in Homecare

C. CMS Waiver Number: **AR.0195**

D. Amendment Number (*Assigned by CMS*):

E.1 Proposed Effective Date: 01-01-2019

E.2 Approved Effective Date (*CMS Use*):

II. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The ARChoices in Homecare waiver is being amended regarding the following:

1. Section 1.F is amended to clarify that the State does not enroll individuals who need a skilled level of nursing care. Conforms to current State administrative rules.

2. For assessments and re-assessments, replacement of (a) independent assessments performed by DHS registered nurses (RNs) using the ArPath assessment instrument with (b) independent assessments performed by RNs of the DHS Independent Assessment Contractor using the new Arkansas Independent Assessment (ARIA) instrument.

3. For Attendant Care Services and Respite Care Services, policy reforms and clarifications to limit the amount, frequency, and duration based on Task and Hour Standards; reduce overuse, misuse, and potential abuse of services; and revise scope of services descriptions.

4. For Attendant Care Services, three Instrumental Activity of Daily Living (IADL) tasks are eliminated (managing basic personal finances; communication with others; and traveling) to align with State Plan personal care services and self-directed personal assistance services (Independent Choices), reduce risk of duplication, and improve program integrity; and (for waiver participants) synchronize the prior authorization/prior approval of State Plan personal care services and waiver Attendant Care Services.

5. The deletion of Adult Family Home Services, an obsolete service not used by enrollees;

6. The addition of a new service, Prevocational Services, for persons with physical disabilities.

7. To ensure cost effectiveness and fiscal sustainability of waiver services, the maximum dollar amount of waiver services authorized for each specific participant is limited by a prospectively determined Individual Services Budget (ISB).

8. Various technical revisions are made to reflect responsibilities of new DHS Division of Provider Services and Quality Assurance (DPSQA) (a new operating agency), new name of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (formerly Division of Aging and Adult Services, an operating agency), and location of Office of Long-Term Care (OLTC) in DPSQA.

9. To accommodate past and projected growth in participation in ARChoices, the limitations on the maximum number of participants served at any point in time are increased to 9,071 for Waiver Year 4; and 9,434 for Waiver Year 5.

III. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies)*:

	Component of the Approved Waiver	Subsection(s)
X	Waiver Application	1.F. 2 7 8 A B
X	Appendix A – Waiver Administration and Operation	A-1 A-2-b A-3 A-5 A-6 A-7 Quality Improvement
X	Appendix B – Participant Access and Eligibility	B-3-b B-5-b B-5-d B-6-c, d, e, f, i, and j Quality Improvement B-7-a B-8
X	Appendix C – Participant Services	C-1/C-3 C-1-c C-2: 1 of 3-a, b, C-2: 3 of 3-e, f C-4-a

	Component of the Approved Waiver	Subsection(s)
		Quality Improvement
X	Appendix D – Participant Centered Service Planning and Delivery	D-1: 3 of 8, 4 of 8, 5 of 8, 6 of 8, 7 of 8, 8 of 8 D-2-a, b Quality Improvement
☐	Appendix E – Participant Direction of Services	
X	Appendix F – Participant Rights	F-1 F-3-b, c
X	Appendix G – Participant Safeguards	G-1-b, c, d, e G-2 Quality Improvement G-3: 1 of 2
X	Appendix H – Quality Improvement Strategy	H-1-a, b
X	Appendix I – Financial Accountability	I-1 Quality Improvement I-2-a, d I-5-b
X	Appendix J – Cost-Neutrality Demonstration	J-1 J-2: 1 of 9 (a.), 3 of 9 (c.i.), 4 of 9, 5 of 9 (d.ii.), 6 of 9 (d.ii.), 7 of 9 (d.ii.), 8 of 9 (d.ii.), 9 of 9 (d.ii.)

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies)*:

☐	Modify target group(s)
X	Modify Medicaid eligibility
X	Add/delete services
X	Revise service specifications
☐	Revise provider qualifications
☐	Increase/decrease number of participants
X	Revise cost neutrality demonstration
☐	Add participant-direction of services
X	Other (specify): 1. Transition independent assessment process from (a) DHS RNs using the ArPath instrument to (b) RNs of independent assessment contractor using the Arkansas Independent Assessment (ARIA) instrument. DHS RNs will gather additional information from individuals in connection with developing the person-centered service plan (PCSP).

2. Add limit on the maximum dollar amount of waiver services authorized for each specific participant by the prospectively determined Individual Services Budget (ISB).

3. To accommodate past and projected growth in participation in ARChoices, the limitations on the maximum number of participants served at any point in time are increased to 9,071 for Waiver Year 4; and 9,434 for Waiver Year 5.

4. Technical edits to reflect changes in operating divisions (names, responsibilities).

IV. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Dave
Last Name	Mills
Title:	Business Operations Manager, Office of Policy Coordination & Promulgation
Agency:	Arkansas Department of Human Services
Address 1:	P. O. Box 1437, Slot S-295
City	Little Rock
State	AR
Zip Code	72203-1437
Telephone:	(501) 320-6306
E-mail	dave.mills@dhs.arkansas.gov
Fax Number	(501) 404-4619

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

First Name:	Mark
Last Name	White
Title:	Deputy Director
Agency:	Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services
Address 1:	P. O. Box 1437, Slot S-530
City	Little Rock
State	AR
Zip Code	72203-1437
Telephone:	(501) 320-6009
E-mail	mark.white@dhs.arkansas.gov
Fax Number	(501) 682-8155

V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Date:	**November 16, 2019**

First Name:	Jay
Last Name	Hill
Title:	Director
Agency:	Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services
Address 1:	P.O. Box 1437, Slot S-530
Address 2:	
City	Little Rock
State	Arkansas
Zip Code	72203-1437
Telephone:	(501) 320-6009
E-mail	jay.hill@dhs.arkansas.gov
Fax Number	(501) 682-8155

REQUESTED AMENDMENT TO WAIVER INFORMATION

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

X **Nursing Facility**

X Nursing Facility as defined in 42 CFR 440.40 and 42 CFR 440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Individuals requiring a skilled level of care are not eligible for the ARChoices program.

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

The purpose of the ARChoices in Homecare (ARChoices) waiver is to offer cost-effective, person-centered home and community-based services as an alternative to nursing home placement to persons aged 21 to 64 years of age with a physical disability or 65 and older who require an intermediate level of care in a nursing facility. Through person-centered service plans managed by State-employed registered nurses (RN), the waiver maintains Medicaid-eligible participants at home, promotes dignity, autonomy, privacy, and safety, fosters community inclusion, and precludes or postpones institutionalization of the participant.

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

Functional eligibility for the waiver is determined using assessments and reassessments performed by the State's Independent Assessment Contractor using a new electronic instrument, the Arkansas Independent Assessment (ARIA) system and the contractor's team of registered nurses. The assessment is sent to the

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

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

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

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

Attachment #1: Changes from Previous Approved Waiver That May Require a Transition Plan.

Instructions: If applicable, check the box next to any of the following changes from the current approved waiver that you are making with this application. Check all of the boxes that apply. If you check any of the boxes, you will be prompted to complete a transition plan.

	Replacing an approved waiver with this waiver.
	Combining waivers.
	Splitting one waiver into two waivers.
X	Eliminating a service.
	Adding or decreasing an individual cost limit pertaining to eligibility
X	Adding or decreasing limits to a service or a set of services, as specified in Appendix C
	Reducing the unduplicated count of participants (Factor C).
	Adding new, or decreasing, a limitation on the number of participants served at any point in time.
X	Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
X	Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

(Please refer to Section Main (B), "Additional Needed Information (Optional)", for the full Transition Plan, as it is too long for this text box in the waiver portal.)

B: Additional Needed Information (Optional):
Provide additional needed information for the waiver (optional):

Transition Plan for the Waiver

Similarities and differences between the services covered in the approved waiver and those covered in the amended waiver:

All types of services covered in the approved waiver continue to be covered in the amended waiver, except as follows:

1. The amended waiver adds a new Prevocational Services benefit for persons with physical disabilities who wish who wish to join the general workforce. Prevocational Services are a range of learning and experiential type activities to help prepare a participant for paid employment or self-employment in the community.

2. The amended waiver eliminates Adult Family Home Services, which is not used by any waiver participants and obsolete.

When services in the approved waiver will not be offered in the new or renewed/amended waiver or will be offered in lesser amount, how the health and welfare of persons who receive services through the approved waiver will be assured:

No type of service covered by the approved waiver and received by any current participant is discontinued under the amended waiver.

The amended waiver modifies the scope of attendant care services to align with Instrumental Activity of Daily Living (IADL) tasks covered for adults under the State Plan personal care services benefit and the self-directed personal assistance program (Independent Choices). The modifications will also support the new assessment system and waiver administration, effectively use the capabilities of the new assessment tool, reduce duplication and inappropriate service substitutions, reduce a risk of abuse of beneficiary personal finances, and reduce other program integrity risks. Specially, three IADL tasks not covered under the under the State Plan personal care services benefit are eliminated from the ARChoices attendant care scope of services (i.e., managing basic personal finances, communication with others, and traveling).

By definition, all IADLs, whether or not assistance is covered, are not necessary for fundamental functioning. Human assistance with medically necessary ADLs (such as toileting and mobility and ambulating) remain covered both in the home setting and outside the home when a waiver participant wishes to participate in community activities or attend religious services and needs such assistance at those venues. Non-emergency medical transportation is already a covered service. Management of a participant's personal finances should be performed by either the participant themselves if able or by a properly delegated and qualified family member or professional. Management of finances by attendants presents risks for abuse and oversight is extremely difficult. With modern communications technology, communication with others is far more readily available and, where assistance is needed, it is incidental to time covered for other covered services or tasks. Finally, under the current ArPath assessment system

replaced in this waiver amendment and ArPath use of RUGs-based hours calculations, time for these three IADL tasks was rarely explicitly covered, identified, or quantified or otherwise supported by the RUGs-determined hours per the assessment results, and/or in approved in service plans. Therefore, these reforms to the IADL-related portion of the attendant care service description are not expected to adversely affect participant health and welfare.

The amended waiver includes policy reforms to improve program integrity, better ensure cost-effectiveness, support fiscal sustainability, and provide transparency of the actual costs of waiver services. Specifically, these reforms are:

1. **Program Integrity Reforms:** The service definitions and service limitations to the amount, duration, and frequency of Attendant Care Services and Respite Care Services are clarified and improved to reduce overuse, misuse, and duplication of services; ensure only medically necessary services are covered; and better ensure waiver services do not inappropriately supplant other services available to the participant (such as family supports, Medicare covered services, and targeted or supplemental services offered by a participant's Medicare Advantage plan).

2. **Prospective Individual Services Budget:** The Individual Services Budget (ISB), a prospectively determined dollar limit on the amount of all waiver services that may be authorized in a service plan over and above any limits on amount, duration, and frequency that apply to individual waiver services. (Please note that the Individual Services Budget applies post-eligibility and is not an "individual cost limit pertaining to eligibility" as defined in CMS guidance.)

In individual cases and as part of the person-centered service planning process, these reforms may result in a lesser amount of authorized waiver services than may have been authorized previously in the participant's most recent service plan under the approved (original) waiver. Through a range of policies and safeguards, the state will assure the health and welfare of persons who now receive services through the approved waiver but for whom services may be offered in a lesser amount under the amended waiver. These include:

1. The registered nurses who develop the person-centered service plans have a reasonable degree of professional discretion to adjust the amount, duration, and frequency of Attendant Care Services and Respite Care Services to meet individual needs and circumstances. The amended waiver itself covers other services that may be adjusted, as appropriate.

2. Waiver eligibility also provides participants with access to a broad mix of services covered under the Arkansas Medicaid State Plan, including personal care, durable medical equipment, and targeted case management.

3. After considering the participant's assessed needs, priorities, preferences, goals, and risk factors, if services authorized in the individual's person-centered service plan are not sufficient to meet their needs, the registered nurse will make referrals to appropriate services available through the Medicaid State Plan or another waiver program, Medicare, the participant's Medicare Advantage plan or Medicare prescription drug plan, and other federal, state, or community programs.

4. In the event the waiver services authorized for the participant within the limit of the applicable Individual Services Budget amount, Medicaid State Plan services, other waiver services, Medicare-covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DAABHS registered nurse will counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing

facility services and assisted living facility services) and make appropriate referrals. The nurse may also order a re-assessment of the participant.

5. In the event that a participant's Individual Services Budget (ISB) amount requires limitations to waiver services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, the participant will be given the opportunity during the person-centered service plan process to choose a different mix, type, or amount of waiver covered services. (For example, the participant could decide to forego a day of adult day health services to have additional attendant care hours.)

6. As detailed in the amended waiver (appendix C-4), the prospective Individual Services Budget amounts are determined using population-based factors.

7. Participants may request an exception to their Individual Services Budget amount. A panel of registered nurses will review exception requests to determine if an adjustment is necessary due to unusual, exceptional circumstances. Approved exceptions will be in the form of a temporary increase in the participant's Individual Services Budget amount for a period not to exceed one year.

8. Further, the revised service definitions and service limitations for Attendant Care Services and Respite Care Services are written to ensure that services authorized and received are reasonable and medically necessary, consistent with the participant's needs and risks as determined through the independent assessment, not duplicative, and exclude coverage of services unrelated or contrary to the participant's health and welfare. This includes nurse review and approval of the number of service hours for tasks according to published medical necessity guidelines (Task and Hour Standards). The overuse, misuse, abuse, or duplication of a covered service do not support a person's health and welfare. The receipt of medically unnecessary services does not serve the health and welfare of participants and in fact may adversely affect a beneficiary's health and welfare. Therefore, by design, the application of these new policies will serve to further protect participant health and welfare by ensuring that service scopes and amounts, durations, and frequencies of services under the amended waiver are sufficient, reasonably flexible to meet differences in participants' assessed needs, and exclude medically unnecessary activities and quantities.

A large proportion of waiver participants are also Medicare enrollees. Whenever possible, dual eligible beneficiaries should access and receive Medicare-covered, medically necessary services and supports rather than relying upon substitute or alternative Medicaid State Plan or waiver-based services. This objective is consistent with Medicare beneficiary rights and Medicaid's status as secondary payor and is essential for Medicaid program integrity and fiscal sustainability. Therefore, it is important to note recent significant policy changes easing or expanding the availability of home-based services and supports through the federal Medicare home health benefit and new Medicare Advantage plan supplemental benefits for persons with chronic conditions.

Broader Medicare home health nursing, home health aide, and therapy services coverage as a result of the Jimmo v. Sebelius settlement and associated CMS policy clarifications in 2013-2017 is expected to eliminate longstanding impediments to beneficiaries receiving these Medicare-reimbursed services. Under the Bipartisan Budget Act of 2018 (BBA 2018), Medicare's documentation requirements for home health eligibility were simplified, reducing a significant obstacle for home health agencies to receive coverage approvals for their patients (BBA 2018 section 51002). In both instances, prior policies tended to restrict access to Medicare-covered services, forcing many providers and their patients nationwide to seek coverage through Medicaid and Medicaid HCBS waiver programs instead. For waiver participants who are dual eligibles, these positive policy changes should improve their ability to access, when medically

necessary, Medicare-covered nursing visits and Medicare home health aide assistance with ADL tasks like bathing, dressing, and toileting.

Further, starting in CY 2019, Medicare Advantage (MA) health plans (including MA Special Needs Plans for dual eligibles) may offer supplemental services not otherwise covered under regular Medicare Part A or Part B benefits and at no additional cost to plan enrollees. These targeted or supplemental benefits may include a wide range of non-medical, in-home services or supports. They must be designed to improve or maintain the health or overall functioning of beneficiaries with chronic conditions. This new supplemental benefit option in Medicare Advantage (Medicare Part C) is through the Medicare Advantage Value-Based Insurance Design demonstration (expanding nationwide as required under BBA 2018 section 50321), the new expanded benefit option for chronically ill enrollees created by BBA 2018 section 50322 (42 U.S.C. 1395w–22(a)(3)(D)), and CMS final rules promulgated on April 2, 2018 (CMS-4182-F). Medicare Advantage plans will vary is how they choose to use this increased flexibility and Medicare Part C enrollment is voluntary. However, many waiver participants may have access to "Medicaid-like" supportive services offered through their MA plan or one or more of the competing MA plans available to them in Arkansas.

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

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

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

The approved waiver provides for assessments using the ArPath system, which is based primarily on the interRAI instrument. The ArPath system includes two algorithms that gather necessary information to ascertain whether an applicant or participant needs the state's level of care criteria related to Alzheimer's or related dementia (Cognitive Performance Scale) and daily skilled monitoring of a life-threatening medical condition (Changes in Health, End-Stage Disease and Symptoms and Signs [CHESS]). Under the new Arkansas Independent Assessment (ARIA) system, the necessary information for these criteria are built into the ARIA instrument. Assessment instruments involve a complex array of questions asked by registered nurses during the face-to-face evaluation meetings with applicants and participants. As with the implementation of any new assessment instrument and routinely in the course of each assessment or re-assessment, new or additional information directly relevant to level of care criteria, and therefore a person's functional / non-financial eligibility, may be received.

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

Before implementation of the amended waiver, the state will promulgate the new/revised provider manual. In Arkansas, manual promulgation includes a public comment period and legislative committee review. Also, the state will provide for a series of regional training sessions and webinars for providers and other stakeholders.

All new policies about person-centered service planning, including authorization of services and the prospective Individual Services Budgets, will be phased in and applied to existing participants as their existing person-centered service plans are renewed, updated, or otherwise revised for a new period (up to

one year). Similarly, re-assessments of existing participants will be performed through the new independent assessment process on a revolving basis as previously approved person-centered service plans near expiration or earlier if appropriate (such as in the event of care transitions).

All new policies about provider service delivery practices and program integrity, including service definitions and limits to eliminate or reduce overuse, misuse, abuse, and duplication of waiver services, are reasonable and necessary to protect program integrity and better ensure provision of covered, medically necessary services appropriate to meet assessed needs. Therefore, these policies will go into effect with the amended waiver.

Specifically, any services authorized under a person-centered service plan in effect on the effective date of the amended waiver and promulgated provider manual must comply with the service definitions and limitations in the amended waiver. For example, providers must adhere to new service definitions and limitations concerning the types of activities that are covered under attendant care and respite care. The quantity of services authorized for a participant may not exceed that specified in the participant's prevailing, approved person-centered service plan. Where the amended waiver establishes new policies affecting quantities, these will apply as new person-centered service plans are created and following an assessment/re-assessment. However, providers must comply with all non-quantity limitations, such as the amended waiver's more precise definitions of covered tasks and the policy excluding coverage of attendant care visits for entertainment activities.

The prevocational services benefit, by being new, will not negatively affect any participant and therefore requires no transition for existing participants.

No participants use the adult family home service proposed for elimination. We expect no requests for it before the effective date of the amended waiver. Therefore, no transition is needed for this service elimination.

If persons served in approved waiver will not be eligible to participate in the new or renewed/amended waiver, the plan describes the steps that the state will take to facilitate the transition of affected individuals to alternate services and supports that will enable the individual to remain in the community:

The amended waiver makes no changes to waiver eligibility policy other than a technical change to Section 1.F, Levels of Care, to clarify that individuals requiring a skilled level of care are not eligible for the ARChoices program. This clarification aligns Section 1.F with the current Brief Waiver Description, which states that the waiver eligibility is limited to "persons aged 21 to 64 years of age with a physical disability, or 65 and older who require an intermediate level of care in a nursing facility." The new assessment process and instrument and eligibility determination process are based on the existing level of care criteria established in state regulations.

In the event that a person in the approved waiver is, for whatever reason, not eligible for the amended waiver, they will be referred to other, alternative services, including, as appropriate, other waivers, Medicaid State Plan services, Medicare services, and community services.

Includes the timetable for transitioning individuals to the new waiver (i.e., will participants in the existing waiver transition to the new waiver all at the same time or will the transition be phased in?).

As described above, existing participants will be transitioned to the amended waiver on revolving basis according to the expiration date of their current person-centered service plan and timing of their next re-

assessment. Existing participants requiring earlier-than-planned re-assessments as a result of care transitions or other life changes will be phased into the amended waiver during that re-assessment and new service plan.

How participants are notified of the changes and informed of the opportunity to request a Fair Hearing:

Participants may request a Fair Hearing concerning eligibility determinations, person-centered service plans, and Individual Services Budgets.

Current notification processes, including letters with information on how to request a Fair Hearing, will continue, with information updated as necessary.

DAABHS will inform participants of their prospective Individual Services Budget amounts as described in Appendix C-4.

Relevant beneficiary materials will be updated to describe policy changes.

Additional public and stakeholder notification are achieved through the state's formal public comment and promulgation process for the waiver program manual.

REQUESTED AMENDMENTS TO APPENDIX A

Appendix A: Waiver Administration and Operation

A-1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver:

X The waiver is operated by a separate agency of the State that is not a division/unit of Medicaid agency

Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) and Division of Provider Services and Quality Assurance (DPSQA)

Appendix A: Waiver Administration and Operation

A-2. Oversight of Performance.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Arkansas Department of Human Services (DHS) uses an Interagency Agreement to define the responsibilities of the three DHS divisions – Division of Medical Services (DMS, the Medicaid agency) DAABHS, and DPSQA – charged with responsibility for administering both the ARChoices in Homecare

(ARChoices) and Living Choices in Assisted Living (Living Choices) HCBS waiver programs. This agreement is reviewed annually and updated as needed. DMS, as the Medicaid agency, monitors this agreement on a continuous basis to assure that the provisions specified are executed.

DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS and DPSQA, including monitoring compliance with the Interagency Agreement.

DAABHS is responsible for the day-to-day administration of the waiver, establishing waiver program policies and procedures, overseeing the development and management of person-centered service plans, developing Individual Services Budgets, and overseeing the Independent Assessment Contractor.

DPSQA is responsible for provider certification, compliance, and provider quality assurance. Through its Office of Long Term Care (OLTC), DPSQA is responsible for level of care determinations. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system.

To oversee and monitor the functions performed by DAABHS and DPSQA in the administration and operation of the waiver, DMS will conduct team meetings as needed with DAABHS and DPSQA staff to discuss compliance with the performance measures in the programs, results of chart reviews performed by DMS and DAABHS, corrective action plans, remediation, and systems improvements to maintain effective administration of the programs.

A-3. Use of Contracted Entities.
Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable)

X **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6*:

A contractor ("Independent Assessment Contractor") will perform independent assessments that gather functional need information about each ARChoices waiver applicant and participant using the Arkansas Independent Assessment (ARIA) instrument. The information gathered is used to determine the individual's level of care, the number of medically necessary hours of attendant care, and the tier level (which is intended to help inform waiver program oversight and administration and person-centered service planning).

A-5 Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.
Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

As described in the Interagency Agreement between the Division of Medical Services (DMS, the Medicaid agency), the Division of Aging, Adult, and Behavioral Health Services (DAABHS), and the

Division of Provider Services and Quality Assurance (DPSQA), DAABHS and DMS will jointly share responsibility for oversight of the performance of the Independent Assessment Contractor, with DMS being ultimately accountable. The contract provides for performance measures the Independent Assessment Contractor is required to meet.

A-6 Assessment Methods and Frequency.
Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The state assesses the performance of the Independent Assessment Contractor on a monthly and annual basis through review and assessment of the monthly and annual Program Performance Reports submitted by the Independent Assessment Contractor to the Contract Monitor. The state's contract with the Independent Assessment Contractor includes performance standards and requirements for a quality monitoring and assurance program.

The Independent Assessment Contractor's quality monitoring and assurance process must include (1) the staff necessary to perform quality monitoring and assurance reviews for accuracy, data consistency, integrity, and completeness of assessments and (2) procedures for assessing the performance of the staff conducting the assessments, include a desk review of assessments, tier determinations, and recommended attendant care services hours according to the Task and Hour Standards for a statistically significant number of cases. The Independent Assessment Contractor is required to include the results of the quality monitoring and assurance process in the monthly reports submitted to the Contract Monitor in the format required by DHS.

The monthly reports include the following:

1. Demographics about the beneficiaries who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all Assessments and Reassessments; and
3. A running total of the activities completed.

The annual report includes the following:

1. A summary of the activities over the prior year;
2. A summary of the Independent Assessment Contractor's timeliness in scheduling and performing assessments and reassessments;
3. A summary of findings from Beneficiary feedback research conducted by the Independent Assessment Contractor;
4. A summary of any challenges and risks perceived by the Independent Assessment Contractor in the year ahead and how the Independent Assessment Contractor proposes to manage or mitigate those; and
5. Recommendations for improving the efficiency and quality of the services performed.

The Contract Monitor and senior staff from DAABHS and DMS review the monthly and annual reports submitted by the Independent Assessment Contractor within 15 days after they have been submitted, and determine whether the Independent Assessment Contractor has submitted the required information, following its quality monitoring and assurance process, and meeting the performance standards in the contract. If not, the state will initiate appropriate corrective and preventive actions, which may include, for example, further analysis and problem solving with the contractor, root cause analysis to identify the

cause of a discrepancy or deviation, enhanced reporting and monitoring, improved performance measures, requiring development and execution of corrective action plans, reallocation of staff resources, data and systems improvements, consultation with stakeholders, and/or sanctions under the contract.

A-7 Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (check each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Prior authorization of waiver services	☑	☑	☐

Appendix A: Waiver Administration and Operation
Quality Improvement: Administration Authority of the Single State Medicaid Agency

a. **Methods for Discovery: Administrative Authority**

i. **Performance Measures**

Performance Measure:
Number and percent of LOC assessments completed using the approved instrument according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed using the approved instrument; Denominator: Number of LOC assessments reviewed.
Medicaid Quarterly QA Report (Chart Reviews)
Case Record Review
Sampling Approach *(check each that applies)*
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Performance Measure:
Number and percent of LOC assessments completed by the Independent Assessment Contractor in the time specified in the agreement with the Medicaid Agency.
Numerator: Number of LOC assessments completed by the Independent Assessment Contractor in time frame; Denominator: Number of LOC assessments reviewed.
Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Performance Measure:
Number and percent of participant service plans completed by DAABHS in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of service plans completed by DAABHS in time frame; Denominator: Number of service plans reviewed.
Case Record Review
Sampling Approach *(check each that applies)*
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Performance Measure:
Number and percent of policies and/or procedures developed by DAABHS, in consultation with DPSQA, that are reviewed and approved by the Medicaid Agency (DMS) prior to implementation. Numerator: Number of policies and procedures by DAABHS reviewed by DMS before implementation; Denominator: Number of policies and procedures developed.

Performance Measure:
Number and percent of providers licensed by the Division of Provider Services and Quality Assurance (DPSQA). Numerator: Number of current providers licensed by DPSQA; Denominator: Number of providers participating in the waiver program.
Case Record Review
Sampling Approach *(check each that applies)*
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Performance Measure:
Number and percent of LOC assessments completed by an Independent Assessment Contractor qualified evaluator according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by an Independent Assessment Contractor qualified evaluator; Denominator: Number of LOC assessments reviewed.
Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Appendix A: Waiver Administration and Operation
Quality Improvement: Administration Authority of the Single State Medicaid Agency

a. Methods for Discovery: Administrative Authority

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency), and the Division of Medical Services (DMS) (Medicaid agency) participate in team meetings as needed to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement for measures related to administrative authority of the waiver.

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

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

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

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

The tool used for record review documents and tracks remediation.

Appendix B: Participant Access and Eligibility
B-3. Number of Individuals Served (1 of 4)

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

The State does not limit the number of participants that it serves at any point in time during a waiver year.

X The State limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During The Year
Year 1	8032
Year 2	8176
Year 3	8320
Year 4	9071
Year 5	9434

Appendix B: Participant Access and Eligibility
B-5. Post-Eligibility Treatment of Income (2 of 7)

b. Regular Post-Eligibility Treatment of Income: SSI State.

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

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

X Other

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

B-5. Post-Eligibility Treatment of Income (4 of 7)

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

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

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

X Other

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

Level of Care Criteria:

The functional level of care criteria for ARChoices in Homecare waiver eligibility are established in administrative rules and the ARChoices manual, as promulgated by the Arkansas Department of Human Services (DHS). Please see DHS rule 016.06 CARR 057 (2017) (Procedures for Determination of Medical Need for Nursing Home Services).

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

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

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

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

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

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

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

2. Not require a skilled level of care, as defined in the State rule.

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

Instrument/Tool Used:

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

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

All State laws, regulations, and policies concerning level of care criteria and the assessment instrument/tool (including the current ArPath instrument, the new ARIA instrument, the ARChoices waiver program manual, and the ARIA manual) are available to CMS upon request through DAABHS.

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

e. Level of Care Instrument(s). Per 42 CFR 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (select one):

The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

X A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

Level of Care Instrument for Institutional Care:

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

perform activities of daily living, along with other relevant information regarding the individual's medical history.

Level of Care Instrument for Waiver Program:

Currently, the instrument used to determine the level of care for the ARChoices program is ArPath, based on the interRAI tool. Following the transition period, the Arkansas Independent Assessment (ARIA) system will be used to support the level of care determination process.

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

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

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

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

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

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

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

In summary:

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

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

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

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

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

Appendix B: Participant Access and Eligibility
B-6. Evaluation/Reevaluation of Level of Care

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

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

Specifically, DAABHS registered nurses (RNs) and RN supervisors use a "tickler" file system approach to monitor upcoming review data and service plan expirations. The process of reassessment begins two months prior to the expiration date of the current person-centered service plan or two months prior to the annual anniversary date of the last independent assessment, whichever is earlier. The case is added to the assessment schedule. Once the re-assessment is completed and the level of care revised as appropriate, the DHS RN begins development of the new person-centered service plan.

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

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

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

Appendix B: Participant Access and Eligibility

B-6. Evaluation/Reevaluation of Level of Care

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

a. Methods for Discovery: Level of Care Assurances/Sub-assurances

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

i. **Sub-Assurances:**

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

Performance Measure: Number and percentage of applicants who had a LOC indicating need for nursing facility LOC prior to receipt of services. Numerator: Number of applicants who received level of care prior to service; Denominator: Total number of applicants.
Case Record Review
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measure: Number and percentage of waiver participants who received an annual redetermination of LOC eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC re-evaluation. Numerator: Number of participants receiving annual redeterminations within 12 months; Denominator: number of records reviewed.
Case Record Review
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

Performance Measures:
Number and percentage of participants annual re-evaluation LOC determinations that were completed as required by the state. Numerator: Number of participants with LOC determinations completed correctly; Denominator: Number of records reviewed.
Number and percentage of participants LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed.
Case Record Review
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations and oversight of the independent assessment process), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for level of care determinations), and the Division of Medical Services (Medicaid agency) – all three of which are part of the Arkansas Department of Human Services (DHS) – participate in team meetings as needed to discuss and address individual problems associated with level of care determinations, assessments, and system improvements, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures related to level of care determinations for the waiver.

The system currently in place for new applicants to enter the waiver program does not allow for services to be delivered prior to an initial level of care determination. Also, DAABHS requires that all initial assessments and reassessments are completed by a registered nurse.

Level of Care assessments are required annually using the approved assessment instrument (currently, the ArPath instrument, and under the amended waiver the Arkansas Independent Assessment (ARIA) instrument) and applying the level of care criteria. For the ArPath instrument, the DHS RN supervisors currently complete a regional monthly activity report, which lists the number of level of care evaluations and re-evaluations conducted. Remediation efforts are included on the DHS RN supervisors' monthly report. For ARIA, the DHS Independent Assessment Contractor will submit data reports to DMS at least monthly listing the number of level of care evaluations and re-evaluations conducted. DMS will require the DHS Independent Assessment Contractor to develop a corrective action plan when remediation in this area is needed, and document completion of the corrective action plan.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.
Copies of the waiver participant's service plan are maintained with the DAABHS (operating agency) and with the providers chosen by the participant and included on the service plan. Freedom of Choice forms and person-centered service plans are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

Appendix B: Participant Access and Eligibility
B-8: Access to Services by Limited English Proficiency Persons
Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

All Department of Human Services (DHS) forms are available in English and Spanish. The forms can be translated into other languages when the need arises. DHS maintains an ongoing contract with a Spanish interpreter and translator agency for translation services.

All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. DHS RNs provide written materials to participants and will read any information to participants if needed. DHS RNs may utilize assistance from other divisions within the Arkansas Department of Human Services (DHS), such as the Division of Services for the Blind, in these instances. When this occurs, it is documented in the participant record.

REQUESTED AMENDMENTS TO APPENDIX C

Appendix C: Participant Services
C-1: Summary of Services Covered

a. **Waiver Services Summary.** ***List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:***

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Respite		
Other Service	Adult Day Services		
Other Service	~~Adult Family Home~~ [delete from table] Prevocational Services [add to table]		
Other Service	Attendant Care Services		
Other Service	Environmental Accessibility Adaptations/Adaptive Equipment		
Other Service	Home-Delivered Meals		
Other Service	Personal Emergency Response System (PERS)		

Appendix C: Participant Services

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Attendant Care Services
HCBS Taxonomy: (no change)

Service Definition (Scope):

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

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

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

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

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

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

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

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

1. Activities of Daily Living (ADLs):

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

    b. Toileting;

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

    d. Dressing;

e. Bathing or showering; and/or

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

2. Instrumental Activities of Daily Living (IADLs):

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

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

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

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

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

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

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

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

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

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

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

b. Any such health-related tasks performed:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the beneficiary in accordance with the Arkansas Medicaid Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The

THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, or month. Any aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the beneficiary in accordance with the THS are not covered.

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

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

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

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

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

   e. On dates of service when the participant:

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

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

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

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

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

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

   g. For a task that was not actually performed.

Appendix C: Participant Services

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Adult Family Home
HCBS Taxonomy:

[Delete Adult Family Home service]

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Environmental Accessibility Adaptations/Adaptive Equipment
HCBS Taxonomy: (no change)

Service Definition (Scope):

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

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

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment provided by a waiver beneficiary's:

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

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Respite
HCBS Taxonomy: (no change)

Service Definition (Scope):

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

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

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

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

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

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

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

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

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

Respite Care is available in the following locations:

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

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

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

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

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

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

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

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

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

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

Respite Care is subject to the following limitations:

1. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with and shall be limited to amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards ("THS"). Any amounts, frequencies, or durations in excess of the unpaid caregiver assistance amounts identified for the beneficiary in the THS are not covered.

2. Respite Care excludes:

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

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

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

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

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

   f. Services provided for any tasks not included in a beneficiary's service plans.

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

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

C-1/C-3: Service Specification

Service Type: Other Service

Service Title: Prevocational Services

HCBS Taxonomy: Category 04 Day Services; Subcategory 04010 Prevocational services

Service Definition (Scope):

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

Prevocational services are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

Service Delivery Method *(check each that applies)*:

☑ Provider managed

Specify whether the service may be provided by (check each that applies):

☐ Legally Responsible Person
☑ Relative
☐ Legal Guardian

C-1/C-3 Provider Specifications

Service: Adult Day Health
Provider Type – Licensed Adult Day Health Care
Provider Qualifications - License (specify)

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

Provider Qualifications - Certificate (specify)

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Health services. To be certified, providers must provide a copy of their current adult day health care agency license through the DHS Division of Provider Services and Quality Assurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Health Care license at all times.

Service: Respite

Provider Type - Licensed Acute Care Hospital

Provider Qualifications – Certificate (specify)

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current acute care hospital license.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Licensed Acute Care Hospital license at all times.

Service: Respite

Provider Type – Licensed Level II Assisted Living Facility

Provider Qualifications - License (specify)

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Level II Assisted Living Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001.

Provider Qualifications - Certificate (specify)

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their level II assisted living facility license through the DHS Division of Provider Services and Quality Assurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Level II Assisted Living Facility license at all times.

Service: Respite

Provider Type - Licensed Medicaid Certified Nursing Facility Agency

Provider Qualifications – License (specify)

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Medicaid Certified Nursing Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001

Provider Qualifications - Certificate (specify)

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their Medicaid certified nursing facility license through the DHS Division of Provider Services and Quality Assurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Medicaid Certified Nursing Facility license at all times.

Service: Respite

Provider Type – Licensed Adult Day Health Care Agency

Provider Qualifications – License (specify)

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

Provider Qualifications – Certificate (specify)

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Health services. To be certified, providers must provide a copy of their current adult day health care agency license through the DHS Division of Provider Services and Quality Assurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Health Care license at all times.

Service: Respite

Provider Type – Licensed Residential Care Facility

Provider Qualifications – License (specify)

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Residential Care Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001.

Provider Qualifications – Certificate (specify)

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their residential care facility license through the DHS Division of Provider Services and Quality Assurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Residential Care Facility license at all times.

Service: Respite
Provider Type – ~~Certified Adult Family Home~~
[Delete provider type]
Provider Qualifications – Certificate (specify)
[Delete current language]
Verification of Provider Qualifications
Entity Responsible for Verification:
[Delete current language]
Frequency of Verification:
[Delete current language]

Service: Respite
Provider Type - Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency
Provider Qualifications – License (specify)
Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency as required by Ark. Code Ann. 20-10-807, History: Acts 1987, No. 956, 4; or licensed as a Private Care Agency.
Provider Qualifications – Certificate (specify)
Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current Class A and/or Class B home health agency license, or Private Care Agency license through the Arkansas Department of Health.
Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current license at all times.

Service: Respite
Provider Type – Licensed Adult Day Care
Provider Qualifications - License (specify)
Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et. seq.
Provider Qualifications - Certificate (specify)
Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Services. To be certified, providers must provide a copy of their current adult day care license through the DHS Division of Provider Services and Quality Assurance.
Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Care license at all times.

Service: Adult Day Services
Provider Type – Licensed Adult Day Care

Provider Qualifications - License (specify)
Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et. seq.
Provider Qualifications - Certificate (specify)
Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Services. To be certified, providers must provide a copy of their current adult day care license through the DHS Division of Provider Services and Quality Assurance.
Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Care license at all times.

Service: ~~Adult Family Home~~
Provider Type – ~~Adult Family Home~~
[Delete Adult Family Home service type and provider type]

Provider Qualifications - Certificate (specify)
[Delete Adult Family Home service type and provider type]

Verification of Provider Qualifications
Entity Responsible for Verification:
[Delete Adult Family Home service type and provider type]
Frequency of Verification:
[Delete Adult Family Home service type and provider type]

Service: Attendant Care Services
Provider Type – Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider
Provider Qualifications - Certificate (specify)
Agencies must be certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, to provide ARChoices agency attendant care services.
Provider Qualifications - Other Standard (specify)
In order to be certified by DPSQA as an agency attendant care provider and enrolled as a Medicaid provider, the attendants hired by the agency must meet the following minimum qualifications:

o Be 18 years of age or older;

o Be a United States citizen or legal alien authorized to work in the U. S.;

o Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime;

o Be free from communicable diseases;

o Be free from diseases readily transmittable through casual contact;

o Be able to read and write at a level sufficient to follow written instructions and maintain records;

o Be in adequate physical health to perform job tasks required; and

o Have a current signed formal agreement with an eligible ARChoices participant for the provision of agency attendant care services.

Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant.

Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:

Annually for recertification; however, DPSQA must maintain a copy of the provider's current Personal Care Agency license in the provider file at all times.

Service: Attendant Care Services

Provider Type – Licensed Home Health Agency

Provider Qualifications - Certificate (specify)

Agencies must be certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, to provide ARChoices agency attendant care services.

Provider Qualifications - Other Standard (specify)

In order to be certified by DPSQA as an agency attendant care provider and enrolled as a Medicaid provider, the attendants hired by the agency must meet the following minimum qualifications:

o Be 18 years of age or older;

o Be a United States citizen or legal alien authorized to work in the U. S.;

o Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime;

o Be free from communicable diseases;

o Be free from diseases readily transmittable through casual contact;

o Be able to read and write at a level sufficient to follow written instructions and maintain records;

o Be in adequate physical health to perform job tasks required; and

o Have a current signed formal agreement with an eligible ARChoices participant for the provision of agency attendant care services.

Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant.

Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the provider's current Home Health Agency license in the provider file at all times.

Service: Environmental Accessibility Adaptations/Adaptive Equipment
Provider Type – Installer (Builder, Tradesman or Contractor)
Provider Qualifications - Certificate (specify)
Environmental Accessibility Adaptations/Adaptive Equipment providers are certified by the Arkansas Department of Human Service, Division of Provider Services and Quality Assurance, as an ARChoices provider of environmental accessibility adaptations/adaptive equipment. Providers must also complete all applicable forms required by DPSQA for certification. Providers must also be enrolled in the Arkansas Medicaid program as an ARChoices environmental accessibility adaptations/adaptive equipment provider before reimbursement may be made for services provided to ARChoices participants.
Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually.

Service: Home-Delivered Meals
Provider Type – Provider of Food Services
Provider Qualifications - Certificate (specify)
Food Establishment Permit issued by the Department of Health

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA), as an ARChoices waiver provider of Home Delivered Meals. To be certified, providers must provide a copy of their current food establishment permit issued by the Department of Health.

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Food Establishment Permit at all times.

Service: Personal Emergency Response System (PERS)
Provider Type – Alarm or Security Company

Provider Qualifications - Certificate (specify)
Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) as an ARChoices waiver provider of Personal Emergency Response System services. To be certified, providers must provide a copy of their current certificate of compliance for protective signaling services issued by the Underwriters Laboratories Safety Standards.
Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Service: Prevocational Services
Provider Type – Certified Prevocational Services Vendor
Provider Qualifications - Certificate (specify)
Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Prevocational Services.
Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually

Appendix C: Participant Services
C-1: Summary of Services Covered (2 of 2)

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

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

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

C-2: General Services Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):
Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All ARChoices waiver providers employing persons providing direct services (personal assistants, attendants) shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere to any disqualifying criminal offense.

Each ARChoices waiver provider must obtain from each employee and from each applicant for employment a signed authorization permitting disclosures to the ARChoices provider of criminal history information as defined in Ark. Code Ann., Section 12-12-1001.

Each provider receiving payment under the ARChoices program must, as a condition of continued participation in the program, comply with the requirement for criminal history checks for new employees, and periodic criminal history checks for agency operators and all employees at least once every five years. The scope of the criminal background checks is national. This requirement applies to any employee who in the course of employment may have direct contact with an ARChoices participant. At the time of initial certification and re-certification, providers must submit a list of all direct care services staff and the dates of their last criminal background check.

If the results of the criminal history check establish that the applicant was found guilty of, or pled nolo contendere (no contest) to a disqualifying offense under Ark. Code Ann., Section 20-33-205 ("disqualifying offense"), then the ARChoices waiver provider may not employ, or continue to employ, the applicant. Disqualifying offenses do not include misdemeanors that did not involve exploitation of an adult, abuse of a person, neglect of a person, theft, or sexual contact.

According to Arkansas Department of Human Services Policy 1088, DHS shall automatically exclude any provider (or, an employee or subcontractor of that provider) that has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or nolo contendere (no contest), to any crime related to:

1. Obtaining, attempting to obtain, or performing a public or private contract or subcontract,
2. Embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty,
3. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony,
4. Federal antitrust statutes,
5. The submission of bids or proposals, or
6. Any physical or sexual abuse or neglect when the offense is a felony.

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor.

The DPSQA Provider Certification unit sends new applications and a list of providers who are due recertification to the Medicaid Provider Enrollment unit, the Medicaid fiscal agent, which processes all criminal background checks. Certification of new providers and recertification of active providers is contingent upon the completion of the criminal background check. The Medicaid program's fiscal agent submits reports detailing the background checks for new and existing providers to DPSQA.

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

X Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Abuse registry screenings of the direct care of services staff of ARChoices agency providers are monitored at initial certification and re-certification. This is a required part of the certification and re-certification process. In addition, agency providers must submit a list of all direct care of services staff and the dates of their last criminal background checks. Criminal background checks are required for agency providers every five years pursuant to Act 762 of 2009. Providers are required to follow all requirements related to employee criminal background checks discussed in the Medicaid Provider Manual.

The Adult Protective Services unit of the Division of Aging, Adult, and Behavioral Health Services is responsible for maintaining the abuse registry.

As part of the qualified provider review, DPSQA verifies that the provider file contains all required documentation, including information regarding the criminal background checks.

C-2: General Services Specifications (3 of 3)

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

X The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

All ARChoices services may be reimbursed if provided by a relative of the participant, subject to the limitations specified below.

Individuals who are legally responsible for the participant (i.e., spouse, legal guardian, or attorney-in-fact granted authority to direct the participant's care) are prohibited from receiving any reimbursement for any ARChoices services provided for the participant.

All providers, including relatives, are required to meet all applicable ARChoices provider certification requirements and Arkansas Medicaid enrollment requirements, comply with all applicable ARChoices provider manual requirements, and provide services according to the participant's approved service plan and any established benefit limits for that specific service, as identified in Appendix C-1/C-3.

Controls are maintained through the required documentation for all service providers. This documentation must support each service for which billing is made and include a copy of the participant's person-centered service plan, a brief description of the specific services provided, the signature and title of the individual providing the service, and the date and actual time services

were provided. DHS RN supervisory staff conducts chart reviews to ensure that services were provided according to the service plan. DPSQA performs audits and quality reviews of providers.

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

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

The DPSQA website lists information for potential ARChoices providers.

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☐ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3

X **Applicable** - The State imposes additional limits on the amount of waiver services

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*

X **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*

☐ **Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

Prospective Individual Budget Amount:

There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

1. Individual Services Budget (ISB):

   a. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant.

This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.

b. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by DAABHS for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.

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

d. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.

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

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

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

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

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

c. In the event that a participant's ISB requires changes or limitations to ARChoices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type,

or amount of ARChoices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.) Any such participant-requested changes and substitutions are subject to the following:

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

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

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

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

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

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

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

iii. Such unique circumstances may include (1) recent major life events not known at the time the current person-centered service plan was approved, including without limitation death of a spouse or caregiver, and loss of a home or residential placement;

and (2) a temporary increase in care needs, for a period not to exceed ninety (90) days after a discharge from inpatient acute treatment or post-acute care.

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

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

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

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

3. Transition Process:

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

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

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

(a) Waiver eligibility is re-evaluated;

(b) The Level of Care is reaffirmed or revised;

(c) A new independent assessment or re-assessment is performed;

(d) Expiration, renewal, extension, or revision of the participant's person-centered service plan occurs; or

(e) Admission to or discharge from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or transfer from a hospice facility occurs.

b. For all other ARChoices participants not otherwise identified above, the Individual Services Budget limit shall apply no later than 60 days after the effective date of this waiver amendment.

c. For the following ARChoices participants, the DAABHS deputy director (or his/her designee) may on a case-by-case basis extend the effective date of the participant's first Individual Services Budget by a maximum of 60 days per participant upon written request of the participant (or legal representative) or the participant's personal physician, if:

i. The specific participant's recent pattern of waiver service expenditures exceeds the average Individual Services Budget amount by an estimated twenty-five (25) percent or more; and/or

ii. DAABHS determines that unique, intervening circumstances indicate that additional time is reasonably needed by the participant and the participant's family and providers. Examples of unique, intervening circumstances include the death of the spouse, loss of home, or unexpected difficulties in accessing or arranging care or placement, among others.

4. Methodology for Determining Individual Services Budgets:

a. The Individual Services Budget amount for a participant is based on that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The three ISB Levels are:

i. Intensive: The participant requires total dependence or extensive assistance from another person in all three areas of mobility, feeding, and toileting.

ii. Intermediate: The participant requires total dependence or extensive assistance from another person in two of the areas of mobility, feeding, or toileting.

iii. Preventative: The participant meets the functional need eligibility requirements for ARChoices in Section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate.

b. The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (c) below, is as follows:

i. For an individual with an assessed ISB Level of Intensive, the Individual Services Budget is $30,000.

ii. For an individual with an assessed ISB Level of Intermediate, the Individual Services Budget is $20,000.

iii. For an individual with an assessed ISB Level of Preventative, the Individual Services Budget is $5,000.

c. For a participant with total waiver expenditures of more than $30,000 for calendar year 2018:

i. The participant will be granted a Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures for calendar year 2018.

ii. In the year following the Transitional Allowance, the participant's maximum Individual Services Budget will be 95% of the participant's total waiver expenditures for calendar year 2019.

iii. For purposes of this subsection (c), "total waiver expenditures" for a calendar year shall be calculated as the sum total of the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:

(a) If the cumulative expenditures are for less than 12 months, annualizing the total to reflect what the expenditures would have been if the participant had received the same monetary amount of services for 12 consecutive months; and

(b) Excluding amounts expended for environmental modifications/adaptive equipment.

d. DHS will monitor and update these ISB amounts if circumstances (including without limitation provider rate increases) warrant a change for CY2020.

e. For purposes of determining the projected cost of all waiver services in an individual's person-centered service plan, DAABHS shall assume that:

i. The individual will receive or otherwise use all services identified in the service plan and in their respective maximum authorized amounts, frequencies, and durations; and

ii. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.

f. Determination of ISB Amounts

i. The maximum ISB amount, $30,000, which is also the threshold for the Transitional Allowance, is based on the average annual state and federal cost of nursing home care, excluding the average resident share, the average revenue from the state-imposed Quality Assurance Fee (QAF), and the average FMAP revenue associated with the QAF. For FY2018, the average amount of state general revenue paid for a nursing home stay was $24.04 per day; the average amount of the FMAP on that state general revenue was $57.67, for an average daily total of $81.71, multiplied by 365 days to produce an annual total average cost of $29,824.15. This amount is then rounded up to the nearest thousand to produce the $30,000 ISB amount.

ii. The ISB amounts for the Preventative and Intermediate levels are based on a DHS review of actual waiver service expenditures during FY2018 by a set of 6,810 ARChoices participants who received an assessment or reassessment during FY2018. The expenditures for each participant were adjusted to produce a projected annual total expenditure amount, and participants were divided into the Preventative, Intermediate, and Intensive ISB levels based on the results of the ArPath assessment or reassessment recorded in FY2018. DHS then reviewed the distribution of projected annual total expenditure amounts by ISB level to determine an appropriate ISB amount.

Appendix C: Quality Improvement

Quality Improvement: Qualified Providers

a. Methods for Discovery: Level of Care Assurances/Sub-assurances

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

i. Sub-Assurances:

a. *Sub-assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measure: Number and percentage of providers, by provider type, which obtain re-certification in accordance with state law and waiver provider qualifications. Numerator: Number of providers with re-certification; Denominator: Total number of providers
Data source (Select one):
Other: Provider Certification Unit (DPSQA) Provider Database
Performance Measure: Number and percentage of providers, by provider type, which obtained the appropriate license/certification in accordance with state law and waiver provider qualifications prior to delivering services. Numerator: number of providers with appropriate license/certification prior to delivery of services; Denominator: Number of new providers
Data source (Select one):
Other: Provider Certification Unit (DPSQA) Provider Database

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

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

The state verifies that providers meet required licensing or certification standards and adhere to other state standards. License expiration dates are maintained in the MMIS and tracked for all participating and active providers.

Each month the DHS RN receives a provider list for each county included in their geographical area. This provider list may be used at each assessment and reassessment to give the participant a choice of providers for each service included on the service plan. In addition, this list is used to identify the providers who are new or who have been reinstated in the program.

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

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

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

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

The Medicaid fiscal agent provides DPSQA access to Provider License/Certification Status. If needed, this provides a second monitoring tool for monitoring licensure and certification compliance.

The mandatory Medicaid contract, signed by each waiver provider, states compliance with required enrollment criteria. Failure to maintain required certification and/or licensure results in loss of their Medicaid provider enrollment. Each provider is notified in writing at least two months prior to the certification/licensure expiration date that renewal is due and failure to maintain proper certification will result in loss of Medicaid enrollment.

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

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for provider certification and quality assurance), and the Division of Medical Services (Medicaid agency) – all three of which are part of the Arkansas Department of Human Services (DHS) – participate in team meetings as needed to discuss and address individual problems related to qualified providers, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver.

All providers must meet required provider qualifications prior to Medicaid enrollment and prior to providing services. Because of this, performance measures related to these processes will always result in 100% compliance, and not allow for the possibility of remediation.

To continue Medicaid enrollment, a waiver provider must maintain certification by DPSQA. In cases where providers do not maintain certification, DPSQA's remediation may include requesting termination of the provider's Arkansas Medicaid enrollment, recouping payment for services provided after certification/licensure has expired, and allowing the participant to choose another provider.

D-1: Service Plan Development (3 of 8)- Supporting the Participant in Service Plan Development

When scheduling the person-centered service plan development visit, the DHS RN explains to the participant or authorized representative the process and informs the participant that they may invite anyone they choose to participate in the service plan development process. Involved in this assessment visit is the participant and anyone they choose to have attend, such as their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment process or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting.

During the service plan development, the DHS RN explains to the participant the services available through the ARChoices waiver.

When developing the person-centered service plan, all services and any applicable benefit limits are reviewed, as well as the comprehensive goals, objectives and appropriateness of the services. The participant and their representatives participate in all decisions regarding the type of services, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services. This information is recorded on the service plan, which is signed by the participant.

D-1: Service Plan Development (4 of 8) – Service Plan Development Process

(a) DHS RNs will develop initial person-centered service plans for ARChoices in Homecare participants based on the Independent Assessment Contractor's assessment of the participant's needs and information gathered during the service plan development meeting with the participant. The DHS RN will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting. The DHS RN will assist in notifying interested parties if requested by the participant or the representative.

The development of the person-centered service plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor within 10 working days of the Independent Assessment Contractor receiving a referral from DHS. Following the assessment and assignment of a tier level by the Independent Assessment Contractor, a DHS RN will schedule a meeting with the participant to develop the service plan. Reassessments, which will be conducted by the Independent Assessment Contractor, will be completed annually or more often, if deemed appropriate by the DHS RN. Following the reassessment by the Independent Assessment Contractor, the DHS RN will develop a person-centered service plan. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans are developed and sent to all providers before services may begin.

(b) The Independent Assessment Contractor will assess the participant's needs. The DHS RN will assess the participant's comprehensive goals and objectives related to the participant's care and reviews the appropriateness of ARChoices services. If necessary, the DHS RN will read any of the information provided during the assessment to the participant. If this is done, it is documented in the participant's record. All forms and information will be provided in an alternate format upon request. If an alternate format is requested and/or provided, the DHS RN will document in the participant's record the format requested and/or provided.

All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. The Independent Assessment Contractor and the DHS RNs will provide written materials to participants and will read any information to participants if needed. DHS RNs may utilize assistance from other divisions within the Arkansas Department of Human Services, such as the Division of Services for the Blind, in these instances. When this occurs, it is documented in the participant's record.

The results of the Independent Assessment Contractor's functional assessment using the ARIA assessment tool will be used by the Office of Long Term Care to evaluate the level of care and by the DHS RN to develop the person-centered service plan. Information collected for the Independent Assessment Contractor's functional assessment using the ARIA tool will include demographic information and information on the waiver participant's ability to perform the activities of daily living; transferring and ambulation; continence status; nutritional status; hearing, vision, speech and language; skin condition; behavior and attitude; orientation level; other medical conditions; psychosocial and cognitive status; and, medications/treatments.

The assessment is a complete functional assessment and includes a medical history. The Independent Assessment Contractor will evaluate the participant's physical, functional, mental, emotional and social

status, and will obtain a medical history to ensure that the service plan addresses the participant's strengths, capacities, health care, and other needs. The DHS RN will assess the participant's preferences, goals, desired outcomes, and risk factors. Support systems available to the participant are identified and documented, along with services currently in place. Based on this assessment information, the DHS RN will discuss the service delivery plan with the participant.

When the service plan development process results in an individual being denied the services or the providers of their choice, the state must afford the individual the opportunity to request a Fair Hearing.

Provisional (Temporary Interim) Service Plan Policy: A provisional person-centered service plan may be developed by the DHS RN prior to determination of Medicaid eligibility, based on information obtained during the in-home functional assessment if the applicant is functionally eligible based on the Independent Assessment Contractor's assessment. The DHS RN must discuss the Provisional Service Plan Policy and have approval from the applicant prior to completing and processing a provisional service plan, which will then be signed by the applicant or the applicant's representative and the DHS RN. The provisional service plan will be provided to the waiver applicant and each provider included on the service plan. The provider will notify the DHS RN via form AAS-9510 (Start of Care Form), indicating the date services begin. No provisional service plans will be developed if the waiting list process has been implemented.

Provisional person-centered service plans expire 60 days from the date signed by the DHS RN and the participant. A comprehensive service plan that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional service plan. Prior to its expiration date, the DHS RN will provide a signed, comprehensive service plan to the ARChoices provider.

The Independent Assessment Contractor will complete a face-to-face functional assessment within 10 working days of receiving a referral from DHS. The DHS RN meets with the participant and develops an ARChoices person-centered service plan. Once the service plan is signed by the DHS RN and the applicant, it is considered a provisional service plan.

If services are started based on the provisional service plan, providers will send the Start of Care (AAS-9510) form to the DHS RN indicating the date services started. No additional notification to the DHS RN is required when the comprehensive service plan is received.

(c) During the person-centered service plan development process, the DHS RN explains the services available through the ARChoices waiver to the participant, including any applicable benefit limits. All services the participant is currently receiving are discussed and documented on the person-centered service plan. This includes all medical and non-medical services, such as diapers, under pads, nonemergency medical transportation, family support or other services that are routinely provided.

(d) The DHS RN develops the person-centered service plan based on the information gathered through the assessment process and the discussion of available services with the participant. The service plan addresses the participant's needs, goals and preferences. The participant may invite anyone they choose to participate in the assessment and service plan development process, including family members and caregivers. Also, the DHS RN may contact anyone who may be able to provide accurate and pertinent information regarding the participant's condition and functional ability.

If there is any indication prior to or during the assessment or person-centered service plan development process that the participant is confused or incapable of answering the questions required for a proper assessment and service plan development, the assessment or service plan development will not be

conducted without another person present who is familiar with the participant and his or her condition. This may be a family member, friend, neighbor, caregiver, etc. If unavailable for the interview, this person may be contacted by phone. These individuals' participation in the service plan development process also helps to ensure that the participant's goals, preferences and needs are met.

When developing or updating the person-centered service plan, the participant and their representatives participate in all decisions regarding the types, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services.

(e) The participant must choose a provider for each waiver service selected. During the service plan development process, the DHS RN informs the participant or their legal guardian or family member of the available services. The participant or guardian/family member may choose the providers from which to receive services. Documentation verifying freedom of choice was assured is included in the participant's record on the person-centered service plan, and on the provider list. Both documents reflect freedom of choice was given to the participant. The freedom of choice form and all related documents are included in the participant's record and reviewed during the DHS RN supervisory review process. Each service included on the service plan is explained by the DHS RN. The amount, frequency, scope and provider of each service is also discussed and entered on the service plan. The DHS RN sends a copy of the service plan to the waiver provider, as well as the participant. The DHS RN tracks the implementation of each service through the Start of Care form, which includes the date services begin.

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

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DHS RN, who is the only authorized individual who may adjust a participant's service plan. Providers agree to render all services in accordance with the Arkansas Medicaid ARChoices in Homecare Home & Community Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or necessitate a change in the participant's person-centered service plan; to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS RN in writing within one week of services being terminated, documenting the termination effective date and the reason for the termination.

Providers assure the Division of Provider Services and Quality Assurance (DPSQA) that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted an ARChoices in Homecare service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS RN. Providers acknowledge that the DHS RN is the only authorized individual who may adjust an ARChoices in Homecare waiver participant's service plan. Providers will implement the service plan with the flexibility to schedule hours to best meet the needs of the participant and will be monitored by DAABHS for compliance.

Service plans are revised by DHS RNs as needed between assessments, based on reports secured through providers, waiver participants and their support systems.

(g) Each reassessment and person-centered service plan development is completed annually or more often, if deemed appropriate by the DHS RN. The service plan may be revised at any time, based on

information relevant to the participant's condition or circumstances. Changes are reported to the DHS RN by the participant, the participant's family or representatives, service providers and Targeted Case Managers. The DHS RN has sole authority for all development and revisions to the waiver service plan. Service plan updates must be based on a change in the participant's status or needs.

D-1: (5 of 8) Risk Assessment and Mitigation

The Independent Assessment Contractor assesses a participant's needs, functional abilities, and performance of activities of daily living during the assessment. The DHS RN assesses a participant's preferences, risks, dangers, and supports during the meeting with the participant to develop a person-centered service plan. In addition, the service plan development process includes assessment of risk factors and strategies to mitigate risk conducted in a manner that is sensitive to the waiver participant's preferences and the responsibilities required to reduce risk. The risk mitigation includes factors regarding the participant's functioning ability, ADL performance, support systems in place, risk of falls, environmental factors, and other dangers. This information is included on the person-centered service plan and in the participant's record. Services are started as soon as possible in order to mitigate risk.

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

Routine monitoring of ARChoices in Homecare participants also helps to assess and mitigate risk. DHS RNs make at least annual contact with participants and take action to mitigate risks if an issue arises. Targeted Case Managers are required to monitor the participant monthly at a minimum and must follow frequency requirements as described in the Targeted Case Management Medicaid Provider Manual regarding face-to-face or telephone contacts with the participant. Potential risks identified during these monitoring contacts require the Targeted Case Manager to take action to mitigate the risk.

Also, providers, family members and others who have regular contact with participants are required to report any change in participant condition, or perceived risk or other problem concerning the participant. The DHS RNs also re-evaluate potential participant risks during monitoring visits. DHS RNs and Targeted Case Managers refer any high-risk participants to Adult Protective Services immediately if it is felt that the participant is in danger. DHS RNs also provide patient education on safety issues during the assessment and annual reassessment. The annual contact by the DHS RN is a minimum contact standard. Visits are made as needed during the interim.

Service providers are required to follow all guidelines in the Medicaid Provider manual related to emergencies, including the emergency backup plan process and contact information for emergencies. The provider assures DAABHS all necessary safeguards and precautions have been taken to protect the health and welfare of the participants they serve. Providers agree to operate and provide services in full compliance with all applicable federal, state and local standards including, but not limited to, fire, health, safety and sanitation standards prescribed by law or regulations. Providers assure DAABHS that conditions or circumstances which place a person, or the household of a person, in imminent danger will be brought to the attention of appropriate officials for follow-up. Providers agree to inform the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or would necessitate a change in the participant's service plan.

Participants, family members or the participant's representative may also contact the DHS RN or Targeted Case Manager any time a change is needed or a safety issue arises. Additional monitoring is performed

by DMS as part of the validation review, by Office of Medicaid Inspector General audits, and in response to any complaints received.

D-1: (6 of 8) Informed Choice of Providers

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

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

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

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

Appendix D: Participant -Centered Planning and Service Delivery
D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

All ARChoices in Homecare person-centered service plans are subject to the review and approval of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (Operating Agency), and the Division of Medical Services (DMS) (Medicaid Agency).

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval and are made available by the operating agency upon request. DMS reviews a validation sample of participants' records which includes the person-centered service plan. Reviewed service plans are compared to policy guidelines, the functional assessment, and the case notes detailing the participant's living environment, physical and mental limitations, and overall needs.

A statistically valid random sample of service plans is determined, using the Raosoft software calculations program, for review by the DHS RN supervisory staff. Records are reviewed to assess the appropriateness of the service plan, to validate service provision, to ensure that services are

meeting the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS RN addresses any needed corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the Office of Medicaid Inspector General.

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

Information reviewed by both DAABHS and DMS during the record review process includes, but is not limited to: development of an appropriate individualized person-centered service plan, completion of updates and revisions to the service plan and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

D-1: Service Plan Development (8 of 8)

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

X Operating agency

Specify:

The service plan is maintained by the DHS RN in the participant's record and by the ARChoices in Homecare waiver service providers.

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Waiver participants are monitored through a variety of means and all monitoring by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) waiver staff, Targeted Case Managers, and providers includes compliance with the service plan, the health and welfare of the participant, access to services, effectiveness of backup plans, and complaints or problems. Contact with ARChoices participants is maintained to ensure that services are furnished according to the person-centered service plan and that the services meet the participant's needs. Monitoring is an essential component of Targeted Case Management. Targeted Case Managers are required to conduct routine monitoring and report to the DHS RN. Targeted Case Managers must follow the monitoring guidelines and timeframes outlined in the Medicaid Provider Manual.

DHS RNs:

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

At each person-centered service planning meeting, the DHS RN provides the participant with their contact information, an Adult Protective Services (APS) brochure to provide information and the toll-free APS hotline for reporting abuse, maltreatment or exploitation. This information may be utilized by the participant or guardians/family members to report any issues they deem necessary, so that DAABHS can ensure prompt follow-up to problems.

ARCHOICES IN HOMECARE PROVIDERS:

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting, and documentation requirements. Provider are required to report any change in the participant's condition to the participant's DHS RN.

TARGETED CASE MANAGERS:

Targeted Case Management is included on each ARChoices service plan, unless declined by the participant.

Targeted Case Managers must maintain contact with participants as frequently as needed, with a minimum of one contact monthly to help determine whether services are being furnished according to the participant's person-centered service plan, the adequacy of the services in the service plan, and changes in the participant's needs or status. These contacts may be face-to-face or by telephone, according to established policy as outlined in the Targeted Case Management Medicaid Provider Manual. Targeted Case Managers must give participants their office phone numbers, and leave a business card or contact sheet in the participant's home in case of concerns or questions.

Targeted Case Managers must conduct monitoring according to current policy, including initial meetings with participants to discuss the participant's needs and to determine who currently provides for any or all of their needs. Following the initial home visit, Targeted Case Managers must make unannounced face-to-face monitoring visits as required by current policy.

If the participant's circumstances remain stable, no provider changes are made and no problems noted, unannounced face-to-face monitoring visits must continue according to current policy. During months no face-to-face visit is conducted, a telephone contact must be made. An ARChoices in Homecare Monitoring Form must be completed during face-to-face visits. A contact is not considered a face-to-face monitoring contact unless the required monitoring form is completed, dated and signed by the case manager and filed in the participant's record. Documentation in the narrative of the participant's record will suffice for telephone contacts, rather than completing the monitoring form. All face-to-face and telephone contacts must be documented in the participant's case record for review and audit purposes.

During each home visit, the Targeted Case Manager must document the participant's condition, the condition of the home, living environment, adequacy of the participant's person-centered service plan, and overall success of service plan delivery. Any problems, changes, complaints, observations, concerns or other participant issues (e.g., provider changes, information regarding change of condition, hospital admissions, hospital discharges, address changes, telephone number changes, deaths, any change in waiver or non-waiver services) must be documented in the participant's record and reported immediately to the DHS RN via the Change of Client Status form (AAS-9511) or email. The AAS-9511 may be transmitted via fax or email to the DHS RN. Copies of required forms and/or communication must be maintained in the participant's record.

Targeted Case Managers review the person-centered service plan with the participant during all face-to-face visits to ensure that services are being provided according to the plan. The Targeted Case Manager will also measure the participant's progress toward service plan goals.

The contacts listed above are a minimum requirement. In an effort to assure health and safety, compliance with the waiver person-centered service plan, and the integrity of services billed to the Medicaid Program, it is the Targeted Case Manager's responsibility to visit, call and support the waiver participant as much as is needed based on the individual's circumstances and the stability of their services.

INFORMATION EXCHANGE:

Both DMS and DAABHS perform regular reviews to support proper implementation and monitoring of the person-centered service plan. Record reviews are thorough and include a review of all required documentation regarding compliance with the service plan development assurance. Reviews include, but are not limited to, completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services; consideration of participants in the service plan development process; clarity and consistency; and, compliance with program policy regarding all aspects of the service plan development, changes and renewal.

The DHS RN maintains an established caseload, covering certain counties in Arkansas. Each participant knows his or her DHS RN and has the DHS RN's contact information. DHS RN supervisors assist in the resolution of problems, monitor the work performed by the DHS RNs by making periodic visits with each DHS RN, and assist in overall program monitoring and quality assurance. Additionally, a record review process is conducted on a monthly basis by DHS RN supervisors. Records are pulled at random and reviewed for accuracy and appropriateness in the areas of medical assessments, service plans, level of care determinations and documentation. Selection begins by reviewing the latest monthly report from the Arkansas Client Eligibility System (ACES). This report reflects all active cases and includes each participant's waiver eligibility date. Records are pulled for review based on established eligibility dates. A comparable pull is made to review new eligibles, established eligibles, recent closures and changes. This method results in all types of charts being reviewed for program and procedural compliance. DAABHS supervisory staff uses the Raosoft Calculation System to determine the appropriate sample size for record review with a 95% confidence level and a margin of error of +/-5%, and selects every name on the list to be included in the sample.

The following reports are used to compile monitoring information and reported as indicated:
1. Monthly Reports - compiled by each DHS RN and reported monthly to RN supervisor. All monitoring visits are reported.
2. RN Supervisor Report - compiled by each RN supervisor and reported monthly to the Nurse Manager. All monitoring visits are reported.
3. Monthly Record Reviews - performed monthly by RN supervisors and reported monthly to Nurse Manager.
4. DMS Monthly Record Reviews - performed monthly by DMS and reported monthly to DAABHS.
5. DMS Annual QA Report - compiled annually by DMS and reported to DAABHS.

D-2: Service Plan Implementation and Monitoring

b. Monitoring Safeguards. *Select one:*

X **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducting in the best interests of the participant. *Specify:*

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to emergencies, including the emergency backup plan process and contact information for emergencies. Providers agree to inform the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or would necessitate a change in the participant's person-centered service plan.

ARChoices in Homecare providers agree to render all services in accordance with the Arkansas Medicaid ARChoices in Homecare Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency); to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS RN in writing within one week of services being terminated documenting the termination effective date and the reason for termination.

ARChoices in Homecare providers assure the Division of Provider Services and Quality Assurance (DPSQA) (operating agency) that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted an ARChoices in Homecare waiver person-centered service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS RN. Providers acknowledge that the DHS RN is the only authorized individual who may adjust an ARChoices in Homecare waiver participant's service plan. Providers accept full responsibility for the quality and number of service units provided to an ARChoices in Homecare waiver participant by their staff, and assure DAABHS appropriate management and supervision of services takes place at all times.

Person-centered service plans are revised by DHS RNs as needed between assessments, based on information secured through providers, waiver participants and their support systems.

Targeted Case Managers monitor waiver participants' status as needed for changes in service need, referring participants for reassessment if necessary and reporting any participant complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant's legal representative, guardian or family member may participate on their behalf. This oversight ensures that participants are receiving the specified services to meet their needs and according to the person-centered service plan.

DHS RNs and Targeted Case Managers must document all contacts (in person, telephone or correspondence) with or on behalf of the participant in the participant's case record. If a monitoring contact produces any information that warrants further action, DHS RNs and Targeted Case Managers are responsible for following through and taking any action deemed appropriate.

Appendix D: Participant-Centered Planning and Service Delivery
Quality Improvement: Service Plan

a. Methods for Discovery: Service Plan Assurance/Sub-Assurances

i. Sub-Assurances

a. Sub-Assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures:

Number and percent of participants reviewed who had service plans that addressed risk factors. Numerator: Number of participants' service plans that address risk factors; Denominator: Number of records reviewed.

Number and percent of participants reviewed who had service plans that were adequate and appropriate to their needs as indicated by the assessment(s). Numerator: Number of participants with service plans that address needs; Denominator: Number of records reviewed.

Number and percent of participants reviewed who had service plans that addressed personal goals. Numerator: Number of service plans that address personal goals; Denominator: Number of records reviewed

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

b. Sub-Assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures:

Number and percent of service plan development procedures that are completed as described in the waiver application. Numerator: Number of participants' service plans completed according to waiver procedures; Denominator: Number of records reviewed.

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

c. Sub-Assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measures:

Number and percent of service plans that were reviewed and updated by the DHS RN according to changes in participants' needs before the waiver participants' annual review date. Numerator: Number of participants' service plans that were reviewed and revised by the DHS RN before annual review date; Denominator: Number of records reviewed.

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

d. ***Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*** **Performance Measures:**
Number and percent of participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan. Numerator: Number of participants' service plans who received services specified in the service plan; Denominator: Number of records reviewed.
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

e. ***Sub-Assurance:*** *Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*
Performance Measures:
Number and percent of waiver participant records reviewed with an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with choice between institutional care waiver services and among waiver services; Denominator: Number of records reviewed
Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed.
Sampling Approach (check each that applies)
X **Representative Sample**
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

The state currently operates a system of review that assures completeness, appropriateness, accuracy, and freedom of choice. This system focuses on participant-centered service planning and delivery, participant rights and responsibilities, and participant outcomes and satisfaction.

Individual records are reviewed monthly by DAABHS for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Remediation is performed on service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the RN supervisor and is a part of the record review process.

DAABHS supervisory staff uses the Raosoft calculation system to determine appropriate sample size for ARChoices in Homecare Record Review, and selects every nth name on the list to be included in the sample.

Record reviews of the overall program files are thorough and include a review of all required documentation regarding compliance with the service plan development assurance and service plan delivery. Reviews include, but are not limited to, completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services; consideration of participants in the service plan development process; clarity and consistency; compliance with program policy regarding all aspects of the service plan development, changes, and renewal.

Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including service plan development and delivery of services. Initial verification of service delivery is verified via the Start of Care form. This documentation is a part of every record review.

Record reviews check for the presence of justification for requested changes and proper documentation, and data is summarized for the Record Review Summary. Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers. Records are reviewed to assure that a Freedom of Choice form was presented to the participant and that a complete, up-to-date list of providers has been made available to the participant.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Remediation is performed on person-centered service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the DHS RN supervisor and is a part of the record review process.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem

correction. In addition, provide information on the methods used by the State to document these items.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for provider certification and quality assurance), and the Division of Medical Services (Medicaid agency) – all three of which are part of the Arkansas Department of Human Services (DHS) – participate in team meetings as needed to discuss and address individual problems related to service plans, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver.

If a participant record lacks required documentation regarding this assurance, DAABHS's remediation includes completing the required documentation according to policy and additional staff training in this area.

The tool used to review waiver participants' records captures and tracks remediation in these areas.

Appendix F: Participant Rights
Appendix F-1: Opportunity to Request a Fair Hearing
Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

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

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

DHS has set guidelines for retention of the form DCO-707 in the applicant's or participant's case record. If the DCO-707 is a request for information only, the form may be discarded when all requested

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

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

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

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

The service providers and the Department of Human Services county office inform the participant of their potential payment liability if a participant has been denied eligibility for the program and if the determination of an appeal is not in the participant's favor.

During the service plan development process, the DHS RN explains these rights to the participant, family member or representative. Signatures on the service plan verify that the choice between waiver services or institutional care was exercised. Also, during this process, participants choose a provider from a list provided by the DHS RN. Choices of provider are documented on the Freedom of Choice form, and the participant signs the list of providers showing that the choice was made.

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

Appendix F-3: State Grievance/Complaint System

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:
Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) and Division of Provider Services and Quality Assurance (DPSQA)

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

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAABHS Central Office or their DHS RN. When DAABHS is contacted regarding a complaint or dissatisfaction, DAABHS explains the complaint process to the participant, and completes the HCBS Complaint Intake Report electronically. Any DAABHS staff receiving a complaint must complete the HCBS Complaint Intake report. DPSQA is responsible for investigating complaints pertaining to provider quality or compliance.

The HCBS Complaint database, is used to track any dissatisfaction or complaint, including complaints against DAABHS staff and DPSQA-certified providers (including individual providers, provider organizations, and employees and contractors of provider organizations). The record of complaint includes the date the complaint was filed.

The complaint database was designed to register different types of complaints. Based on the data entered, the complaint can be tracked by type of complaint (service, provider, DAABHS, etc.) and complaint source (participant, county office, family, etc.), and monitored for trends, action taken to address complaint, access, quality of care, health and welfare. The complaint database provides a means to address any type complaint filed by any source. The complaint database also tracks resolution.

Information entered into the database includes the complaint source and contact information, participant information, person or provider against whom the complaint is being made, the person who received the complaint, the person to whom the complaint is assigned for investigation, the complaint being made, and the action taken relative to investigation findings.

Complaints concerning abuse, neglect and exploitation are routed to Adult Protective Services immediately for appropriate action. State law allows HCBS staff and APS staff to share information concerning clients on a need to know basis, but that information may not be re-disclosed to a third party. A.C.A. 12-12-1717(a)(9) allows disclosure of reports to "the department" (DHS) for founded reports and A.C.A. 12-12-1718(a) and (b)(1)(A) allow disclosure of pending and screened out reports to "the department". All APS reports involving waiver participants are reported on the monthly report and tracked by RN supervisory staff.

The HCBS Complaint Intake Report must be completed within five working days from when DAABHS staff received the complaint. Complaints must be resolved within 30 days from the date the complaint was received. If a complaint received by a DHS RN cannot be resolved by a DHS RN supervisor, the information is forwarded to the DAABHS central office administrative staff to resolve. To ensure that participants are safe during these time frames, the DHS RN may

put in place the backup plan on the participant's service plan or report the situation to Adult Protective Services, if needed.

DHS RNs and DHS RN supervisors work to resolve any complaints. This involves contacting all parties involved to obtain all sides of the issue, a participant home visit and a review of the participant's person-centered service plan, if necessary. The Nurse Manager at the DAABHS central office may also be asked to assist. Based on the nature of the complaint, the Nurse Manager will use their professional judgment on issues that must be resolved more quickly, such as instances where the participant's health and safety are at risk. Compliance with this policy is tracked and reported through the database. This issue continues to be tracked and reviewed by the DHS RN Supervisors and the Medicaid Quality Assurance staff during the record review process.

A follow-up call or correspondence is made to the reporter, if appropriate, to discuss how the issue was resolved without violating confidentiality rules. The participant or representative is informed of the right to appeal any decision and that filing a complaint is not a prerequisite or substitute for a fair hearing.

If a participant is dissatisfied with the resolution of a complaint, a fair hearing request may be made at the local DHS county office.

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

A complaint received on a DHS RN is reported to his or her supervisor, who investigates the complaint.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Arkansas state law requires that suspected abuse, neglect, and exploitation of endangered and impaired adults be reported to the Adult Maltreatment Hotline for investigation. The method of reporting is primarily by phone to the Hotline; written reports of allegations will be entered into the Adult Protective Services system or routed to the appropriate investigative department.

A.C.A. 12-12-1708(a) specifies mandatory reporters who are required to report suspected adult maltreatment, including abuse, exploitation, neglect, or self-neglect of endangered or impaired adults. Mandated reporters include all physicians, nurses, social workers, case managers, home health workers, DHS employees, facility administrators or owners, employees of facilities, and any employee or volunteer of a program or organization funded partially or wholly by DHS who enters the home of, or has contact with an elderly person. ARChoices in Homecare waiver staff, providers, and DAABHS contractors are mandatory reporters. The statute requires immediate

reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

According to the statute, adult abuse includes intentional acts to an endangered or impaired adult which result in physical harm or psychological injury; or credible threats to inflict pain of injury which provoke fear or alarm; or unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Exploitation includes illegal or unauthorized use of the person's funds or property; or use of the person's power of attorney or guardianship for the profit of one's own self; or improper acts or process that deprive the person of rightful access to benefits, resources, belongings and assets. Neglect is an act or omission by the endangered or impaired person (self-neglect), or an act or omission by the person's caregiver (caregiver neglect) constituting failure to provide necessary treatment, care, food, clothing, shelter, supervision or medical services; failure to report health problems and changes in health condition to appropriate medical personnel; or failure to carry out a prescribed treatment plan.

Reporting requirements for providers:

In addition to statutory requirements, the Division of Provider Services and Quality Assurance (DPSQA), the licensing and certification agency, requires home and community-based services (HCBS)/non-institutional providers to report the following incident types:

(a) Abuse
(b) Neglect
(c) Exploitation or Misappropriation of Property
(d) Unnatural Death
(e) Unauthorized use of restrictive interventions
(f) Significant Medication Error
(g) Elopement/Missing Person
(h) Other: Includes but is not limited to abandonment, serious bodily injury, incidents that require notification to police or fire department.

In accordance with DPSQA Policy 1001, the above events must be reported to the Division of Provider Services and Quality Assurance by facsimile transmission to telephone number 501-682-8551 of the completed Incident & Accident Intake Form (Form DPSQA-731) no later than 11:00 a.m. on the next business day following discovery by the provider. In addition to the requirement of a facsimile report by the next business day, the provider must conduct a thorough investigation of the alleged or suspected incident and complete an investigation report and submit it to DPSQA on Form DPSQA-742 within five working days.

Reporting requirements for DHS employees and contractors:

DHS employees and contractors are required to report incidents in accordance with DHS Policy 1090 (Incident Reporting). Under this policy, any incident requiring a report to the DHS Communications Director must be reported by telephone within one hour of the incident. All other reports must be filed with the Division Director or Designee and the DHS Client Advocate no later than the end of the second business day following the incident. Any employee not filing reports within the specified time is subject to disciplinary action unless the employee can show that it was not physically possible to make the report within the required time.

Telephone notifications and informational e-mails to Division Directors or Designees, the DHS Client Advocate and other parties as appropriate for early reporting of unusual or sensitive

information are welcomed. All such reports must be followed with completion and submission of Form DHS-1910.

If the incident alleges maltreatment by a hospital, a copy of the report will be sent to the Arkansas Department of Health by the Division Director or Designee, who should note the notification in the appropriate space on the Form DHS-1910, and forward the information to the DHS Client Advocate as a follow up Incident Report.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The DHS RN provides waiver applicants and their families with an Adult Protective Services (APS) brochure when initial contact is made. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including to the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DHS RNs review this information with participants and family members at the initial assessment and at each annual reassessment. In addition, providers are required to post information about how to report a complaint to APS and the Adult Maltreatment Hotline in a visible area on their premises.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

For incidents involving alleged abuse, neglect, and exploitation regarding adult clients, Adult Protective Services (APS) receives, investigates, evaluates, and resolves reports. Additionally, all incidents defined in DPSQA Policy 1001 must be reported to Division of Provider Services and Quality Assurance (DPSQA). These include alleged abuse, neglect, and exploitation, unnatural death, unauthorized use of restrictive interventions, significant medication error, elopement/missing person, abandonment, serious bodily injury, and incidents requiring notification to the police or fire department.

Adult Protective Services (APS) Responsibilities:

APS visits clients within 24 hours for emergency cases or within three working days for non-emergency cases. Emergency cases are instances when immediate medical attention is necessary or when there is imminent danger to health or safety which means a situation in which death or serious bodily harm could reasonably be expected to occur without intervention, according to Ark. Code Ann. 12-12-1703(8). Non-emergency cases refer to situations when allegations do not meet the definition of imminent danger to health or safety. APS fast tracks waiver participants so they can be seen in 24 hours if possible.

As required by law, investigations are completed and an investigative determination entered within 60 days. APS notifies the client and other relevant parties, including the offender, of the determination.

APS communicates with the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.

APS communicates with DAABHS waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. DPSQA and DAABHS staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

Division of Provider Services and Quality Assurance (DPSQA) Responsibilities:

DPSQA receives and triages incidents to appropriate divisions for investigation. DPSQA will investigate those incidents that relate to providers licensed and/or certified by DPSQA and forwards incidents regarding clients to the Division of Aging, Adult, and Behavioral Health Services.

Reports to DPSQA are entered into a tracking system which DPSQA uses to determine if further investigation is needed in the event of multiple complaints at one provider locations or facility. DPSQA uses this resource to monitor active participants of the waiver for critical incidents.

As required by statute, investigations are completed and an investigative determination entered within 60 days.

Unexpected client deaths must be reported immediately to the DPSQA contact using the DHS Client Unexpected Death Report. The DPSQA contact investigates the report within two days of receiving the notice of the occurrence and prepares a report of the investigation within 30 days of receiving the notice of the occurrence. The investigation includes reviewing a written report of the facts and circumstances of the unexpected death and documentation listing the client's condition, including diagnoses, prescriptions and service plan.

The DPSQA contact will determine the facts and circumstances of the occurrence. DPSQA's role includes performing a thorough investigation, reviewing current policy, making corrections if necessary and identifying patterns during the process. Final results of investigations are electronically made available to .

All reports to the Adult Maltreatment Hotline and instances of unexpected client deaths are investigated and addressed by DPSQA. Incidents reported to the DHS Incident Reporting Information System (IRIS), a system which enables online submission and transmittal of incident reports, are investigated depending on the type of incident reported.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Division of Provider Services and Quality Assurance assumes responsibility for compiling all incident reports from providers for review and action. Incidents are reported to DPSQA staff through submission of Form DPSQA-731.

DPSQA staff review the reports as incidents occur and identify patterns and make systematic corrections when necessary. Current policy is reviewed at each occurrence and revisions may be made if necessary.

The Adult Protective Services unit tracks APS incidents. APS informs DPSQA of the outcomes of incidents reported to APS applicable to waiver participants. There is a Memorandum of Understanding between DPSQA and APS unit detailing the relationship and activities of each unit, as they relate to the waiver program.

Final results of APS investigations, final results of unexpected death findings, and results of incident reports are electronically made available to DPSQA.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

X The state does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restraints. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.

DHS RNs reassess participants annually.

Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact the DHS RN regarding any concerns for the participant's health and welfare.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

X The state does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.

DHS RNs reassess participants annually.

Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact the DHS RN regarding any concerns for the participant's health and welfare.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

a. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014. and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

X The state does not permit or prohibits the use of seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.

DHS RNs reassess participants annually.

Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact the DHS RN regarding any concerns for the participant's health and welfare.

Appendix G-3: Medication Management and Oversight (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

b. Medication Management and Follow-Up.

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The allowed provider types for Respite Care include licensed facilities that may provide respite care in a licensed facility on a round-the-clock basis for a period of time. Medication oversight or administration must be conducted in accordance with state law and the licensure and scope of practice requirements applicable to the particular type of facility and staff.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The allowed provider types for Respite Care include licensed facilities that may provide respite care in a licensed facility on a round-the-clock basis for a period of time. Medication oversight or administration must be conducted in accordance with state law and the licensure and scope of practice requirements applicable to the particular type of facility and staff.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

a. Methods for Discovery: Health and Welfare

i. Sub-Assurances

a. *Sub-Assurance:* *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.* (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures:

Number and percent of critical incidents reviews/investigations that were initiated and completed according to program policy and state law. Numerator: Number of critical incident investigations initiated/completed according to policy/law; Denominator: Number of critical incidents reviewed.

Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up; Denominator: Number of critical incidents reviewed.

Number and percent of participant records reviewed where the participant and/or family or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents as specified in the waiver application. Numerator: Number of participants receiving information on abuse, neglect, exploitation and critical incidents; Denominator: Number of records reviewed.

Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents reviewed.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

d.*Sub-Assurance:* *The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

Number and percent of changes in Level of Care Tier Levels and ISB Levels. Numerator - number of changes in Level of Care Tier Levels and ISB Levels. Denominator - Number of records reviewed.

Case Record Review

Sampling Approach (check each that applies)

X **Representative Sample**

Confidence Interval =

DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

Arkansas addresses this assurance with a three-step process that involves record review, ongoing communication with Adult Protective Services (APS), and Division of Medical Services (DMS) audits of waiver participants' records. Monthly record reviews are performed by DHS RN supervisors to assure that DHS RNs report incidences of abuse or neglect, and that safety and protection are addressed at each assessment and reassessment and reported in the Record Review Summary Report. APS reports specific cases of abuse and neglect affecting waiver participants to DAABHS waiver staff. Findings are reported to DMS.

DAABHS staff are required to review the APS information with participants and other interested parties at each assessment and reassessment. This must include providing APS brochures, as well as information on how to identify possible abuse and neglect and a toll-free number for reporting abuse. Compliance with this requirement is documented in the participant record and reviewed by RN supervisors during each record review. Compliance is a part of the record review and annual reporting process.

Policy requires compliance and mandates the DHS RN to report alleged abuse to APS and/or the DPSQA Office of Long Term Care (OLTC). All reports of alleged abuse, follow-ups and actions taken to investigate the alleged abuse, along with all reports to APS or OLTC must be documented in the nurse narrative. Record reviews include verification of this requirement and are included on the annual report.

The process for reporting abuse as established in Arkansas Code Annotated 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult Maltreatment Hotline refers the matter immediately to the appropriate investigating agency. Under this statute, a resident of an assisted living facility is identified as a long-term care facility resident, and for the purposes of the statute is presumed to be an impaired person. A report for a long-term care facility resident is to be made immediately to the local law enforcement agency for the jurisdiction in which the long-term care facility is located, and to OLTC under the regulations of that office. DHS has jurisdiction to investigate all cases of suspected maltreatment of an endangered person or an impaired person. The APS unit of DHS shall investigate all cases of suspected adult maltreatment if the act or omission occurs in a place other than a long-term care facility; and all cases of suspected adult maltreatment if a family member of the adult person is named as the suspected offender, regardless of whether or not the adult is a long-term care facility resident. The OLTC unit of DHS shall investigate all cases of suspected maltreatment of a long-term care facility resident.

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging, Adult, and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings to discuss

and address individual problems related to participant health and welfare, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to participant health and welfare for the waiver.

DAABHS's remediation efforts in cases where participants or their family members or legal guardians have not received information about how to report abuse, neglect, exploitation or critical incidents include providing the appropriate information to the participant and family member/legal guardian upon discovery that this information was not provided, providing additional training for DHS RNs and considering this remediation as part of RNs' performance evaluations.

In cases where critical incidents were not reported within required time frames, DAABHS provides remediation, including reporting the critical incident immediately upon discovery, and providing additional training and counseling to staff.
If critical incident reviews and investigations are not initiated and completed according to program policy and state law, DAABHS's remediation includes initiating and completing the investigation immediately upon discovery, and providing additional training and counseling to staff. When appropriate follow-up to critical incidents is not conducted according to methods discussed in the waiver application, DAABHS provides immediate follow-up to the incident and staff training as remediation.

DAABHS provides remediation in cases of investigation and review of unexplained, suspicious and untimely deaths that did not result in identification of preventable and unpreventable causes to include staff and provider training, implementing additional services and imposing provider sanctions. The Unexpected Death Report ensures that remediation of preventable deaths is captured and that remediation data is collected appropriately.

The DAABHS complaint database collects complaints, the outcomes and the resolution for substantiated complaints. Remediation for complaints that were not addressed during the required time frame includes DAABHS addressing the complaint immediately upon discovery, and providing additional staff training and counseling.

All substantiated incidents are investigated by the DAABHS Deputy Director or his/her designee. DAABHS plans to continue this process and reviewing remediation plans remains in development.

Appendix H: Quality Improvement Strategy (2 of 2)
H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, the Division of Medical Services (DMS) (Medicaid agency) will meet with the operating agencies (DAABHS and the Division of Provider Services and Quality Assurance (DPSQA)) to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue,

etc.), complexity of the solution (does it require an amendment to the waiver application), and the financial impact. If it is determined that a system change is needed, a computer service request will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DMS and a priority status is assigned. MMIP prioritizes system changes to MMIS and coordinates implementation with the state fiscal agent. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. The MMIP Unit and DMS monitor the system changes.

As a result of the discovery processes:

The interagency agreements were revised to provide a more visible product to clarify roles and responsibilities between DMS, DAABHS, and DPSQA.

The agreement between the three divisions has been modified and is updated at least annually.

Medicaid related issues are documented by DAABHS waiver staff and reviewed by DMS, and recorded on a monthly report to identify, capture and resolve billing and claims submission problems. Error reports are worked and billing issues are resolved by DAABHS waiver staff and DMS. DMS reviews reports for proper resolution. These activities occur on a daily basis, and reviews occur monthly by DMS.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of Medical Services (DMS) both employ staff to assist in system design. When an issue arises that requires development of a Computer Service Request (CSR), meetings with the DHS information technology consultants, DMS Program Development and Quality Assurance staff, DMS Program Integrity staff, and DAABHS waiver staff are held to address needs and resolve issues, including developing new elements and testing system changes. Meetings are scheduled on an as-needed basis with the assigned DHS information technology consulting firm, the Medicaid program's fiscal agent, the DAABHS Deputy Director, DMS staff, and others as may be appropriate depending on the issue for discussion.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DAABHS and DMS monitor the Quality Improvement Strategy on an ongoing basis and review the Quality Improvement Strategy annually. A review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systematic issues found through discovery and notating desired outcomes. When change in the strategy is indicated, a collaborative effort between DMS and DAABHS is set in motion to complete a revision to the Quality Improvement Strategy which may include submission of a waiver amendment. DMS utilizes the Quality Improvement Strategy during all levels of QA reviews.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MMIS claims data are audited periodically for program policy alignment, and claims processing worksheets are audited, processed and returned on a daily basis. Discovery and monitoring also includes an ongoing review of annual CMS-372S reports and quarterly CMS-64 reports. Division of Medical Services (DMS) (Medicaid agency) reviews are validation reviews of 20% of the records reviewed by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) and include a review of the services billed and paid when compared with the services listed on a participant's person-centered service plan.

The Arkansas Office of Medicaid Inspector General (OMIG) conducts an annual random review of HCBS waiver programs. If the review finds errors in billing, OMIG recoups the money from the waiver provider. If fraud is suspected, the Office of Medicaid Inspector General refers the waiver provider to the Medicaid Fraud Control Unit and Arkansas Attorney General's Office for appropriate action.

Appendix 1: Financial Accountability

Quality Improvement: Financial Accountability

a. Methods for Discovery: Financial Accountability Assurance:

i. Sub-Assurances

a. *Sub-Assurance:* *The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.* (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures:

Number and percent of reviewed claims with services specified in the participant's service plan. Numerator: Number of claims with services specified in service plan; Denominator: Number of claims

Sampling Approach (check each that applies)

X **Other**

Specify =

DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

b.*Sub-Assurance:* *The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures:

Number and percent of waiver claims that were paid using the correct rate as specified in the waiver application. Numerator: Number of claims paid at correct rate; Denominator: Number of claims

Sampling Approach (check each that applies)

X **Other**
Specify =
DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging, Adult and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings as needed to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to financial accountability for the waiver.

The performance measure for number and percent of waiver claims paid using the correct rate specified in the waiver application will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate.

DAABHS' remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discovery, making system changes and training staff.

DAABHS remediation for claims for services not specified in the participant's service plan includes adding services to the participant's service plan if necessary, recouping payment to the provider, imposing provider sanctions, training providers and conducting a participant monitoring visit.

The tool used for record review captures and tracks remediation in these areas.

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) is responsible for the rate determination with oversight conducted by the Division of Medical Services (DMS) (Medicaid agency) Financial Section prior to implementation. There is an established procedure followed by both divisions that ensures DMS reviews and approves all reimbursement rates and methodologies. As ARChoices is not a participant-directed program, payment rates are not routinely sent separately to waiver participants. Rates are published for comment and are made available to all providers. Additionally, providers are notified any time a rate changes via a Provider Information Memorandum from DAABHS and/or an Official Notice from DMS. The public is afforded an opportunity to comment on the rate determination process through the DMS website, in

the Proposed Rules for Public Comment section. Upon certification, new providers are referred to the Medicaid Provider Manual, which lists rate information.

Various methodologies are used for rate determination depending on the waiver service. The following are the methods used for rate setting for the ARChoices waiver services:

Attendant Care - Attendant Care service is a fee-for-service rate established and approved by DMS and is equivalent to a rate modeled by actuaries under contract with DMS. The assumptions used to develop the model rate are based on feedback from DAABHS and DPSQA and on responses to provider surveys developed by the contracted actuaries. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Adult Day Health – Adult Day Health is a fee-for-service rate established and approved by DMS and is equivalent to a rate modeled by actuaries under contract with DMS. The assumptions used to develop the model rate are based on feedback from DAABHS and DPSQA and on responses to provider surveys developed by the contracted actuaries. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Respite - Respite service is a fee-for-service rate established and approved by the Division of Medical Services (Medicaid agency) and is equivalent to a rate modeled by actuaries under contract with DMS. The assumptions used to develop the model rate are based on feedback from DAABHS and DPSQA and on responses to provider surveys developed by the contracted actuaries. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Adult Day Services – Adult Day Services is a fee-for-service rate established and approved by DMS and is equivalent to a rate modeled by actuaries under contract with DMS. The assumptions used to develop the model rate are based on feedback from DAABHS and DPSQA and on responses to provider surveys developed by the contracted actuaries. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Home-Delivered Meals - The home delivered meal rate was established using the cost for the meal, plus the cost for delivery. The rate is sufficient to secure a sufficient number of providers.

Personal Emergency Response System (PERS) - The rate for the PERS service was established using usual and customary rates and is sufficient to secure a sufficient number of providers.

Prevocational Services – Prevocational services is a fee-for-service rate established and approved by DMS and is equivalent to the rate established for state plan supportive employment services that are services similar to prevocational services. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Environmental Accessibility Adaptations/Adaptive Equipment - A maximum amount of $7,500 per lifetime of each active participant was approved by the Medicaid agency to cover this service. The amount may be utilized all at once or for separate services. The amount was established utilizing usual and customary charges for adaptive equipment and environmental accessibility adaptations. The rate is consistent with efficiency, economy and quality of care, and is sufficient to enlist plenty of providers.

I-2: Financial Integrity and Accountability

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan: and, (c) the services were provided:

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) staff verifies services were provided according to the person-centered service plan through an internal monthly monitoring system. When claims are paid incorrectly, adjustments are made, recoupments are initiated, or case is referred to the Office of Medicaid Inspector General.

All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable.

I-5: Exclusion of Medicaid Payment for Room and Board

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Facility-Based Respite care is available in licensed facilities, as indicated in Appendix C. Reimbursement does not include the cost for room and board. Rates are a fee for service, 1 unit equals 15 minutes of service as described in the service definition.

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8504.21	9666.00	18170.21	47580.00	2520.00	50100.00	31929.79
2	7726.73	9934.00	17660.73	48898.00	2590.00	51488.00	33827.27
3	8248.90	10209.00	18457.90	50252.00	2662.00	52914.00	34456.10
4	4704.78	10492.00	15196.78	51644.00	2735.00	54379.00	39182.22
5	5503.42	10782.00	16285.42	53075.00	2811.00	55886.00	39600.58

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
		Year 1
Year 1	11350	
Year 2	11350	
Year 3	11350	
Year 4	11350	
Year 5	11350	

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

For Waiver Years 1 through 3, historic utilization and cost data from SFYs 2011, 2012 and 2013 were used to derive utilization rates and cost for the elderly in home-based settings (ElderChoices waiver - EC), and adults with physical disabilities in home-based services (Alternatives for Adults with Physical Disabilities waiver - AAPD). The utilization rates for the existing EC and AAPD were used to estimate the future utilization of these services for individuals, assuming that the elderly will have similar utilization rates to those found among adults with physical disabilities and vice versa.

For Waiver Years 4 and 5, the average costs/unit for Adult Day Health, Respite In-Home, Adult Day Services, Personal Emergency Response System (PERS) Unit Monitoring, and Attendant Care Services were modified to reflect the new payment rates to be effective January 1, 2019. The number of users for Adult Day Health was modified to reflect expected use based on experience to date, and the number of users for Attendant Care was modified to reflect changes expected due to the expected transition of service hours to state plan Personal Care services and modifications made to the Attendant Care service definitions. The number of users for the new service of Prevocational Services was projected as 1% of the unduplicated cap, and the average units/user was projected as the maximum number of units permitted for this service under the limits on amount, frequency, and duration identified in Appendix C-1/C-3 for this service. The number of users and average units per user for all components of Adult Family Home were changed to 0 to reflect the elimination of that service effective with Waiver Year 4.

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Health	
Respite	
Adult Day Services	
~~**Adult Family Home**~~ [delete from table] Prevocational Services [Add to table]	
Attendant Care Services	
Environmental Accessibility Adaptations/Adaptive Equipment	
Home-Delivered Meals	
Personal Emergency Response System (PERS)	

J-2: Derivation of Estimates (5 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year:
Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**799606.08**
Adult Day Health		15 Minutes	63	4068.00	3.12	**799606.08**	
Respite Total:							**6441773.60**
Respite In-Home		15 Minutes	1147	1228.00	4.50	**6338322.00**	
Respite Short-Term Facility-Based		15 Minutes	75	779.00	1.68	**98154.00**	

Respite Long-Term Facility-Based		15 Minutes	10	946.00	0.56	5297.60	
Adult Day Services Total:							2176785.00
Adult Day Services		15 Minutes	234	3721.00	2.50	2176785.00	
Adult Family Home Total:							12000.40
Adult Family Home - Level A		Day	1	76.00	56.25	4275.00	
Adult Family Home - Level C		Day	1	76.00	48.22	3664.72	
Adult Family Home - Level B		Day	1	76.00	53.43	4060.68	
Attendant Care Services Total:							77957590.50
Attendant Care Services		15 Minutes	6577	2291.00	4.50	67805581.50	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	1050	3806.00	2.43	9711009.00	
CSM Transition Costs-1st Year		1 Month	1050	6.00	70.00	441000.00	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							715864.00
Environmental Accessibility Adaptations/Adaptive Equipment		Package	172	1.00	4162.00	715864.00	
Home-Delivered Meals Total:							6927038.76
Home-Delivered Meals		Meal	5422	214.00	5.97	6927038.76	
Personal Emergency Response System (PERS) Total:							1492092.96
PERS Installation		One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring		Day	5324	257.00	1.07	1464046.76	
Prevocational Services Total:							0.00
Prevocational - Skills Development		15 Minutes	0	0.00	0.01	0.00	
Prevocational - Career Exploration		15 Minutes	0	0.00	0.01	0.00	
GRAND TOTAL:							96522751.30
Total: Services included in capitation:							96522751.30
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							8504.21

Services included in capitation:	0
Services not included in capitation:	8504.21
Average Length of Stay on the Waiver:	276

J-2: Derivation of Estimates (6 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year:
Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							799606.08
Adult Day Health		15 Minutes	63	4068.00	3.12	799606.08	
Respite Total:							6574397.60
Respite In-Home		15 Minutes	1171	1228.00	4.50	6470946.00	
Respite Short-Term Facility-Based		15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based		15 Minutes	10	946.00	0.56	5297.60	
Adult Day Services Total:							2176785.00
Adult Day Services		15 Minutes	234	3721.00	2.50	2176785.00	
Adult Family Home Total:							12000.40
Adult Family Home - Level A		Day	1	76.00	56.25	4275.00	
Adult Family Home - Level C		Day	1	76.00	48.22	3664.72	
Adult Family Home - Level B		Day	1	76.00	53.43	4060.68	
Attendant Care Services Total:							68857150.50
Attendant Care Services		15 Minutes	6679	2291.00	4.50	68857150.50	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0.00	0.01	0.00	
CSM Transition Costs-1st Year		1 Month	0	0.00	0.01	0.00	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							753322.00

Environmental Accessibility Adaptations/Adaptive Equipment		Package	181	1.00	4162.00	753322.00	
Home-Delivered Meals Total:							7033077.90
Home-Delivered Meals		Meal	5505	214.00	5.97	7033077.90	
Personal Emergency Response System (PERS) Total:							1492092.96
PERS Installation		One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring		Day	5324	257.00	1.07	1464046.76	
Prevocational Services Total:							0.00
Prevocational - Skills Development		15 Minutes	0	0.00	0.01	0.00	
Prevocational - Career Exploration		15 Minutes	0	0.00	0.01	0.00	
GRAND TOTAL:	87698432.4						87698432.44
Total: Services included in capitation:							
Total: Services not included in capitation:	87698432.4						87698432.44
Total Estimated Unduplicated Participants:	**11350**						11350
Factor D (Divide total by number of participants):	**7726.73**						7726.73
Services included in capitation:							0
Services not included in capitation:	7726.73						7726.73
Average Length of Stay on the Waiver:							276

J-2: Derivation of Estimates (7 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year:
Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**863066.88**
Adult Day Health		15 Minutes	68	4068.00	3.12	**863066.88**	
Respite Total:							**6707021.60**
Respite In-Home		15 Minutes	1195	1228.00	4.50	**6603570.00**	
Respite Short-Term Facility-Based		15 Minutes	75	779.00	1.68	**98154.00**	
Respite Long-Term Facility-Based		15 Minutes	10	946.00	0.56	**5297.60**	
Adult Day Services Total:							**2223297.50**
Adult Day Services		15 Minutes	239	3721.00	2.50	**2223297.50**	
Adult Family Home Total:							**24000.80**
Adult Family Home - Level A		Day	2	76.00	56.25	**8550.00**	
Adult Family Home - Level C		Day	2	76.00	48.22	**7329.44**	
Adult Family Home - Level B		Day	2	76.00	53.43	**8121.36**	
Attendant Care Services Total:							**74331495.00**
Attendant Care Services		15 Minutes	7210	2291.00	4.50	**74331495.00**	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0.00	0.01	**0.00**	
CSM Transition Costs-1st Year		15 Minutes	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**844886.00**
Environmental Accessibility Adaptations/Adaptive Equipment		Package	203	1.00	4162.00	**844886.00**	
Home-Delivered Meals Total:							**7139117.04**
Home-Delivered Meals		Meal	5588	214.00	5.97	**7139117.04**	
Personal Emergency Response System (PERS) Total:							**1492092.96**
PERS Installation		One Installment	938	1.00	29.90	**28046.20**	
PERS Unit Monitoring		Day	5324	257.00	1.07	**1464046.76**	
Prevocational Services Total:							**0.00**
Prevocational - Skills Development		15 Minutes	0	0.00	0.01	**0.00**	
Prevocational - Career Exploration		15 Minutes	0	0.00	0.01	**0.00**	
GRAND TOTAL:							93624977.78

State:	
Effective Date	

Total: Services included in capitation:	
Total: Services not included in capitation:	93624977.78
Total Estimated Unduplicated Participants:	11350
Factor D (Divide total by number of participants):	8248.90
Services included in capitation:	0
Services not included in capitation:	8248.90
Average Length of Stay on the Waiver:	276

J-2: Derivation of Estimates (8 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**983561.04**
Adult Day Health		15 Minutes	77	4068.00	3.14	**983561.04**	
Respite Total:							**7223886.80**
Respite In-Home		15 Minutes	1280	1228	4.53	**7120435.20**	
Respite Short-Term Facility-Based		15 Minutes	75	779	1.68	**98154.00**	
Respite Long-Term Facility-Based		15 Minutes	10	946	0.56	**5297.60**	
Adult Day Services Total:							**2343671.85**
Adult Day Services		15 Minutes	255	3721	2.47	**2343671.85**	
Adult Family Home Total:							**0.00**
Adult Family Home - Level A		Day	0	0.00	56.25	**0.00**	
Adult Family Home - Level C		Day	0	0.00	48.22	**0.00**	
Adult Family Home - Level B		Day	0	0.00	53.43	**0.00**	
Prevocational Services Total:							**283084.80**
Prevocational - Skills Development		15 Minutes	114	268	6.40	**195533.00**	

Prevocational - Career Exploration		15 Minutes	114	120	6.40	87552.00	
Attendant Care Services Total:							32724720.00
Attendant Care Services		15 Minutes	4200	1720	4.53	32724720.00	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0	0.01	0.00	
CSM Transition Costs-1st Year		1 Month	0	0	0.01	0.00	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							915640.00
Environmental Accessibility Adaptations/Adaptive Equipment		Package	220	1	4162	915640.00	
Home-Delivered Meals Total:							7429127.20
Home-Delivered Meals		Meal	5815	214	5.97	7429127.20	
Personal Emergency Response System (PERS) Total:							1495548.24
PERS Installation		One Installment	938	1	29.9	28046.20	
PERS Unit Monitoring		Month	5324	8.45	32.62	1467502.04	

GRAND TOTAL:	53399240.43
Total: Services included in capitation:	
Total: Services not included in capitation:	53399240.43
Total Estimated Unduplicated Participants:	11350
Factor D (Divide total by number of participants):	4704.78
Services included in capitation:	0
Services not included in capitation:	4704.78
Average Length of Stay on the Waiver:	276

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							996334.56
Adult Day Health		15 Minutes	78	4068.00	3.14	996334.56	
Respite Total:							8030498.60

State:	
Effective Date	

Respite In-Home		15 Minutes	1425	1228	4.53	7927047.00	
Respite Short-Term Facility-Based		15 Minutes	75	779	1.68	98154.00	
Respite Long-Term Facility-Based		15 Minutes	10	946	0.56	5297.60	
Adult Day Services Total:							2499916.64
Adult Day Services		15 Minutes	272	3721	2.47	2499916.64	
Adult Family Home Total:							0.00
Adult Family Home - Level A		Day	0	0	0.00	56.25	
Adult Family Home - Level C		Day	0	0	0.00	48.22	
Adult Family Home - Level B		Day	0	0	0.00	53.43	
Prevocational Services Total:							283084.80
Prevocational - Skills Development		15 Minutes	114	268	6.40	195532.80	
Prevocational - Career Exploration		15 Minutes	114	120	6.40	87552.00	
Attendant Care Services Total:							40516320.00
Attendant Care Services		15 Minutes	5200	1720	4.53	40516320.00	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0	0.01	0.00	
CSM Transition Costs-1st Year		1 Month	0	0	0.01	0.00	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							1040500.00
Environmental Accessibility Adaptations/Adaptive Equipment		Package	250	1	4162.00	1040500.00	
Home-Delivered Meals Total:							7601601.00
Home-Delivered Meals		Meal	5950	214	5.97	7601601.00	
Personal Emergency Response System (PERS) Total:							1495548.24
PERS Installation		One Installment	938	1	29.90	28046.20	
PERS Unit Monitoring		Month	5324	8.45	32.62	1467502.04	

GRAND TOTAL:	62463803.84
Total: Services included in capitation:	
Total: Services not included in capitation:	62463803.84
Total Estimated Unduplicated Participants:	11350
Factor D (Divide total by number of participants):	5503.42
Services included in capitation:	0
Services not included in capitation:	5503.42
Average Length of Stay on the Waiver:	276

200.000 ARCHOICES IN HOMECARE (ARCHOICES) HCBS WAIVER PROGRAM GENERAL INFORMATION

201.000 Arkansas Medicaid Certification Requirements for ARChoices HCBS Waiver Program 1-1-16

All ARChoices Home and Community-Based Services (HCBS) Waiver providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

ARChoices HCBS Waiver providers must be licensed and/or certified by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

Certification by the Division of Provider Services and Quality Assurance ~~Aging and Adult Services~~ does not guarantee enrollment in the Medicaid program.

All providers must maintain their provider files at the Provider Enrollment Unit by submitting current certification, licensure, all DPSQA~~DAAS~~-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider, etc.

Copies of licensure/certifications and renewals required by DPSQA~~DAAS~~ must be maintained by DPSQA~~DAAS~~ to avoid loss of provider certification. These copies must be submitted to DPSQA~~DAAS~~ Provider Certification. **View or print the Division of Provider Services and Quality Assurance ~~Aging and Adult Services~~ Provider Certification contact information.** Payment cannot be authorized for services provided beyond the certification period.

~~201.010 ARChoices Transition Plan 10-1-16~~

~~The ARChoices Program began January 1, 2016. The program is the combination of the ElderChoices and Alternatives for Adults with Physical Disabilities (AAPD) waivers. Beginning January 1, 2016, beneficiaries enrolled in the ElderChoices and AAPD waiver programs became beneficiaries of the ARChoices program. The following transition plan explains the process of how services will be executed and billed until the beneficiary receives a new Person-Centered Service Plan (PCSP).~~

~~Individuals currently in the ElderChoices waiver will continue receiving current services at the same level and from the same provider until the next scheduled reassessment with the following exceptions:~~

- ~~Homemaker and Adult Companion - Individuals will continue receiving Homemaker and Adult Companion hours as shown on the plan of care, except the services will be billed by the provider as Attendant Care in ARChoices.~~
- ~~Respite - Individuals will continue receiving Respite and the definition will remain the same, but providers will bill for ARChoices Respite.~~
- ~~Chore - This service is being eliminated due to underutilization. The number of participants who utilized the Chore service in State Fiscal Year 2015 was zero. Chore providers will be notified of the elimination of Chore services.~~

~~At reassessment, the DAAS RN will complete a new ARChoices PCSP and indicate any changes in services. A new service will be available to ElderChoices beneficiaries, Environmental Accessibility Adaptations/Adaptive Equipment.~~

~~Individuals currently in the Alternatives for Adults with Physical Disabilities (AAPD) waiver will be converted to ARChoices in Homecare when changes are implemented with no lapse in coverage or services. Beneficiaries will be notified of the changes at least 30 days in advance of implementation. During the reassessment and PCSP development, the AAPD individual will choose a TCM provider, and the DAAS RN will make a referral to the TCM provider of choice. The TCM provider will then make arrangements to visit the participant. The IndependentChoices counseling provider will also begin a series of visits to ensure proper support for self-direction under 1915(j). At reassessment, the DAAS RN and the beneficiary will complete a new ARChoices PCSP and indicate any changes in services.~~

~~Participants receiving AAPD Attendant Care under the Participant-Directed (PD) model will continue to receive the same services from the same provider until reassessment, at which time the service may continue under ARChoices Attendant Services as a PD service. The PD model for ARChoices will be different from the PD model for AAPD as ARChoices will use the 1915(j) authority approved by CMS for the operation of the IndependentChoices program and the self-directed supports offered to program participants. The same Attendant Care provider will continue to provide services under the IndependentChoices program. At the next reassessment, the IndependentChoices Counseling Support and Financial Management Services (FMS) provider will work with the beneficiary and Attendant Caregiver to provide training, support and assistance in understanding the changes in the PD model and in completing the paperwork necessary to transition to the new model.~~

~~Provider training will be offered to current ElderChoices and AAPD providers regarding these changes as well as training on the new billing requirements. Training will be provided to HCBS waiver staff regarding the transition from the existing waivers to one waiver.~~

~~Beginning with the first reassessment, the individual will have an expanded array of services from which to choose. Individuals will also be able to keep the same services and providers when turning age 65.~~

~~Arkansas Medicaid does not provide ARChoices Waiver services in non-bordering states.~~

201.100 Providers of ARChoices HCBS Waiver Services in Bordering and Non-Bordering States 1-1-16

An ARChoices provider must be physically located in the State of Arkansas or physically located in a bordering state and serving a trade-area city. The trade-area cities are limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas.

All providers must be licensed and/or certified by their states' appropriate licensing/certifying authorities. Copies of all appropriate licenses and certifications must be submitted to DPSQA~~DAAS~~ for certification as a potential ARChoices provider.

Arkansas Medicaid does not provide ARChoices Waiver services in non-bordering states.

201.105 Provider Assurances 10-1-16

A. Agency Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted an ARChoices Waiver Person-Centered Service Plan (PCSP).

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Department of Human Services (DHS), ~~Division of Aging and Adult Services (DAAS)~~ Division of Provider Services and Quality Assurance (DPSQA), requires mandatory training. The provider must attend one of the two provider workshop trainings in the calendar year. "Provider" in this context means at least one provider representative who will be able to inform the rest of the provider staff of what was covered in training. Failure to attend one of these trainings could jeopardize the provider's licensure or certification for the waiver. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to an ARChoices beneficiary.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:
    a. Description of the purpose and philosophy of the ARChoices Waiver Program;
    b. Discussion and distribution of the provider agency's written code of ethics;
    c. Discussion of activities which shall and shall not be performed by the employee;
    d. Discussion, including instructions, regarding ARChoices Waiver record keeping requirements;
    e. Discussion of the importance of the PCSP;
    f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
    g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality;
    h. Discussion of the beneficiary's rights regarding HCBS Settings as discussed in C of this section.

B. Code of Ethics

The Provider agrees to follow and/or enforce for each employee providing services to an ARChoices Waiver beneficiary a written code of ethics that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized beneficiaries are to accompany the employee to beneficiary's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the beneficiary's residence;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

C. Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
   a. Choice must be identified and included in the PCSP.
   b. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services and supports and who provides them.
5. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.
6. In a provider-owned or controlled residential setting ~~(e.g., Adult Family Homes)~~, in addition to the qualities specified above, the following additional conditions must be met:
   a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
   b. Each individual has privacy in their sleeping or living unit:
      i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
      ii. Beneficiaries sharing units have a choice of roommates in that setting.
      iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
   c. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
   d. Beneficiaries are able to have visitors of their choosing at any time.

e. The setting is physically accessible to the individual.

f. Any modification of the additional conditions specified in items 6.a. through 6.de. above must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:

i. Identify a specific and individualized assessed need.

ii. Document the positive interventions and supports used prior to any modifications to the PCSP.

iii. Document less intrusive methods of meeting the need that have been tried but did not work.

iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

viii. Include an assurance that interventions and supports will cause no harm to the individual.

210.000 PROGRAM COVERAGE

211.000 Scope 1-1-16

The Arkansas Medical Assistance (Medicaid) Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to persons age 21 through 64 who are determined to have a physical disability through the Social Security Administration or the DHS Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or are 65 years of age or older and require an intermediate level of care in a nursing facility. The community-based services offered through the ARChoices Home and Community-Based Waiver, described herein as ARChoices, are as follows:

~~Adult Family Homes~~

A. Attendant Care Services

B. Home-Delivered Meals

C. Personal Emergency Response System

D. Adult Day Services

E. Adult Day Health Services

F. Prevocational Services

G. Respite Care

H. Environmental Accessibility Adaptations/Adaptive Equipment

These services are designed to maintain Medicaid eligible beneficiaries at home in order to preclude or postpone institutionalization of the individual.

In accordance with 42 CFR 441.301(b) (1) (ii) ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

212.000 Eligibility for the ARChoices Program 10-1-16

A. To qualify for the ARChoices Program, a person must be age 21 through 64 and have been ~~who are~~ 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 65 years of age or older and require an intermediate level of care in a nursing facility. Persons determined to meet the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the ARChoices Program.

~~The beneficiary intake and assessment process for the ARChoices Program includes a determination of categorical eligibility, financial eligibility, a nursing facility level of care determination, the development of a PCSP and the beneficiary's notification of his or her choice between home and community-based services and institutional services.~~

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

1. Determination of categorical eligibility;
2. Determination of financial eligibility;
3. Determination of nursing facility level of care;
4. Development of a person-centered service plan (PCSP);
5. Development of an individual services budget (ISB);
6. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services; and
7. Choice by the beneficiary among certified providers.

B. Applicants for participation in the program (or their representatives) must make application for services at the DHS office in the county of their residence. Medicaid eligibility is determined by the DHS Division of County Operations ~~county office~~, the results of the independent assessment, and the ~~DAAS Long-Term Services and Supports (LTSS) Program~~ DPSQA Office of Long Term Care (OLTC) Eligibility Specialist, and is based on non-functional and functional criteria. Income and resources comprise the non-functional criteria. The individual must be an individual with a functional need.

C. To be determined an individual with a functional need; an individual must meet at least one of the following three criteria, as determined by a licensed medical professional:

1. The individual is unable to perform either of the following:
   a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon another person; or
   b. At least 2 of the 3 ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or
2. ~~Functional assessment results in a score of three or more on Cognitive Performance Scale~~ The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,

3. ~~Functional assessments results in a Change in Health, End-Stage Disease and Signs and Symptoms (CHESS) score of three or more.~~ The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

~~4. Definitions:~~

~~a. CHESS means the Changes in Health, End-Stage Disease, Signs and Symptoms Scale was designed to identify individuals at risk of serious decline. It can serve as an outcome where the objective is to minimize problems related to declines in function, or as a pointer to identify persons whose conditions are unstable.~~

~~CHESS, originally developed for use with nursing home residents, has been adapted for use with other instruments in the interRAI suite. It creates a 6-point scale from 0 = not at all unstable to 5 = highly unstable, with higher levels predictive of adverse outcomes such as mortality, hospitalization, pain, caregiver stress and poor self-rated health. (RE: **http://www.interrai.org/scales.html**)~~

~~b. COGNITIVE PERFORMANCE SCALE (CPS) combines information on memory impairment, level or consciousness and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment). The CPS has been shown to be highly correlated with the MMSE in a number of validation studies. (RE: **http://www.interrai.org/scales.html**)~~

~~c. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.~~

~~d. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.~~

~~e. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.~~

~~f. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.~~

~~g. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.~~

~~h. INTELLECTUAL AND DEVELOPMENTAL DISABILITIES means a level of intellectual disability as described in the American Association on Intellectual and Developmental Disabilities' Manual on Intellectual Disability: Definition Classification, and systems and supports. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.~~

~~i. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.~~

~~j. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care;~~

and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.

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

ii. Intravenous injections and hypodermoclysis or intravenous feedings.

iii. Levin tubes and nasogastric tubes.

iv. Nasopharyngeal and tracheostomy aspiration.

v. Application of dressings involving prescription medication and aseptic techniques.

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

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

viii. Initial phases of a regimen involving administration of medical gases.

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

x. Ventilator care and maintenance.

xi. The insertion, removal and maintenance of gastrostomy feeding tubes.

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

l. TOILETING means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.

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

n. TRANSFERRING means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.

D. Individuals who require a skilled level of care as defined in Department of Human Services regulations are not eligible for the ARChoices waiver.

E. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment. The tiers are intended to help inform waiver program oversight and

administration and person-centered service planning. Tier levels are also a population-based factor used in determining participants' prospective individual services budgets. The tiers do not replace the Level of Care criteria described in Section C above, waiver eligibility determinations, or the person-centered service plan process.

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

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

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

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

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

~~D~~F. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than 21 days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than 21 days.

~~E~~G. Beneficiaries diagnosed with a serious mental illness or intellectual disability are not eligible for the ARChoices Program unless they have medical needs unrelated to the diagnosis of mental illness or intellectual disability and meet the other qualifying criteria. A diagnosis of severe mental illness or intellectual disability must not bar eligibility for beneficiaries having medical needs unrelated to the diagnosis of serious mental illness or intellectual disability when they meet the other qualifying criteria.

~~F~~H. Eligibility for the ARChoices Waiver program begins the date the DHS Division of County Operations ~~county office~~DAAS LTSS Program Specialist approves the application unless there is a provisional plan of care. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.)

~~G~~I. The ARChoices Waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once beneficiaries meet all functional and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated, and active, beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated, or active, beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:

1. Each ARChoices application will be accepted and medical and financial eligibility will be determined.

2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled and that the applicant is number X in line for an available slot.

3. Entry to the waiver will then be prioritized based on the following criteria:

   a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;

   b. Waiver application determination date for persons being discharged from a

nursing facility after a 90- day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;

c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);

d. Waiver application determination date for all other persons.

212.050 Definitions

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

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

C. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.

D. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.

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

F. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.

G. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.

H. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.

I INTELLECTUAL AND DEVELOPMENTAL DISABILITIES means a level of intellectual disability as described in the American Association on Intellectual and Developmental Disabilities' Manual on Intellectual Disability: Definition Classification, and systems and supports. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.

J. PCSP means a person-centered service plan.

K. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.

L. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.

1. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.
2. Intravenous injections and hypodermoclysis or intravenous feedings.
3. Levin tubes and nasogastric tubes.
4. Nasopharyngeal and tracheostomy aspiration.
5. Application of dressings involving prescription medication and aseptic techniques.
6. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.
7. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.
8. Initial phases of a regimen involving administration of medical gases.
9. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.
10. Ventilator care and maintenance.
11. The insertion, removal and maintenance of gastrostomy feeding tubes.

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

N. TOILETING means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.

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

P. TRANSFERRING means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.

~~212.100 An Overview of Resource Utilization Groups (RUGs) 12-1-18~~

~~The ARChoices Waiver provides beneficiaries with a monthly allocation of attendant care hours to be used at the beneficiary's discretion throughout the month. The number of attendant care hours approved for each beneficiary is based on the results of that beneficiary's most recent assessment using the ArPath Assessment Tool.~~

~~The ArPath Assessment Tool uses a software program that includes an algorithm to evaluate certain responses within an extensive questionnaire to determine whether the beneficiary meets the functional eligibility criteria to participate in the waiver program. The ArPath Assessment Tool then uses another algorithm to evaluate other responses to determine which Resource Utilization Group (RUG) reflects the beneficiary's functional abilities. A RUG is a tier group consisting of individuals with similar functional abilities.~~

~~In 2013, attendant care services were determined based on an RN's discretionary interpretation of a beneficiary's responses to the ArPath Assessment Tool's questionnaire. Between 2013 and~~

January 1, 2016, when the ARChoices program was implemented, DAAS recorded beneficiary RUG placement and the number of paid attendant care hours utilized by beneficiaries each month in order to determine the type and amount of resources that beneficiaries with similar functional abilities were used in a given month.

While the reality of living with a disease or condition can vary greatly even among individuals with the same diagnosis, a RUG placement allows DAABHS to better predict the type and extent of care that an individual needs. The purpose of transitioning to a RUG-based care allocation system is to provide more predictable and objective outcomes that better reflect the reality of a beneficiary's needs by organizing the allocation around functional ability.

As of January 1, 2016, the allocation of attendant care hours became based on which RUG the beneficiary is placed in by the ArPath Assessment Tool. The specific number of attendant care hours assigned to a particular RUG was determined by considering an average of the number of hours used by beneficiaries placed in that RUG prior to the implementation of the ARChoices program. The following chart shows the number of hours assigned to each RUG.

RUG Category	RUG	Monthly Hours
Special Rehab	RB0	157
	RA2	97
	RA1	55
Extensive Care	SE3	352
	SE2	201
	SE1	153
Special Care	SSB	161
	SSA	112
Clinically Complex	CC0	143
	CB0	94
	CA2	69
	CA1	36
Impaired Cognition	IB0	116
	IA2	81
	IA1	38
Behavioral Problems	BB0	118
	BA2	62
	BA1	30
Reduced Physical Function	PD0	137
	PC0	99
	PB0	81
	PA2	53
	PA1	28

RUG Requirements

~~The ArPath Assessment Tool evaluates the assessment responses using an algorithm, which is basically a "rule book" for the software. This particular rulebook is divided into chapters, known as screeners, and each screener is responsible for evaluating a small portion of the assessment responses in order to produce a numerical score. Below is a list of the screeners and the possible scores:~~

~~Screener~~	~~Possible Scores~~
~~Activities of Daily Living (ADL)~~	~~4-18~~
~~Instrumental Activities of Daily Living (IADL)~~	~~0-3~~
~~Rehab~~	~~0-1~~
~~Behavior Problems~~	~~0-1~~
~~Extensive Care~~	~~0-1~~
~~Special Care~~	~~0-1~~
~~Clinically Complex~~	~~0-1~~
~~Cognitive Impairment~~	~~0-1~~
~~Cumulative~~	~~0-5~~

~~Each RUG requires a different combination of screener scores in order for a beneficiary to be placed in that RUG. The ArPath Assessment Tool utilizes the criteria for each RUG in the exact order that they are listed in the above chart and it places the beneficiary in the first RUG on the list whose criteria are satisfied by the assessment responses.~~

~~The following is a description of the screener scores required for each Special Rehab RUG.~~

~~A. RB0 requires a Rehab screener score of 1 and an ADL score of at least 11.~~

~~B. RA2 requires a Rehab screener score of 1, an IADL score of at least 2, and an ADL score of no more than 10.~~

~~C. RA1 requires a Rehab screener score of 1, an IADL score of 1 or 0, and an ADL score of no more than 10.~~

~~The following is a description of the screener scores required for each Extensive Care RUG.~~

~~A. SE3 requires a Cumulative screener score of at least 4, an Extensive Care screener score of 1, and an ADL score of at least 7.~~

~~B. SE2 requires a Cumulative screener score of either 2 or 3, an Extensive Care screener score of 1, and an ADL score of at least 7.~~

~~C. SE1 requires a Cumulative screener score of no more than 1, an Extensive Care screener score of 1, and an ADL score of at least 7.~~

~~The following is a description of the screener scores required for each Special Care RUG.~~

~~A. SSB requires an ADL score of at least 14 and a score of 1 for either the Extensive Care screener or the Special Care screener.~~

~~B. SSA has two possible combinations:~~

1. An Extensive Care screener score of 1 with and ADL score of no more than 6, or

2. An ADL score within the range of 7-13 and a score of 1 for either the Extensive Care screener or the Special Care screener.

The following is a description of the screener scores required for each Clinically Complex RUG.

A. CC0 requires an ADL score of at least 11 and a score of 1 for either the Clinically Complex screener or the Special Care screener.

B. CB0 requires an ADL score within the range of 6-10 and a score of 1 for either the Clinically Complex screener or the Special Care screener.

C. CA2 requires and ADL score no higher than 5, an IADL score of at least 1, and a score of 1 for either the Clinically Complex screener or the Special Care screener.

D. CA1 requires and ADL score no higher than 5, an IADL score of 0, and a score of 1 for either the Clinically Complex screener or the Special Care screener.

The following is a description of the screener scores required for each Impaired Cognition RUG.

A. IB0 requires a Cognitive Impairment screener score of 1 and an ADL score within the range of 6-10.

B. IA2 requires a Cognitive Impairment screener score of 1, an IADL score of at least 1, and an ADL score of no more than 5.

C. IA1 requires a Cognitive Impairment screener score of 1, an IADL score of 0, and an ADL score of no more than 5.

The following is a description of the screener scores required for each Behavioral Problems RUG.

A. BB0 requires a Behavior Problems screener score of 1 and an ADL score within the range of 6-10.

B. BA2 requires a Behavior Problems screener score of 1, an IADL score of at least 1, and an ADL score of no more than 5.

C. BA1 requires a Behavior Problems screener score of 1, an IADL score of 0, and an ADL score of no more than 5.

The following is a description of the screener scores required for each Reduced Physical Function RUG.

A. PD0 requires a Rehab screener score of 0 and an ADL score of at least 11.

B. PC0 requires a Rehab screener score of 0 and an ADL score of 9 or 10.

C. PB0 requires a Rehab screener score of 0 and an ADL score of 6, 7, or 8.

D. PA2 requires a Rehab screener score of 0, an IADL score of at least 1, and an ADL score of no more than 5.

E. PA1 requires a Rehab screener score of 0, an IADL score of 0, and an ADL score of no more than 5.

Screener Requirements

Activities of Daily Living (ADL)

~~A beneficiary's ADL score ranges from 4 to 18. It is based on the collective score among responses to the 5 items in the assessment that are listed below. Only 4 of the 5 responses will add to the overall ADL score because the response to Mode of nutritional intake may override the response to Eating.~~

~~A. Bed mobility~~

~~B. Transfer toilet~~

~~C. Toilet use~~

~~D. Eating~~

~~E. Mode of nutritional intake~~

~~Bed mobility, Transfer toilet, and Toilet use are all scored in the following way:~~

~~A. Independent gets 1 point,~~

~~B. Independent, set up help only gets 1 point,~~

~~C. Supervision gets 1 point,~~

~~D. Limited assistance gets 3 points,~~

~~E. Extensive assistance gets 4 points,~~

~~F. Maximal assistance gets 5 points,~~

~~G. Total dependence gets 5 points, and~~

~~H. Activity did not occur gets 5 points~~

~~Eating is scored in the following way:~~

~~A. Independent gets 1 point,~~

~~B. Independent, set up help only gets 1 point,~~

~~C. Supervision gets 1 point,~~

~~D. Limited assistance gets 2 points,~~

~~E. Extensive assistance gets 3 points,~~

~~F. Maximal assistance gets 3 points,~~

~~G. Total dependence gets 3 points, and~~

~~H. Activity did not occur gets 3 points.~~

~~However, 3 points will be added to the ADL score, and the Eating score will be overridden if the response to Mode of nutritional intake is any of the following:~~

~~A. Combined oral and parenteral or tube feeding,~~

~~B. Nasogastric tube feeding only,~~

~~C. Abdominal feeding tube, or~~

~~D. Parenteral feeding tube only~~

~~E. Instrumental Activities of Daily Living (IADL)~~

A beneficiary's IADL score ranges from 0 to 3. It is based on the collective score among the responses to the following items in the assessment:

A. Meal preparation performance,

B. Managing medication performance, or

C. Phone use performance.

The responses to each item are scored in the following way.

A. Independent gets 0 points.

B. Independent, set up help only gets 0 points.

C. Supervision gets 0 points.

D. Limited assistance gets 0 points.

E. Extensive assistance gets 0 points.

F. Maximal assistance gets 1 point.

G. Total dependence gets 1 point.

H. Activity did not occur gets 1 point.

Rehab

A beneficiary's Rehab screener score is 0 by default, but it equals 1 if during the week prior to the assessment the beneficiary spends a total of at least 120 minutes in any combination of the following types of therapy:

A. Speech language pathology,

B. Occupational therapy, or

C. Physical therapy.

Behavior Problems

A beneficiary's Behavior Problems score is 0 by default, but it equals 1 if the beneficiary has exhibited any of the following at any time within 3 days of the assessment:

A. Wandering,

B. Verbal abuse,

C. Physical abuse,

D. Socially inappropriate or disruptive behavior,

E. Resists care,

F. Delusions, or

G. Hallucinations.

Extensive Care

A beneficiary's Extensive Care screener score is 0 by default, but it equals 1 if the response to Mode of nutritional intake is either Abdominal feeding tube or Parenteral feeding tube only. It will

also equal 1 if the assessment records that any of the following treatments have been utilized within 3 days of the assessment:

A. IV medication,

B. Suctioning,

C. Tracheostomy care, or

D. Ventilator or respirator.

Special Care

A beneficiary's Special Care screener score is 0 by default, but it equals 1 if the assessment records that Radiation therapy has been utilized within 3 days of the assessment or any of the following combinations of responses are logged in the assessment:

A. A turning/repositioning program has been utilized within 3 days of the assessment and the response to Most severe pressure ulcer is either:

1. Deep craters in the skin or

2. Breaks in the skin exposing muscle or bone;

B. Aphasia has been exhibited within 3 days of the assessment and the Mode of nutritional intake is either:

1. Nasogastric tube feeding or

2. Combined oral and parenteral or tube feeding;

C. Wound care has been performed within 3 days of the assessment and the response to either of the following items is yes:

1. Major skin problems or

2. Skin tears or cuts;

D. Fever and Vomiting are exhibited within 3 days of the assessment;

E. Fever is exhibited within 3 days of the assessment and the response to Weight loss of 5% is yes;

F. Fever is exhibited within 3 days of the assessment and the response to Mode of nutritional intake is either:

1. Nasogastric tube feeding or

2. Combined oral and parenteral or tube feeding;

G. Fever is exhibited within 3 days of the assessment and the response to Pneumonia is any of the following:

1. Primary diagnosis for current stay;

2. Diagnosis present, receiving active treatment; or

3. Diagnosis present, monitored but no active treatment;

H. Fever is exhibited within 3 days of the assessment and the response to Dehydration is yes; or

I. A beneficiary's ADL score is at least 10 and the response to either Multiple sclerosis or Quadriplegia is any of the following:

1. Primary diagnosis for current stay;

2. Diagnosis present, receiving active treatment; or

3. Diagnosis present, monitored but no active treatment.

Clinically Complex

A beneficiary's Clinically Complex screener score is 0 by default, but it equals 1 if any of the following is recorded during the assessment:

A. Mode of nutritional intake is either Nasogastric tube feeding or Combined oral and parenteral or tube feeding;

B. The response to Cognitive skills for daily decision making is No discernable consciousness, coma and the response to any of the following is either Total dependence or Activity did not occur:

1. Bed mobility,

2. Transfer toilet,

3. Toilet use, or

4. Eating;

C. Any form of Sepsis is recorded in the Other Diseases section of the assessment;

D. The response to Dehydration is yes;

E. The beneficiary's ADL score is at least 10 and the response to Hemiplegia is any of the following:

1. Primary diagnosis for current stay;

2. Diagnosis present, receiving active treatment; or

3. Diagnosis present, monitored but no active treatment;

F. GI or GU bleeding has been exhibited in the 3 days prior to the assessment;

G. The response to Pneumonia is any of the following:

1. Primary diagnosis for current stay;

2. Diagnosis present, receiving active treatment; or

3. Diagnosis present, monitored but no active treatment;

H. The response to End stage disease, 6 or fewer months to live is yes;

I. Chemotherapy was utilized within 3 days of the assessment;

J. Dialysis was utilized within 3 days of the assessment;

K. A transfusion occurred within 3 days of the assessment;

L. Oxygen therapy was utilized within 3 days of the assessment; or

M. The response to Foot problems is either Foot problems limit walking or Foot problems prevent walking.

Impaired Cognition

A beneficiary's Impaired Cognition screener score is 0 by default, but it equals 1 if the score recorded on the Cognitive Performance Scale (CPS) is at least a 3.

Cumulative

~~A beneficiary's Cumulative screener score can range from 0 to 5. It is based on the collective score after adding the scores from the Special Care, Clinically Complex, and Impaired Cognition screeners. An additional point may be added if either of the following occurs:~~

~~A. The response to Mode of nutritional intake is Parenteral feeding only or~~

~~B. IV medication is utilized within 3 days of the assessment.~~

212.200 Prospective Individual Services Budget

A. Individual Services Budget (ISB):

1. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.

2. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by DAABHS for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.

3. Each participant's Individual Services Budget shall be explained when the DHS RN consults with the individual on the person-centered service plan. This may be done through written information.

4. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.

B. Adjustments, Considerations, and Safeguards Regarding Individual Services Budgets:

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

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

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

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

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

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

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

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

    d. The DHS RN determines the changes are reasonable and necessary for the individual and reflected in the approved person-centered service plan.

4. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. This exceptions process is intended as a safeguard to address exceptional circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:

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

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

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

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

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

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

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

C. Transition Process:

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

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

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

i. Waiver eligibility is re-evaluated;

ii. The Level of Care is reaffirmed or revised;

iii. A new independent assessment or re-assessment is performed;

iv. Expiration, renewal, extension, or revision of the participant's person-centered service plan occurs; or

v. Admission to or discharge from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or transfer from a hospice facility occurs.

2. For all other ARChoices participants not otherwise identified above, the Individual Services Budget limit shall apply no later than 60 days after the effective date of this waiver amendment.

3. For the following ARChoices participants, the DAABHS deputy director (or his/her designee) may on a case-by-case basis extend the effective date of the participant's first Individual Services Budget by a maximum of 60 days per participant upon written request of the participant (or legal representative) or the participant's personal physician, if:

   i. The specific participant's recent pattern of waiver service expenditures exceeds the average Individual Services Budget amount by an estimated twenty-five (25) percent or more; and/or

   ii. DAABHS determines that unique, intervening circumstances indicate that additional time is reasonably needed by the participant and the participant's family and providers. Examples of unique, intervening circumstances include the death of the spouse, loss of home, or unexpected difficulties in accessing or arranging care or placement, among others.

D. Methodology for Determining Individual Services Budgets:

1. The Individual Services Budget amount for a participant is based on that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The three ISB Levels are:

   a. Intensive: The participant requires total dependence or extensive assistance from another person in all three areas of mobility, feeding, and toileting.

   b. Intermediate: The participant requires total dependence or extensive assistance from another person in two of the areas of mobility, feeding, or toileting.

   c. Preventative: The participant meets the functional need eligibility requirements for ARChoices in Section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate.

2. The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (3) below, is as follows:

   a. For an individual with an assessed ISB Level of Intensive, the Individual Services Budget is $30,000 annually.

   b. For an individual with an assessed ISB Level of Intermediate, the Individual Services Budget is $20,000 annually.

   c. For an individual with an assessed ISB Level of Preventative, the Individual Services Budget is $5,000 annually.

3. For a participant with total waiver expenditures of more than $30,000 for calendar year 2018:

   a. The participant will be granted a Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures for calendar year 2018.

   b. In the year following the Transitional Allowance, the participant's maximum Individual Services Budget will be 95% of the participant's total waiver expenditures for calendar year 2019.

   c. For purposes of this subsection (3), "total waiver expenditures" for a calendar year shall be calculated as the sum total of the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:

i. If the cumulative expenditures are for less than 12 months, annualizing the total to reflect what the expenditures would have been if the participant had received the same monetary amount of services for 12 consecutive months; and

ii. Excluding amounts expended for environmental accessibility adaptations/adaptive equipment services.

4. For purposes of determining the projected cost of all waiver services in an individual's person-centered service plan, DAABHS shall assume that:

a. The individual will receive or otherwise use all services identified in the service plan and in their respective maximum authorized amounts, frequencies, and durations; and

b. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.

212.300 Person-Centered Service Plan (PCSP) 10-1-16

A. Each beneficiary in the ARChoices Program must have an individualized ARChoices PCSP. The authority to develop an ARChoices PCSP is given to the Medicaid State agency's designee, the DHS RN ~~Division of Aging and Adult Services (DAAS) Registered Nurse (DAAS RN)~~. At the discretion of the beneficiary, the ARChoices PCSP is developed with the ARChoices beneficiary, representative, the participant's family or anyone requested by the participant, including the provider, if requested by the beneficiary. At the request of the beneficiary or their representative, the ~~DAAS~~DHS RN can assist in coordinating and inviting any requested beneficiaries.

B. When developing the waiver PCSP, the beneficiary may freely choose a family member or individual to appoint as a representative. The beneficiary and representative may participate in all decisions regarding the types, amount and frequency of services included in the PCSP. The representative may participate in choosing the provider(s) for the beneficiary. If anyone other than the beneficiary chooses the provider, the ~~DAAS~~DHS RN will identify that individual on the PCSP. Should the self-directed service delivery model be selected by an individual other than the beneficiary, that individual may not be the paid employee ~~for one year unless the DAAS approves a release based upon extenuating circumstances and in the best interest of the beneficiary~~.

C. The ARChoices PCSP developed by the ~~DAAS~~DHS RN includes, but is not limited to:

1. Beneficiary identification and contact information, including full name and address, phone number, date of birth, Medicaid number and the effective date of ARChoices Waiver eligibility;
2. Contact person;
3. Physician's name and address;
4. The amount, frequency and duration of ARChoices Waiver services to be provided and the name of the service provider chosen by the beneficiary or representative to provide the services. **Note: Attendant Care, Respite Care, and State Plan Personal Care hours are authorized ~~on the waiver PCSP~~ based on the number of hours calculated by application of the Arkansas Medicaid Task and Hour Standards (THS) which is described below in Section D ~~a Resource Utilization Group (RUG) score produced from the ArPath assessment~~. Attendant Care, Respite Care, and State Plan Personal Care hours are authorized in a monthly amount ~~on~~ in the waiver PCSP. ~~The provider and beneficiary determine how to use the Attendant Care hours based on the beneficiary's needs and preferences.~~ The beneficiary's chosen, Medicaid-certified provider is**

responsible for properly delivering Attendant Care, Respite Care, and State Plan Personal Care services to support the needed activity of daily living (ADL) and instrumental activity of daily living (IADL) tasks, consistent with the approved PCSP, this manual, and other applicable Arkansas Medicaid policy.

5. Other services outside the ARChoices services, regardless of payment source, identified and/or ordered to meet the beneficiary's needs including the option for the self-directed service delivery model;
6. The election of community services by the waiver beneficiary or representative; ~~and,~~
7. The name and title of the ~~DAAS~~DHS RN responsible for the development of the beneficiary's PCSP; and
8. The individual services budget for the participant.

D. **Task and Hour Standards (THS):**

1. Background on THS

   The Arkansas Medicaid Task and Hour Standards ("THS") is the written methodology used by the DHS RNs as the basis for calculating the number of Attendant Care, Respite Care, and State Plan Personal Care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

   The current DAABHS-approved THS is located on the web at [insert website address]

The THS includes the following four components, described in a grid format:

a. The participant's Needs Intensity Score (0, 1, 2, or 3) for each task;
b. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;
c. The frequency with which a task is necessary and reasonably performed; and
d. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary Attendant Care, Respite Care, and State Plan Personal Care services hours, with the minute ranges and frequencies providing DHS nurses with the ability to adjust PCSPs based on unique factors related to a given beneficiary's needs, preferences, and risks.

The number of Attendant Care, Respite Care, and State Plan Personal Care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN consistent with the THS grid and based on:

a. Responses by the participant and their representatives to certain relevant questions in the ARIA assessment instrument, and
b. As appropriate, information obtained by the DHS RN during their PCSP meeting with the participant and participants' representatives or from participant's physician.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

The Arkansas THS is also used to calculate the reasonable quantity of hours to perform medically necessary tasks covered under IndependentChoices self-directed personal assistance or State Plan personal care services for adults aged 21 or older.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

2. Needs Intensity Score:

For each task, the DHS RN will assign a Needs Intensity Score to the participant based on the participant's and/or representative's responses to questions during the ARIA assessment and information collected by the DHS RN during the PCSP meeting with the participant. The four Impairment Scores are defined as follows:

Needs Intensity Score 0 – The participant has no functional impairment with regard to the task and can perform it without assistance.

Needs Intensity Score 1 (Mild): Minimal/mild functional impairment. The participant is able to conduct activities with minimal difficulty and need minimal assistance.

Needs Intensity Score 2 (Severe): Extensive/severe functional impairment. The participant has extensive difficulty carrying out activities and needs extensive assistance.

Needs Intensity Score 3 (Total): The participant is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

3. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN preparing the PCSP will determine the number of minutes within the range that are appropriate for the participant based on conditions specific to the participant. For example, if a participant has cognitive or behavioral issues, the DHS RN may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a participant who is bald.

If the participant has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN must obtain supervisory approval. For supervisory approval, the DHS RN must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the PCSP.

4. The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information collected by the DHS RN during the PCSP meeting with the participant.

5. The amount of assistance with ADLs and IADLs provided by other sources

ARChoices does not cover assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then ARChoices attendant care is not necessary and no time for that task is included in the PCSP. When another source is available to provide assistance with a needed ADL or IADL task, the time associated with the assistance from that other source is deducted from the total minutes per week.

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information gathered by the DHS RN during the PCSP meeting with the participant.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task. For example, the participant's daughter may bathe her mother once a week and prepare all meals on weekends, eliminating the need for an attendant care aide to perform those tasks. For this participant, the total minutes per week for the tasks of bathing and meal preparation would be adjusted by the minutes associated with an aide assisting with one bath and six meals per week.

6. Calculation of total hours of attendant care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of attendant care hours approved for the participant for a month. **The projected total cost of attendant care plus all other authorized services in the PCSP (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.**

E. If waiver eligibility is approved by the DHS Division of County Operations ~~county office~~, ~~and the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist,~~ a copy of the PCSP signed by the ~~DAAS~~DHS RN and the waiver beneficiary or representative, will be forwarded to the beneficiary or representative and the Medicaid enrolled service provider(s) included in the PCSP. The service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Services cannot begin until the Medicaid provider receives the authorized PCSP from the ~~DAAS~~DHS RN. The original PCSP will be maintained by the ~~DAAS~~DHS RN.

The implementation of the PCSP by a provider must ensure that services are:

1. Individualized to the beneficiary's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the beneficiary's welfare;
4. Monitored and adjusted as needed, based on changes authorized and reported by the ~~DAAS~~DHS RN regarding the waiver PCSP;
5. Provided within a system that safeguards the beneficiary's rights to quality services as authorized on the waiver PCSP; and,
6. Documented carefully, with assurance that required information is recorded and maintained.

NOTE: Each service included on the ARChoices PCSP must be justified by the ~~DAAS~~DHS RN. This justification is based on medical necessity, the beneficiary's physical, cognitive and functional status, other support services available to the beneficiary and other factors deemed appropriate by the ~~DAAS~~DHS RN.

Each ARChoices service must be provided according to the beneficiary PCSP. For services included in the waiver PCSP, Medicaid reimbursement is limited to the amount and frequency that is authorized in the PCSP, subject to the participant's individual services budget. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

NOTE: PCSPs are updated annually by the ~~DAASDHS~~ RN and sent to the ARChoices provider prior to the expiration of the current PCSP. However, the provider has the responsibility for monitoring the PCSP expiration date and ensuring that services are delivered according to a valid PCSP. At least 30 and no more than 45 days before the expiration of each PCSP, the provider shall notify the ~~DAASDHS~~ RN via email and copy the RN supervisor of the PCSP expiration date.

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

REVISIONS TO A BENEFICIARY PCSP MAY ONLY BE MADE BY THE ~~DAASDHS~~ RN.

NOTE: All revisions to the waiver PCSP must be authorized by the ~~DAASDHS~~ RN. A revised PCSP will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on an ARChoices PCSP, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the ARChoices PCSP are subject to recoupment.

All revisions to the PCSP must be consistent with and not exceed the participant's applicable individual services budget.

212.305 Targeted Case Management Services (Non-Waiver Service) 1-1-16

Each ARChoices PCSP will include Targeted Case Management, unless refused by the waiver beneficiary. The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in their service need, referring the beneficiary for reassessment, if necessary, and reporting any beneficiary complaints and changes in status to the ~~DAASDHS~~ RN or Nurse Manager immediately upon learning of the change.

NOTE: As stated in this manual, the service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Each service included on the ARChoices PCSP must be justified by the ~~DAASDHS~~ RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the ~~DAASDHS~~ RN.

For ARChoices beneficiaries whose waiver PCSP includes TCM at the time the ~~DAASDHS~~ RN signs the PCSP, the ARChoices PCSP, signed by a ~~DAASDHS~~ RN, will serve as the authorization for TCM services for one year from the date of the ~~DAASDHS~~ RN's signature, as described above.

212.310 Provisional Person-Centered Service Plan (PCSP) 10-1-16

The ARChoices registered nurse (~~DAASDHS~~ RN) may develop a provisional PCSP prior to establishment of Medicaid eligibility, based on information obtained during the in-home functional assessments administered by the Independent Assessment Contractor and the DHS RN, when recommending functional approval based on the nursing home criteria. The ~~DAASDHS~~ RN must discuss the provisional PCSP policy and have the approval of the applicant prior to completing and processing the provisional PCSP. The PCSP will be developed by the applicant and the ~~DAASDHS~~ RN and signed by the applicant or the applicant's representative and the ~~DAASDHS~~ RN.

The provisional PCSP will include all current PCSP information, except for the waiver eligibility date and the Medicaid beneficiary ID number.

The provisional PCSP will be mailed to the waiver applicant and each provider included on the PCSP. If the beneficiary and the provider accept the risk of ineligibility, the provider must begin services within an established time frame as determined by the ~~Division of Aging and Adult Services (DAAS)~~ Division of Aging, Adult, and Behavioral Health Services (DAABHS) and notify the ~~DAAS~~DHS RN, via Start Services form AAS-9510, that services have started. The ~~DAAS~~DHS RN will track the start of care dates and give the applicant options when services are not started.

The provisional PCSP will expire 60 days from the date signed by the applicant and the ~~DAAS~~DHS RN. A PCSP that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional PCSP.

A. A provisional PCSP may be developed and sent to providers only when the assessment outcome indicates functional eligibility and the ~~DAAS~~ DPSQA-Office of Long Term Care determines based on the results of the ARIA assessment, ~~believes, in his or her professional judgment,~~ that the applicant meets the level of care criteria for an adult with a functional need, as explained in Section 212.000, Eligibility for the ARChoices Program.

   The waiver eligibility date will be established retroactively, effective on the day the provisional PCSP was signed by the applicant or applicant's representative and the ~~DAAS~~DHS RN, if:

   1. At least one waiver service begins within 30 days of the development of the provisional PCSP

      AND

   2. The waiver application is approved by the Division of County Operations.

B. If waiver services begin within 31 through 60 days of the development of the provisional PCSP, the retroactive eligibility date will be the effective date that a waiver service is started.

C. If waiver services do not begin within 60 days from the date the provisional PCSP is signed by the ~~DAAS~~DHS RN, the DHS Division of County Operations ~~county office~~, ~~DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist~~ will establish the waiver eligibility date as the date the application is entered into the system as an approved application. There will be no retroactive eligibility.

D. Provisional PCSPs are subject to the participant's individual services budget.

E. Provisional PCSPs may not include the non-waiver self-directed service delivery model

212.311 Denied Eligibility Application 10-1-16

A. If the DHS Division of County Operations ~~county office~~, ~~and the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist~~ denies the Medicaid eligibility application for any reason, Medicaid and waiver services provided during a period of ineligibility will be the financial responsibility of the applicant. The DHS Division of County Operations ~~county office~~ ~~DAAS LTSS Program Eligibility Specialist~~ will notify the ~~DAAS~~DHS RN. The ~~DAAS~~DHS RN will notify the providers via form AAS-9511 immediately upon learning of the denial. Reasons for denial include but are not limited to:

   1. Failure to meet the nursing home admission criteria
   2. Failure to meet financial eligibility criteria
   3. Withdrawal of the application by the applicant
   4. Death of the applicant when no waiver services were provided

NOTE: If waiver services were provided and the applicant dies prior to approval of the application, waiver eligibility will begin (if all other eligibility requirements are met) on the date waiver service(s) began and end on the date of death.

B. The applicant has the right to appeal by filing for a fair hearing. When an appeal ruling is made in favor of the applicant, the actions to be taken by the DHS Division of County Operations ~~county office~~ are as follows:

1. If the individual has no unpaid ARChoices Waiver charges, Medicaid coverage will begin on the date of the appeal decision. However, the waiver portion of the case will not be approved until the date the DHS Division of County Operations ~~county office and the DAAS LTSS Program Eligibility Specialist~~ completes the case.
2. If the individual has unpaid waiver charges and services were authorized by the ~~DAAS~~DHS RN, eligibility for both Medicaid and waiver services will begin on the date service began unless the hearing decision sets a begin date.

NOTE: Under no circumstances will waiver eligibility begin prior to the date of application or the date the provisional PCSP is signed by the ~~DAAS~~DHS RN and the applicant or the applicant's representative, whichever is later.

212.312 Comprehensive Person-Centered Service Plan (PCSP) 10-1-16

Prior to the expiration date of the provisional PCSP, the ~~DAAS~~DHS RN will send the comprehensive PCSP to the waiver beneficiary and all providers included on the PCSP. The comprehensive PCSP will replace the provisional PCSP. The comprehensive PCSP will include the Medicaid beneficiary ID number, the waiver eligibility date established according to policy and the comprehensive PCSP expiration date.

The comprehensive PCSP expiration date will be 365 days from the date of the ~~DAAS~~DHS RN's signature on form AAS-9503, the ARChoices PCSP. Once the application is either approved or denied by the DHS Division of County Operations ~~county office~~, ~~DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialis~~ the providers will be notified by the ~~DAAS~~DHS RN. The notification for the approval will be in writing via a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.

212.313 ARChoices Applicants Leaving an Institution 1-1-16

The policy regarding retroactive eligibility applies to applicants entering the waiver program from the community and to applicants entering the program from an institution. The same process and the same policy determining the waiver eligibility date will apply to applications of each type.

EXCEPTION: No waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a provisional PCSP is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest waiver eligibility date will be the day the applicant is discharged from the facility.

NOTE: For inpatients, if a waiver application is filed at the local DHS Division of County Operations ~~county office~~, prior to discharge AND if a provisional PCSP is developed by the ~~DAAS~~DHS RN prior to discharge, it may be possible to establish retroactive eligibility back to the date the applicant returned to his or her home if the applicant is ultimately found eligible for the program. (Note: Medicaid beneficiaries in nursing facilities do not have to complete a new application when applying for ARChoices. Their signature on the PCSP electing waiver services serves as the application.)

If no waiver application is filed and no functional assessment or provisional PCSP is completed by the Independent Assessment Contractor and ~~DAAS~~DHS RN prior to an applicant's discharge from an institution, retroactive eligibility will not be possible back to the date the applicant returned to his home.

Functional assessments and PCSPs may be completed during a period of institutionalization; however, a discharge date must be scheduled. Since the purpose of the assessment and the PCSP is to depict the applicant's condition and needs in the home, premature assessments and PCSP development do not meet the intent of the program.

This policy applies to applicants leaving hospitals or nursing facilities.

212.320 Authorization of The ARChoices Person-Centered Service Plan (PCSP) with Personal Care Services 1-1-16

The following applies to individuals receiving both personal care services and ARChoices services.

A. The ~~DAAS~~DHS RN is responsible for developing an ARChoices PCSP that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the ~~DAAS~~DHS RN authorizing the services.

B. ~~A~~ PCSP developed on or after the effective date of this Provider Manual may not include attendant care services unless the PCSP provides for at least 64 hours per month of personal care services. Attendant care services are intended to supplement personal care services available under the Medicaid state plan.

C. The ARChoices PCSP signed by the ~~DAAS~~ DHS RN will suffice as the "Personal Care Authorization" for services required in the Personal Care Program. The personal care service plan developed by the Personal care provider is still required.

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

NOTE: For ARChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a ~~DAAS~~DHS RN, will serve as the authorization for personal care services for one year from the date of the ~~DAAS~~DHS RN's signature, as described above.

D. The ARChoices PCSP is effective for one year, once signed by the ~~DAAS~~ DHS RN~~; the authorization for personal care services, when included on the ARChoices PCSP, will be for one year from the date of the DAAS RN's signature, unless revised by the DAAS RN. If personal care services continue unchanged as authorized on the ARChoices PCSP, a new service plan is not required at the 6-month interval~~.

~~**NOTE: It is the personal care provider's responsibility to place information regarding the agency's presence in the home in a prominent location so that the DAAS RN will be aware that the provider is serving the beneficiary. Preferably, the provider will place the information atop the refrigerator or under the phone the beneficiary uses, unless the beneficiary objects. If so, the provider will place the information in a location satisfactory to the beneficiary, as long as it is readily available to and easily accessible by the DAAS RN.**~~

~~212.322 Revisions when the Person-Centered Service Plan (PCSP) Contains Personal Care Services~~ ~~10-1-16~~

~~Requested changes to the personal care services included on the ARChoices PCSP may originate with the personal care RN or the DAAS RN, based on the beneficiary's circumstances. Unless requested by an IndependentChoices beneficiary, the individual or agency requesting revisions to the Personal Care services on the ARChoices PCSP is responsible for securing any required signatures authorizing the change prior to the ARChoices PCSP being revised.~~

~~If revised by the DAAS RN, a copy of the revised ARChoices PCSP and a Start of Care Form (AAS-9510) will be mailed to the personal care provider within 10 working days after being revised. If authorization is secured by the Personal Care agency, a copy of the revised personal care order, signed by the physician, must be sent to the DAAS RN prior to implementing any revisions. Once received, the ARChoices PCSP will be revised accordingly within 10 working days of its receipt. If any problems are encountered with implementing the requested revisions, the DAAS RN will contact the personal care provider to discuss possible alternatives. These discussions and the final decision regarding the requested revisions must be documented in the nurse narrative. The final decision rests with the DAAS RN.~~

212.400 Temporary Absences from the Home 10-1-16

Once an ARChoices eligibility application has been approved, waiver services must be provided in a home and community-based services setting for eligibility to continue. Unless stated otherwise below, the DHS Division of County Operations ~~county Department of Human Services (DHS) office~~ must be notified immediately by the ~~Division of Aging and Adult Services Registered Nurse (DAAS~~DHS RN~~)~~ when waiver services are discontinued and action will be initiated by the ~~DAAS LTSS Program Eligibility Specialist~~ DHS Division of County Operations ~~county office~~ to close the waiver case. Providers will be notified by the ~~DAAS~~DHS RN.

A. Absence from the Home due to Institutionalization

An individual cannot receive ARChoices Waiver services while in an institution. The following policy applies to any inpatient stay where Medicaid pays the facility for the date of admission, i.e., hospitals, nursing homes, rehab facilities, etc., for active waiver cases when the beneficiary is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver beneficiary is admitted to a hospital, the ~~DAAS LTSS Program Eligibility Specialist~~ DHS Division of County Operations ~~county office~~, will not take action to close the waiver case unless the beneficiary does not return home within 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the ~~DAAS~~DHS RN will notify the ~~DAAS LTSS Program Eligibility Specialist~~ DHS Division of County Operations ~~county office~~ and action will be initiated to close the waiver case.
2. If the DHS Division of County Operations ~~county office~~ becomes aware that a beneficiary has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of the admission, but the Medicaid case will be left open. When the beneficiary returns home, the waiver case may be reopened effective the date the beneficiary returns home. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the beneficiary's admission to the facility.

NOTE: Nursing facility admissions, when referenced in this section, do not include ARChoices beneficiaries admitted to a nursing facility to receive facility-based respite services.

NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.

Payment for ARChoices services may be allowed for the date of a beneficiary's admission to an inpatient facility if the provider can provide verification that services were provided before the beneficiary was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:

- **Copies of claim forms or timesheets listing the times that services were provided**
- **A statement from the inpatient facility showing the time that the beneficiary was admitted**
- **This information must be submitted to ~~DAAS~~ DAABHS within 10 working days of receiving a request for verification.**

If providers are unable to provide proof that ARChoices services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. ARChoices services provided on the same day the beneficiary is discharged from the inpatient facility are billable when provided according to policy and after the beneficiary was discharged.

B. Absence due to Reasons Other than Institutionalization

When a waiver beneficiary is absent from the home for reasons other than institutionalization, the ~~DAAS LTSS Program Eligibility Specialist~~ DHS Division of County Operations ~~county office~~will not be notified unless the beneficiary does not return home within 30 days. If, after 30 days, the beneficiary has not returned home and the providers can no longer deliver services as authorized on the Person-Centered Service Plan (PCSP) (e.g., the beneficiary has left the state and the return date is unknown), the ~~DAAS~~DHS RN will notify the ~~DAAS LTSS Program Eligibility Specialist~~ DHS Division of County Operations ~~county office~~. Action will be taken by the ~~DAAS LTSS Program Eligibility Specialist~~ DHS Division of County Operations ~~county office~~ to close the waiver case.

NOTE: It is the responsibility of the provider to notify the ~~DAAS~~DHS RN immediately via form AAS-9511 upon learning of a change in the beneficiary's status.

212.500 Reporting Changes in Beneficiary's Status 10-1-16

Because the provider has more frequent contact with the beneficiary, many times the provider becomes aware of changes in the beneficiary's status sooner than the ~~Division of Aging and Adult Services (DAAS) Registered Nurse (DAAS~~DHS RN~~)~~, or Case Manager~~, or DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist~~. It is the provider's responsibility to report these changes immediately so proper action may be taken. Providers must complete the Waiver Provider Communication – Change of Participant Status Form (AAS-9511) and send it to the ~~DAAS~~DHS RN. A copy must be retained in the provider's beneficiary case record. Regardless of whether the change may result in action by the DHS Division of County Operations ~~county office~~,~~DAAS LTSS Program Eligibility Specialist~~, providers must immediately report all changes in the beneficiary's status to the ~~DAAS~~DHS RN.

The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in service need, referring the beneficiary for reassessment if necessary and

reporting any beneficiary complaints and changes in status to the ~~DAAS~~DHS RN, or ~~DAAS~~DHS RN Supervisor immediately upon learning of the change.

212.600 Relatives Providing ARChoices Services 1-1-16

All ARChoices services~~, except for Adult Family Homes,~~ may be provided by a beneficiary's relative, unless stated otherwise in this manual. ~~No Adult Family Home provider, employee or family member of the provider may be related to the Adult Family Home waiver beneficiary.~~

For the purposes of this section, a relative or family member shall be defined as all persons related to the beneficiary by virtue of blood, marriage, or adoption.

The following is applicable for all waiver services:

A. Under no circumstances may Medicaid payment be made for any waiver service rendered by the waiver beneficiary's:

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

B. All providers, including relatives, are required to meet all ARChoices provider certification requirements, Arkansas Medicaid enrollment requirements and provide services according to the beneficiary's PCSP and any established benefit limits for that specific service.

213.000 Description of Services

~~213.100 Adult Family Homes~~ ~~10-1-16~~

~~Procedure Code~~	~~Modifier~~	~~Description~~
~~S5140~~	~~U1~~	~~Adult Family Homes Level A~~
~~S5140~~	~~U2~~	~~Adult Family Homes Level B~~
~~S5140~~	~~U3~~	~~Adult Family Homes Level C~~

~~Adult Family Homes services are personal care and supportive services (e.g., Attendant Care, transportation and medication oversight (to the extent permitted under State Law)), provided in a certified private home by a principal care provider who lives in the home.~~

~~Payment for Adult Family Home services is not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for Adult Family Home services does not include payments made, directly or indirectly, to members of the beneficiary's immediate family.~~

~~Adult Family Home services provide a family living environment for adults who are functionally impaired and who, due to the severity of their functional Needs Intensitys, are considered to be at imminent risk of death or serious bodily harm and, as a consequence, are not capable of fully independent living.~~

~~The number of beneficiaries served by an Adult Family Home may not exceed three (3) and beneficiaries must be unrelated to the adult family home provider. "Unrelated" is defined as any person who is not related to the provider by virtue of blood, marriage, or adoption. Other than the Adult Family Home provider, immediate family members or caregivers residing in the adult family home with the waiver beneficiary are prohibited from receiving Medicaid reimbursement for direct provision of any ARChoices services.~~

~~Adult Family Home services shall be included in the Person-Centered Service Plan (PCSP) only when it is necessary to prevent the permanent institutionalization of a beneficiary as determined by the Division of Aging and Adult Services Registered Nurse (DAAS RN). The Adult Family Home provider is responsible for meeting the needs of the waiver beneficiary, as defined by this waiver service description, 24 hours/day, 7 days/week.~~

~~Adult Family Homes add a dimension of family living to the provision of supportive services and personal care services such as:~~

~~A. Bathing~~

~~B. Dressing~~

~~C. Grooming~~

~~D. Care for occasional incontinence (bowel/bladder)~~

~~E. Assistance with eating~~

~~F. Enhancement of skills and independence in daily living~~

~~G. Transportation to allow access to the community~~

~~Services are provided in a home-like setting. The provider must include the beneficiary in the life of the family as much as possible. The provider must assist the beneficiary in becoming or remaining active in the community.~~

~~Services must be provided according to the participant's written ARChoices PCSP.~~

~~There are three (3) different reimbursement rates for Adult Family Homes based on the Level of Care required for the individual beneficiary. Level of Care is indicated by using a modifier with CPT Code **S5140**.~~

~~One (1) unit of service equals one (1) day. Adult Family Homes are limited to a maximum of thirty-one (31) units per month. Room and board costs are not included as a part of this service. Service payments are for the provision of daily living care to the beneficiary.~~

~~For any given year of the ARChoices Waiver, Adult Family Homes shall charge waiver residents no more than 90.8% of the current Individual SSI Benefit amount rounded to the nearest dollar for room and board. For any given year of the ARChoices Waiver, ARChoices Waiver beneficiaries shall receive 9% of the current Individual SSI Benefit amount rounded to the nearest dollar for personal needs allowance.~~

~~The waiver eligible person will cover the cost of room and board in the Adult Family Home. In addition, the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist will determine individual liability for care services based on the waiver eligible person's available resources. Medicaid will cover the remaining cost of waiver services provided to the waiver eligible person. The personal needs allowance is adequate to meet the other expenses of the waiver eligible person in the Adult Family Home and exceeds the personal needs allowance for beneficiaries in long term care facilities.~~

~~The Adult Family Home waiver beneficiary may receive up to 600 hours (2,400 units) of long-term facility-based respite per state fiscal year. The service of Adult Family Home is not allowed on the same date of service as respite service.~~

~~BENEFICIARIES RECEIVING ADULT FAMILY HOMES SERVICES ARE NOT ELIGIBLE TO RECEIVE ANY OTHER ARCHOICES SERVICE, EXCEPT FOR LONG-TERM FACILITY-BASED RESPITE.~~

~~**213.110 Adult Family Homes Certification Requirements** 10-1-16~~

~~Enrollment as an ARChoices Adult Family Homes provider requires certification by the Department of Human Services, Division of Aging and Adult Services (DAAS), as an Adult Family Home. Adult Family Homes providers must complete an application packet including Medicaid Provider forms; be tested over designated training materials and achieve a passing score and submit the home for inspection by designated DAAS staff. If substitute caregivers are identified, these beneficiaries must meet the same training and testing requirements as the Adult Family Homes provider. In addition, drug screens and background checks are required for the provider, substitute care givers and provider family members residing in the home and who are over the age of sixteen (16). Providers must recertify with DAAS annually. This requires submission of a renewal application packet and home inspection, as well as documentation of at least twelve hours of related training activities.~~

~~An Adult Family Home, for the purpose of the ARChoices Program, does not include any house, institution, hotel or other similar living situation that supplies room and board only, room only, or board only.~~

~~As a condition of certification, each Adult Family Homes provider shall execute with and provide to each beneficiary an admission agreement specifying services to be provided, the beneficiary's cost for room and board, conditions and rules governing the beneficiary and grounds for termination of residency. Each Adult Family Homes provider will also be required to develop and maintain written program policies. Program policies must include and comply with the HCBS Settings rules found in section C of 201.105.~~

~~**NOTE: The Adult Family Home provider's ElderChoices certification will be valid as an ARChoices Adult Family Home provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**~~

~~**NOTE: At the next annual certification, the Adult Family Home provider must have policies in place that include and comply with the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.**~~

213.210 Attendant Care Services 10-1-16

Procedure Code	Modifier	Description
S5125	U2	Attendant Care Services
S5125		Attendant Care Self-Directed Model

Attendant Care services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible beneficiary's functioning in his or her own home or elsewhere in the community where the beneficiary engages in activities, including work-related activities. Attendant 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 section 213.220.

Attendant Care services consists of assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks through hands-on assistance, supervision and/ or cueing.

Hands-on assistance, supervision and/or cueing are defined as:

A. "Hands-on assistance" means a provider physically performs all or part of an activity because the individual is unable to do so.

B. "Set-up", a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.

C. "Supervision" means a provider must be near the individual to observe how the individual is completing a task.

D. "Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the individual complete activities without hands-on assistance.

E. "Monitoring", a form of supervision, means a provider must observe the individual to determine if intervention is needed.

F. "Stand-by", a form of supervision, means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

G. "Support", a form of supervision, means to enhance the environment to enable the individual to be as independent as possible.

H. The following forms of assistance combine elements of Hands-on assistance, supervision and/or cueing:

I. "Redirection", a form of supervision or cueing, means to divert the individual to another more appropriate activity.

J. "Memory care support", a blend of supervision, cueing and hands-on assistance. Includes services related to observing behaviors, supervision and intervening as appropriate in order to safeguard the service beneficiary against injury, hazard or accident. These specific supports are designed to support beneficiaries with cognitive impairments.

Activities of daily living include:

A. Eating

B. Bathing

C. Dressing

D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene, etc.)

E. Toileting

F. Mobility/ambulating, including functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

A. Meal planning and preparation of meals consumed only by the participant

B. ~~Managing finances~~

~~C.~~ Laundry for the participant or incidental to the participant's care

~~D.~~ C. Shopping ~~and errands~~ for food, clothing, and other essential items required specifically for the health and maintenance of the participant;

~~E. Communication~~

~~F. Traveling~~

D. Housekeeping (cleaning of furniture, floors, and areas directly used by the participant)

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

Health-related tasks are limited to the following activities:

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

B. Additional assistance with self-administration of prescribed medications; and/or

C. Emptying and replacing colostomy and ostomy bags.

Health-related tasks must be:

A. Consistent with all applicable State scope of practice laws and regulations;

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

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

D. Necessary to meet specific needs of the participant consistent with a written plan of care by a physician or registered nurse; and

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

The provision of assistance with ADLs, IADLs, or health-related tasks does not entail nursing care.

Attendant care services tasks must be:

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

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

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

D. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services;

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

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

Attendant care services exclude all of the following:

A. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including without limitation: aseptic or sterile procedures; application of dressings; medication administration; injections, observation and

assessment of health conditions, other than as permitted for health-related tasks above; insertion, removal, or irrigation of catheters; tube or other enteral feedings; tracheostomy care; oxygen administration; ventilator care; drawing blood; and care and maintenance of any medical equipment;

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

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

D. Companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);

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

F. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

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

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

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

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

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

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

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

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

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

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

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

E. On dates of service when the participant:

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

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

3. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the DHS RN;

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

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

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

G. For a task that was not actually performed.

Beneficiaries may choose to self-direct this service through Arkansas's IndependentChoices program under 1915(j) authority; or may receive services through an agency. The IndependentChoices Medicaid Provider Manual describes the self-directed service delivery model.

Attendant Care services must be provided according to the beneficiary ARChoices written PCSP.

A brief description of the service(s) provided, including the signature and title of the individual rendering the service, must be documented in the beneficiary's case record. See Section 214.000 for additional documentation requirements.

Benefit limits will be determined on a client basis based on application of the Arkansas Medicaid Task and Hour Standards (THS) and the service limitations described in this manual. ~~the assessed level of need by the DAAS RN. The highest RUG level allows a maximum allocation of 324 units (81 hours) per week, 1,436 units (359 hours) per month, or 16,848 units (4,212 hours) per year.~~

DAABHS will update the Person-Centered Service Plan to take into account any changes in the participant's condition and/or living arrangements that would affect the number of hours of attendant care that could be approved under the Task and Hour Standards.

Fifteen (15) minutes of service equals one (1) unit.

An ARChoices beneficiary who spends more than five (5) hours (20 units) at an adult day services or adult day health services facility or who is receiving short-term, facility-based respite care will not be eligible for Attendant Care services on the same date of service unless authorized by the ~~DAAS~~DHS RN.

An ARChoices beneficiary receiving long-term, facility-based respite care is not eligible for Attendant Care services on the same date of service.

213.220 Travel Time of Attendant Accompanying Participant **1-1-19**

A. The Attendant Care benefit only covers attendant travel time when all of the following apply:

1. The attendant accompanies the participant in the same vehicle as the participant travels to and returns from a community location for medical appointment or community activity;
2. The travel time billed is solely for necessary time in transit from the participant's home to the community location and the return travel from the community location to the participant's home.
3. The participant's participation in the local community activity is for the benefit of the participant and to meet the participant's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the attendant, a family member, the driver, or other passengers);
4. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;
5. The participant's approved patient-centered service plan includes Attendant Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;
6. While in transit to and from the community location, the participant requires, or is likely to need given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility / ambulating; and
7. The travel time is reasonable given driving distances, traffic conditions, and weather, with time and locations documented.

B. Travel time is not reimbursable if any other adult person accompanying (or driving) the participant is a family member and is reasonably able to assist the participant in transit if needed.

C. Travel time accompanying a participant will count against the total number of Attendant Care hours per month authorized in the participant's person-centered service plan.

D. Requesting Hours for Travel Time of Attendant Accompanying Participant:

Participants vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of an attendant accompanying a participant is incident to but itself not the ADL task of toileting or the ADL task of mobility / ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Attendant Care hours, if

any, associated solely with travel time of an attendant accompanying a participant to a medical visit or community activity. During the home visit to discuss the person-centered service plan, the participant (or their legal representative) should inform the DHS nurse of the individual's community activities, need for an attendant to accompany them, and the distances and roundtrip travel times typically involved. Based on this information, consistent with the above requirements, and within the person's applicable Individual Services Budget, the DHS nurse may increase the number of Attendant Care hours per month covered in the PCSP to reasonably accommodate the travel time of an attendant accompanying the participant.

213.230 Attendant Care Services Certification Requirements 1-1-18

The following requirements must be met prior to certification by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ by providers of attendant care services. The provider must:

A. Hold a current Arkansas State Board of Health Class A and/or Class B license, Or Private Care Agency license.

B. All owners, principals, employees, and contract staff of an attendant care services provider must have ~~comply with~~national and state criminal background checks and central registry checks. Criminal background and central registry checks must comply with ~~according to~~ Arkansas ~~State Law at~~ 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.

C. Employ and supervise direct care staff who:

1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
2. Possess the necessary skills to perform the specific services required to meet the needs of the beneficiary the direct care staff member is to serve; and
3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and ~~DAAS~~DPSQA certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DPSQA annually ~~DAAS every three years; however, the provider must submit a copy the agency's current license to DAAS each year when the license is renewed~~.

Providers are required to submit copy of renewed license to DPSQA~~DAAS~~.

~~**NOTE: The Class A, Class B or Private Care Agency license provider's ElderChoices and AAPD certification will be valid as an Attendant Care services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices and AAPD.**~~

213.240 Environmental Accessibility Adaptations/Adaptive Equipment 10-1-16

Environmental Accessibility Adaptations/Adaptive Equipment services enable the individual to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise. Environmental Accessibility Adaptations/Adaptive Equipment is physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, to function with greater independence in the home and preclude or postpone institutionalization. Adaptive equipment also enables the ARChoices beneficiary to increase, maintain and/or improve his/her functional capacity to perform daily life tasks that would not be possible otherwise and perceive, control or communicate with the environment in which he or she lives.

Excluded are adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes. All dwellings that receive adaptations must be in good repair and have the appearance of sound structure.

Permanent fixtures are not allowed on rented or leased properties.

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment services provided by a waiver beneficiary's:

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

213.280 Provider Qualifications Environmental Accessibility Adaptations/Adaptive Equipment 1-1-16

Individuals or businesses seeking certification by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ and enrollment as Medicaid providers of environmental accessibility adaptations/adaptive equipment services must meet the following criteria:

A. The provider of services must be a builder, tradesman or contractor.

B. The provider must be licensed (where applicable) as appropriate for home improvement contracting or adaptation and equipment provided.

C. The provider must certify that his or her work meets state and local building codes.

D. The provider must obtain all applicable permits.

E. The provider must be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines.

F. Contractors are required to adhere to the Uniform Federal Accessibility Standards.

NOTE: All environmental modifications requiring electrical or plumbing work must be completed by a an appropriately licensed professional. If the proposed work requires a plumbing or electrical license, the contractor must submit a copy of the contractor's plumbing or electrical license with the claim form.

If a contractor subcontracts with an electrician or plumber, the contractor must submit a copy of the subcontractor's license with the claim form.

213.290 Environmental Modifications/Adaptive Equipment 10-1-16

Prior to payment for this service, the waiver beneficiary is required to secure 3 separate itemized bids for the same service. Each bid must itemize the work to be done and must specifically identify any work that requires a plumbing or electrical license. The bids are reviewed by the ~~Division of Aging and Adult Services (DAAS)~~ Division of Aging, Adult, and Behavioral Health Services (DHS~~DAAS~~ RN) or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided. All modification funds must be verified by DAABHS ~~the DAAS Provider Certification Unit~~ prior to receiving services.

Each claim must be signed by the provider, the waiver beneficiary and ~~DAAS~~DHS RN, or designee. A statement of satisfaction form must be signed by the waiver beneficiary prior to any claim being submitted. All claim forms, bids and client satisfaction statement forms must be submitted to DAABHS ~~the DAAS Provider Certification Unit~~ prior to submission for payment.

NOTE: The Environmental Modification provider's Alternatives for Adults with Physical Disabilities (AAPD) certification will be valid as an ARChoices Environmental Modification provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under AAPD.

213.310 Hot Home-Delivered Meals 1-1-16

Hot Home-Delivered Meals provide one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with the ~~DAAS~~DAABHS Nutrition Services Program Policy Number 206.

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible beneficiaries who are homebound. Homebound is defined as a person with normal inability to leave home without assistance (physical or mental) from another person; a person who is frail, homebound by reason of illness or incapacitating disability or otherwise isolated; or for whom leaving home requires considerable and taxing effort by the individual and absences from the home are infrequent, relatively short in duration or are attributable to the need to receive medical treatment.

Additionally, the beneficiary must:

A. Be unable to prepare some or all of his or her own meals;

B. Have no other individual to prepare his or her own meals; and

C. Have the provision of the Home-Delivered Meals included on his or her PCSP

The provision of a Home-Delivered Meal is the most cost-effective method of ensuring a nutritiously adequate meal.

The Home-Delivered Meals provider must maintain a log sheet signed by the beneficiary that includes date and time of delivery each time a meal is delivered to document receipt of the meal.

Hot Home-Delivered Meals must be provided according to the beneficiary's written ARChoices PCSP.

Procedure Code	Required Modifier	Description
S5170	U2	Hot Home-Delivered Meal
S5170	—	Frozen Home-Delivered Meal
S5170	U1	Emergency Home-Delivered Meal

213.311 Hot Home-Delivered Meal Provider Certification Requirements 1-1-18

To be certified by the ~~Division of Aging and Adult Services (DAAS)~~ Division of Provider Services and Quality Assurance (DPSQA) as a provider of Hot Home-Delivered Meal services, a provider must:

A. Be a nutrition services provider whose kitchen is approved by the Department of Health, and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and ~~DAAS~~DAABHS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, assure that the provider's intermediate source of delivery meets or exceeds federal, state and local laws regarding food transportation and delivery;*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law;*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

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

F. Notify the ~~DAAS~~DHS RN immediately if:

1. There is a problem with delivery of service
2. The beneficiary is not consuming the meals
3. A change in the individual's condition is noted

NOTE: Changes in service delivery must receive prior approval by the ~~DAAS~~DHS RN who is responsible for the individual's Person-Centered Service Plan (PCSP). Requests must be submitted in writing to the ~~DAAS~~DHS RN. Any changes in the individual's circumstances must be reported to the ~~DAAS~~DHS RN via form AAS-9511.

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Hot Home-Delivered Meals providers must recertify with ~~DAAS every three years; however,~~ DAAS ~~must maintain,~~ DPSQA annually, and the provider shall attach a copy of the agency's current Food Establishment Permit ~~at all times~~ to the annual recertification.

~~**NOTE: The Home-Delivered Meals provider's ElderChoices certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**~~

213.320 Frozen Home-Delivered Meals 1-1-16

Frozen Home-Delivered Meals service provides one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with ~~DAAS~~DAABHS Nutrition Services Program Policy Number 206.

The goal of the Frozen Home-Delivered Meals service is to supplement, not replace, the Hot Home-Delivered Meal service by providing one daily nutritious meal to homebound persons at risk of being institutionalized who:

A. Reside in remote areas where daily hot meals are not available;

B. Choose to receive a frozen meal rather than a hot meal; or

C. Are at nutritional risk and are certified to receive a meal for use on weekends or holidays when the hot meal provider is not in operation.

NOTE: While the individual has freedom of choice regarding this service, it is the responsibility of the ~~DAAS~~DHS RN developing the PCSP to ensure the appropriateness of the service. A hot meal delivered daily remains the food service of choice, when available. Therefore, a frozen meal must be approved by the ~~DAAS~~DHS RN. The service must be included on the PCSP. If the individual responsible for developing the PCSP does not think the frozen meals are appropriate for the individual, other options will be considered. Those options include removing the Home-Delivered Meal service rather than authorizing a frozen meal.

It is the certified provider's responsibility to deliver the meals regardless if they are hot or frozen. Meals may not be left on the doorstep. The meals cannot be mailed to the individual via United States Postal Service or delivered by paid carrier such as Fed Ex or UPS.

213.321 Beneficiary Requirements for Frozen Home-Delivered Meals 1-1-16

The beneficiary must:

A. Be homebound, which is defined by the following requirements:

1. The person is normally unable to leave home without assistance (physical or mental) from another person;
2. The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
3. Leaving home requires considerable and taxing effort by the individual; and
4. Absences of the individual from home are infrequent, of relatively short duration or attributable to the need to receive medical treatment.

B. Be unable to prepare some or all of his or her meals or require a special diet and be unable to prepare it.

C. Have no other individual available to prepare his or her meals and the provision of a Frozen Home-Delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal.

D. Have adequate and appropriate storage and be able to perform the simple tasks associated with storing and heating a Frozen Home-Delivered Meal or have made other appropriate arrangements approved by ~~DAAS~~DAABHS.

E. Have the provision of frozen meals included on his or her PCSP as developed by the appropriate ~~DAAS~~DHS RN.

Frozen Home-Delivered Meals must be documented on the ARChoices PCSP by the ~~DAAS~~DHS RN and must be provided in accordance with the beneficiary's written ARChoices PCSP.

213.323 Frozen Home-Delivered Meal Provider Certification Requirements 1-1-18

In order to become approved providers of frozen meals, providers must meet all applicable requirements of the ~~Aging and Adult Services (DAAS)~~ DAABHS Nutrition Services Program Policy Number 206.

To be certified by ~~DAAS~~DPSQA as a provider of Home-Delivered Meal services, a meal provider must:

A. Be a nutrition services provider whose kitchen is approved by the Department of Health, and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and ~~DAAS~~DAABHS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, ensure that intermediate sources of delivery meet or exceed federal, state and local laws regarding food transportation and delivery*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

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

F. Provide frozen meals that:

1. Were prepared or purchased according to the Department of Health and ~~DAAS~~ DAABHS Nutrition Services Program Policy guidelines in freezer-safe containers that can be reheated in the oven or microwave.
2. Are kept frozen from the time of preparation through placement in the individual's freezer.
3. Have a remaining freezer life of at least three months from the date of delivery to the home.
4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).
5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the ARChoices beneficiary), menu analysis as required by DAABHS~~DAAS~~ Nutrition Services Program Policy if other than DAABHS~~DAAS~~ menus are used and both packaging and expiration dates.

NOTE: The milk must be delivered to the beneficiary at least seven (7) days prior to its expiration date.

~~F.~~ G. Instruct each individual, both verbally and in writing, in the handling and preparation required for frozen meals and provide written re-heating instructions with each meal, preferably in large print.

~~G.~~ H. Ensure that meals that are not commercially prepared but produced on-site in the production kitchen:

1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;
2. Are prepared specifically to be frozen;
3. Are frozen as quickly as possible;
4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;
5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;
6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;
7. Are frozen in a manner that allows air circulation around each individual tray;
8. Are kept frozen throughout storage, transport and delivery to the beneficiary; and
9. Are discarded after 30 days.

~~H.~~ I. Verify quarterly that all beneficiaries receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks unless other appropriate arrangements have been made and approved by ~~DAAS~~DAABHS. Any changes in the individual's circumstances must be reported to the ~~DAAS~~DHS RN via form AAS-9511.

~~I.~~ J. Notify the appropriate ~~DAAS~~DHS RN immediately if:

1. There is a problem with delivery of service
2. The individual is not consuming the meals
3. A change in an individual's condition is noted

NOTE: Changes in service delivery must receive prior approval by the ~~DAAS~~DHS RN who is responsible for the individual's Person-Centered Services Plan

(PCSP). Requests must be submitted in writing to the ~~DAAS~~DHS RN. Any changes in the individual's circumstances must be reported to the ~~DAAS~~DHS RN via form AAS-9511.

K. Contact each individual daily Monday through Friday, either in person or by phone, to ensure the individual's safety and well-being. This is not required for:

1. Individuals receiving Frozen Home-Delivered Meals only for weekends; or

2. Individuals who receive Attendant Care services or Personal Care services at least three (3) times per week.

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Frozen Home-Delivered Meals providers must recertify with DPSQA annually ~~DAAS every three years~~; however, ~~DAAS~~DPSQA must maintain a copy of the agency's current Food Establishment Permit at all times.

~~**NOTE: The Home-Delivered Meals ElderChoices provider's certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**~~

213.330 Limitations on Home-Delivered Meals (HDMs) 10-1-16

One unit of service equals one meal. The maximum number of HDMs eligible for Medicaid reimbursement per month equals 31 meals. This includes hot, frozen or a combination of the two. There is no separate benefit limit for frozen meals.

The maximum number of emergency meals per State Fiscal Year is four (4).

Frozen HDMs may be provided daily to eligible beneficiaries. A maximum of seven (7) meals may be delivered at one time.

HDM providers may deliver more than seven meals at one time, if:

A. The waiver beneficiary receives Attendant Care services or Personal Care services at least three (3) times per week,

B. Frozen HDMs are ordered on the Person-Centered Services Plan (PCSP),

C. The waiver beneficiary has the means of storing 14 frozen meals (as verified by the ~~DAAS~~DHS RN).

HDM providers delivering frozen meals may deliver 14 at one time if the ~~DAAS~~DHS RN enters 14 meals delivery approved in the comments section of the HDM entry on the PCSP. If this statement is not on the PCSP, or if any of the other factors above are not in place, the meal providers cannot deliver more than seven (7) meals at one time.

An ARChoices beneficiary may not be provided with a Hot or Frozen HDM on any day during which the individual receives more than five (5) hours of in-home or facility-based Respite care or more than five (5) hours of Adult Day Services or Adult Day Health Services. (Licensure mandates that providers of these services provide a meal or meals; therefore, a HDM on these dates is a duplicative service and prohibited under waiver guidelines.)

NOTE: Medicaid reimbursement for HDMs is not allowed on the same day to beneficiaries who are also attending Adult Day Services, Adult Day Health Services, or facility-based Respite care for more than five (5) hours. When applying this policy, the time of day the beneficiary receives day services or

respite services are also a factor. Whether there is duplication of services will be determined by comparing the time of day during which services occur.

When considering whether a HDM is billable for an individual receiving Adult Day Services, Adult Day Health Services or facility-based Respite services, on a specific date of service, the following must be applied:

If an ARChoices beneficiary is receiving Adult Day Services, Adult Day Health Services or facility-based Respite at any time between the hours of 11:00 a.m. and 1:30 p.m. **and** the noon meal is routinely served to others at the facility during this timeframe, the noon meal must also be served to this individual. A HDM is not allowable on the same date of service. This is true **regardless of the total number of Adult Day Services, Adult Day Health Services or Respite hours provided.**

213.340 Combination of Hot and Frozen Home-Delivered Meals 1-1-16

In instances where the ARChoices beneficiary wishes to receive a combination of hot and frozen meals, the ~~DAAS~~DHS RN shall evaluate the beneficiary's situation based on the criteria set forth in Section 213.320, Frozen Home-Delivered Meals. If the criteria are met, the ~~DAAS~~DHS RN may prescribe on the PCSP a combination of hot and frozen meals to be delivered.

213.350 Emergency Meals 10-1-16

Beneficiaries may receive up to four (4) emergency meals per state fiscal year. The meals must:

A. Contain 33 1/3 percent of the Dietary Reference intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and ~~Division of Aging and Adult Services (DAAS)~~ (DAABHS~~DAAS~~) Nutrition Services Program Policy Number 206.

B. Be labeled "Emergency Meal" in large print, with instruction on use of the meal.

C. Be used within the limits of their shelf life, usually within six months.

213.400 Personal Emergency Response System 1-1-16

Procedure Code	Required Modifier	Description
S5161	UA	PERS Unit
S5160	—	PERS Installation

The Personal Emergency Response System (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. PERS enables an elderly, infirm or homebound individual to secure immediate help in the event of a physical, emotional or environmental emergency.

PERS is specifically designed for high-risk beneficiaries whose needs have been carefully determined based on their level of medical vulnerability, functional impairment and social isolation. PERS is not intended to be a universal benefit. The ~~DAAS~~DHS RN must verify that the individual is capable, both physically and mentally, of operating the PERS unit.

PERS must be included in the beneficiary's written ARChoices PCSP.

PERS providers must contact each beneficiary at least once per month to test the system's operation. The provider shall maintain a log of test calls that includes the date and time of the test, specific test results, corrective actions and outcomes.

A log of all beneficiary calls received must be maintained by the emergency response center. The log must reflect the date, time and nature of the call and the response initiated by the center. All calls must be documented in the beneficiary's record. See Section 214.000 for other documentation requirements.

One (1) unit of service equals one (1) ~~day~~ month. PERS is limited to a maximum of ~~thirty-one (31) units per month~~ twelve (12) units per year.

The installation of PERS will be allowed once per lifetime or period of eligibility. Claims submitted for the installation of PERS should use procedure code **S5160**. Procedure code **S5160** may be billed for ARChoices beneficiaries who are accessing PERS services for their first time or for the current period of re-eligibility for ARChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging, Adult, and Behavioral Health Services ~~of Aging and Adult Services~~ for extension of the benefit.

~~**View or print Division of Aging, Adult, and Behavioral Health Services contact information of Aging and Adult Services .**~~

213.410 Personal Emergency Response System (PERS) Certification Requirements 10-1-16

To be certified by Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ as a provider of personal emergency response services, a provider must:

A. Provide, install and maintain Federal Communications Commission (FCC) approved equipment which meets all Underwriter Laboratories Safety Standards;

B. Designate or operate an emergency response center to receive signals and respond according to specified operating protocol;

C. Establish a response system for each beneficiary and ensure responders receive necessary instruction and training; and

D. Ensure that equipment is installed by qualified providers who also provide instruction and training to beneficiaries.

PERS providers must recertify annually with DPSQA~~DAAS~~.

~~**NOTE: The PERS ElderChoices provider's certification will be valid as an ARChoices PERS provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**~~

213.500 Adult Day Services 10-1-16

Procedure Code	Required Modifier	Description
S5100	U1	Adult Day Services, 8-20 Units Per Date of Service
S5100	—	Adult Day Services, 21-40 Units Per Date of Service

Adult day services facilities are licensed by the ~~Office of Long-Term Care (OLTC)~~ Division of Provider Services and Quality Assurance (DPSQA) to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than 24 hours but more than two (2) hours per day, in a place other than the beneficiaries' own homes.

When provided according to the beneficiary's written ARChoices Person-Centered Service Plan (PCSP), ARChoices beneficiaries may receive adult day services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day, according to the beneficiary's written PCSP. Adult day services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month. One (1) unit of service equals 15 minutes.

As required, beneficiaries who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than 20 units (5 hours) of adult day services. Additionally, beneficiaries who attend an adult day service for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the ~~Division of Aging and Adult Services Registered Nurse (DAAS~~DHS RN~~)~~.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the beneficiary is receiving day services, day health services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the ~~DAAS~~DHS RN and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day services, day health services or facility-based respite services on a specific date of service.

If an ARChoices beneficiary is receiving day services, day health services or **facility-based** respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to this individual. A home-delivered meal is not allowable on the same date of service. This is true **regardless of the total number of day services or respite units provided**.

Adult day services and day health services providers are required to maintain a daily attendance log of beneficiaries. Section 214.000 contains information regarding additional documentation requirements.

213.510 Adult Day Services Certification Requirements 10-1-16

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)~~ as a provider of adult day services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by the Arkansas Department of Human Services, ~~Office of Long Term Care~~ Division of Provider Services and Quality Assurance as a long-term adult day care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Care Facility.

In order to be certified by ~~DAAS~~DPSQA, Adult Day Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Services providers must recertify with ~~DAAS every three years~~ DPSQA annually; however, ~~DAAS~~ DPSQA must maintain a copy of the agency's current Adult Day Care license at all times.

In order to be recertified by DPSQA~~DAAS~~, Adult Day Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DPSQA~~DAAS~~.

~~NOTE: The Adult Day Services ElderChoices provider's certification will be valid as an ARChoices Adult Day Services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.~~

213.600 Adult Day Health Services (ADHS) 10-1-16

Procedure Code	Required Modifier	Description
S5100	TD, U1	Adult Day Health Services, 8-20 Units Per Date of Service
S5100	TD	Adult Day Health Services, 21-40 Units Per Date of Service

Adult day health services facilities are licensed to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to beneficiaries who are functionally impaired and who, due to the severity of their functional impairment, are not capable of fully independent living.

Adult day health services programs provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary that cannot be provided by adult day care programs. Adult day health services are appropriate only for beneficiaries whose facility-developed care plans specify one or more of the following health services:

A. Rehabilitative therapies (e.g., physical therapy, occupational therapy),

B. Pharmaceutical supervision,

C. Diagnostic evaluation or

D. Health monitoring

ARChoices beneficiaries may receive adult day health services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day when the service is provided according to the beneficiary's written ARChoices Person-Centered Service Plan (PCSP). Adult day health services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day health services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month.

Beneficiaries who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**, modifier **TD**) must be served a nutritious meal that equals one-third of the Recommended Daily Dietary Allowances. Therefore, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day health services. Additionally, beneficiaries who attend an adult day health services for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the ~~Division of Aging and Adult Services (DAAS (DHSDAAS~~ RN~~)~~.

Adult day health services providers are required by licensure to maintain a daily attendance log of beneficiaries. See Section 214.000 for additional documentation requirements.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the beneficiary is receiving day services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the ~~DAAS~~DHS RN and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day services or facility-based respite services on a specific date of service.

If an ARChoices beneficiary is receiving day services or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to the individual. A home-delivered meal is not allowable on the same date of service. **This is true regardless of the total number of day services or respite units provided.**

213.610 Adult Day Health Services (ADHS) Provider Certification Requirements 10-1-16

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of adult day health services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by Arkansas Department of Human Services, Division of Provider Services and Quality Assurance as ~~a long-term~~ an adult day health care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Health Care Facility.

In order to be certified by ~~DAAS~~DPSQA, Adult Day Health Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Health Services providers must recertify with ~~DAAS every three years~~ DPSQA annually; however, ~~DAAS~~DPSQA must maintain a copy of the agency's current Adult Day Health Care license at all times. In order to be recertified, Adult Day Health Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to ~~DAAS~~DAABHS.

NOTE: Adult day services and adult day health services are not allowed on the same date of service.

~~**NOTE: The Adult Day Health Services ElderChoices provider's certification will be valid as an ARChoices Adult Day Health Services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**~~

213.620 Prevocational Services

Procedure Code	Modifier	Description
T2015		Prevocational Services Skills Development
T2015	U3	Prevocational Services Career Exploration

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

Prevocational services are as follows:

1. Development and teaching of general employability skills (non-job-task-specific strengths and skills) directly relevant to the participant's pre-employment needs and successful participation in individual paid employment. These skills are: ability to communicate

effectively with supervisors, coworkers, and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; and skills related to obtaining paid employment. Excluded are services involving development or training of job-specific or job-task oriented skills.

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

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

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

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

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

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

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

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

Fifteen (15) minutes of service equals one (1) unit.

Providers of Prevocational Services under the ARChoices waiver program must be certified by the Division of Provider Services and Quality Assurance and must recertify annually.

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

a. Spouse;
b. Legal guardian of the person; or

c. Attorney-in-fact granted authority to direct the beneficiary's care

213.700 Respite Care 10-1-16

Procedure Code	Description
T1005	Long-Term Facility-Based Respite Care
S5135	Short-Term Facility-Based Respite Care
S5150	In-Home Respite Care

~~Respite care services provide temporary relief to persons providing long-term care for beneficiaries in their homes. Respite care may be provided outside of the beneficiary's home to meet an emergency need or to schedule relief periods in accordance with the regular caregiver's need for temporary relief from continuous care giving. If there is no primary caregiver, respite care services will not be deemed appropriate and subsequently will not be authorized on the Person-Centered Service Plan (PCSP).~~

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

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

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

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

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

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

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

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

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

Respite Care is available in the following locations:

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

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

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

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

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

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

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

Respite care is subject to the following limitations:

1. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with the amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards ("THS"). Any amounts, frequencies, or durations in excess of the unpaid caregiver assistance amounts identified for the beneficiary in the THS are not covered.

2. Respite Care excludes:

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

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

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

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

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

   f. Services provided for any tasks not included in a beneficiary's service plans.

3. Participants are limited to no more than 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof. Respite care is not

subject to a monthly or weekly limit, but is limited to the annual amount of time identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards.

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

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

   a. Spouse,
   b. Legal guardian of the person, or
   c. Attorney-in-fact granted authority to direct the beneficiary's care.

In the event the in-home functional assessments performed by the Independent Assessment Contractor and the ~~Division of Aging and Adult Services Registered Nurse (DAASDHS~~ RN~~)~~ substantiates a need for respite care services, the service will be authorized as needed, via the beneficiary's PCSP, not to exceed an hourly maximum. The ~~DAASDHS~~ RN will establish the service limitation based on the beneficiary's medical need, other services included on the PCSP and support services available to the beneficiary. Respite care services must be provided according to the beneficiary's written PCSP subject to the participant's Individual Services Budget.

An individual living in the home with the beneficiary is prohibited from serving as a Respite Services provider for the beneficiary.

213.711 Facility-Based Respite Care 10-1-16

Facility-based respite care may be provided outside the beneficiary's home on a short- or long-term basis by ~~certified adult family homes,~~ residential care facilities, nursing facilities, adult day care facilities, adult day health care facilities, Level I and Level II Assisted Living Facilities and hospitals.

Facility-based providers rendering services for eight (8) hours or less per date of service must bill **S5135** for short-term, facility-based respite care. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible beneficiaries may receive up to 32 units (8 hours) of short-term, facility-based respite care per date of service.

Facility-based providers rendering services for more than 32 units (8 hours) per day must bill **T1005** for long-term, facility-based respite care. One (1) unit of service for procedure code **T1005** equals 15 minutes. A beneficiary may receive up to 96 units (24 hours) of service per date of service if the provider bills procedure code **T1005**.

Facility-based respite care services include short-term and long-term respite care services and can include any combination of billing codes **S5135** or **T1005**. A single provider may provide both long-term and short-term facility-based respite care services for a particular beneficiary, but not on the same date of service.

Eligible beneficiaries may receive up to 4800 units (1200 hours) per State Fiscal Year of Facility-Based Respite Care- or In-Home Respite Care, or a combination of the two. ~~Adult Family Home beneficiaries are limited to 2400 units (600 hours) of long-term facility-based respite per state fiscal year.~~

Beneficiaries receiving long-term, facility-based respite care services may receive only ARChoices Personal Emergency Response System (PERS) services concurrently.

Please refer to the NOTE found in Section 213.500 regarding Home-Delivered Meals and facility-based respite services.

213.712 In-Home Respite Care Certification Requirements 1-1-16

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) ~~Aging and Adult Services (DAAS)Division of Aging and Adult Services (DAAS)~~ as a provider of in-home respite care services, a provider must:

A. Hold a current Class A and/or Class B Home Health Agency license or a Private Care Agency license to provide personal care and/or home health services as issued by the state licensing authority;

B. Employ and supervise direct care staff trained and qualified to provide respite care services; and

C. Agree to the minimum Assurances of Providers of ARChoices Waiver Services.

In-Home Respite Care providers as described in A. above must recertify with ~~DAAS every three years~~ annually; however, DPSQA~~DAAS~~ must maintain a copy of the agency's current license at all times.

Providers are required to submit copy of renewed license to DPSQA~~DAAS~~.

~~**NOTE: The Class A, Class B or Private Care Agency license ElderChoices provider's certification will be valid as a Respite services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**~~

213.713 Facility-Based Respite Care Certification Requirements 1-1-16

To be certified by the Division ~~of Aging and Adult Services~~ Provider Services and Quality Assurance (DPSQA) as a provider of facility-based respite care services, a provider must be licensed in their state as one or more of the following:

~~A. A certified adult family home~~

A. A licensed adult day care facility

B. A licensed adult day health care facility

C. A licensed nursing facility

D. A licensed residential care facility

E. A licensed Level I or Level II Assisted Living Facility

F. A licensed hospital

Facility-Based Respite Care providers as listed above~~, with the exception of a certified adult family home~~, must recertify with ~~DAAS every three years~~ DPSQA annually; however, DPSQA~~DAAS~~ must maintain a current copy of the facility's current license at all times.

~~A certified and Medicaid enrolled adult family home which is also certified by DAAS to provide facility-based respite services must recertify with DAAS annually.~~

~~**NOTE: The Class A, Class B or Private Care Agency facility-based respite ElderChoices provider's license certification will be valid as a facility-based respite services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**~~

214.000 Documentation 1-1-16

In addition to the service-specific documentation requirements previously listed, ARChoices providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the beneficiary's PCSP.

B. A brief description of the specific service(s) provided.

C. The signature and title of the individual rendering the service(s).

1. For records created through an electronic data system such as telephony, computer or other electronic devices, a unique identifier such as a PIN number assigned to and entered by the employee at the time of data input may suffice as an electronic signature and title; and

D. The date and actual time the service(s) was rendered. For Attendant Care or In-Home Respite Care, it is not necessary to itemize the time spent on each individual ADL or IADL task.

A provider's failure to maintain sufficient documentation to support his or her billing practices may result in recoupment of Medicaid payment.

No documentation for ARChoices services, as with all Medicaid services, may be made in pencil.

215.000 ARChoices Forms

ARChoices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the ~~Division of Aging and Adult Services~~Division of Aging, Adult, and Behavioral Health Services. These forms include but are not limited to:

A. Person Centered Service Plan — AAS–9503

B. Start Services — AAS–9510

C. Beneficiary Change of Status — AAS–9511

Providers may request form AAS–9511 by writing to the Division of Aging, Adult, and Behavioral Health ~~and Adult~~ Services. ~~**View or print the Division of Aging and Adult ServicesDivision for Aging, Adult, and Behavioral Health Services contact information.**~~

Forms AAS–9503 and AAS–9510 will be mailed to the provider by the ~~DAAS~~DHS RN.

Instructions for completion and retention are included with each form. If there are questions regarding any ARChoices form, providers may contact the ~~DAAS~~DHS RN in your area.

240.000 PRIOR AUTHORIZATION 1-1-16

Attendant care, personal care, and prevocational services provided under an authorized PCSP require prior authorization. ~~Services~~ Other services provided under the ARChoices Program under an authorized PCSP do not require prior authorization.

250.000 REIMBURSEMENT

251.010 Fee Schedules 1-1-16

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.

260.000 BILLING PROCEDURES 1-1-16

262.100 HCPCS Procedure Codes 10-1-16

The following procedure codes must be billed for ARChoices Services.

Electronic and paper claims now require the same National Place of Service code.

Procedure Code	Modifiers	Description	Unit of Service	National POS for Claims
~~S5140~~	~~Level A – U1~~ ~~Level B – U2~~ ~~Level C – U3~~	~~Adult Family Homes~~	~~1 day~~	~~99~~
S5125		Attendant Care Services	15 minutes	12
S5125	U2	Agency Attendant Care Traditional	15 minutes	12, 99
S5170	U2	Home-Delivered Meals	1 meal	12
S5170		Frozen Home-Delivered Meal	1 meal	12
S5170	U1	Emergency Home Delivered Meals	1 meal	12
S5161	UA	Personal Emergency Response System	1 day	12
S5160		Personal Emergency Response System – Installation	One install	12
S5100	U1	Adult Day Services, 8 to 20 units per date of service	15 minutes	99
S5100		Adult Day Services, 21 to 40 units per date of service	15 minutes	99

Procedure Code	Modifiers	Description	Unit of Service	National POS for Claims
S5100	TD, U1	Adult Day Health Services, 8 to 20 units per date of service	15 minutes	99
S5100	TD	Adult Day Health Services, 21 to 40 units per date of service	15 minutes	99
S5150		Respite Care – In-Home	15 minutes	12
S5135		Respite Care – Short-Term Facility-Based	15 minutes	99, 21, 32
T1005		Respite Care – Long-Term Facility-Based	15 minutes	21, 32, 99
T2015		Prevocational Services Skills Development	15 minutes	11, 12, 99
T2015	U3	Prevocational Services Career Exploration	15 minutes	11, 12, 99

262.210 Place of Service Codes 1-1-16

The national place of service (POS) code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Beneficiary's Home	12
Day Care Facility	99
Nursing Facility	32
Provider's Office	11
Other Locations	99

262.400 Special Billing Procedures – Environmental Modifications/Adaptive Equipment 10-1-16

Prior to payment for this service, the ARChoices beneficiary is required to secure three separate itemized bids for the same service. The bids are reviewed by the ~~Division of Aging and Adult Services (DAAS Registered Nurse (DAASDHS~~ RN~~)~~ or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided.

Each claim must be signed by the provider, the ARChoices beneficiary, and ~~DAAS~~DHS RN, or designee. A statement of satisfaction form must be signed by the ARChoices beneficiary prior to any claim being submitted. Please refer to 213.290 for additional information.