TOC Required

201.000 Arkansas Medicaid Certification Requirements for ElderChoices H&CB Waiver Program ~~11-1-08~~1-1-13

All ElderChoices home and community-based (H&CB) 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:

ElderChoices H&CB Waiver providers must be certified by the Division of 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 Aging and Adult Services does not guarantee enrollment in the Medicaid program.

All providers must maintain their provider files at the HP Enterprise Services Provider Enrollment Unit by submitting current certification, licensure, etc., all DAAS-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider.

Copies of certifications and renewals required by DAAS must be maintained by DAAS to avoid loss of provider certification. These copies must be submitted to DAAS ElderChoices Provider Certification. **View or print the Division of Aging and Adult Services ElderChoices Provider Certification contact information.** Payment cannot be authorized for services provided beyond the certification period.

201.105 Provider Assurances 1-1-13

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 ElderChoices Waiver Plan of Care.

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 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 ElderChoices 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 are required to attend orientation training prior to allowing the employee to deliver any ElderChoices Waiver service(s). This orientation shall include, but not be limited to, a:

   a. Description of the purpose and philosophy of the ElderChoices 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 ElderChoices Waiver record

keeping requirements;

e. Discussion of the importance of the Plan of Care;

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.

B. Code of Ethics.

The Provider agrees to follow and/or enforce for each employee providing services to an ElderChoices 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 individuals 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 breaech of the beneficiary's privacy or confidentiality of records.

211.000 Scope ~~10-1-08~~1-1-13

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 individuals aged 65 years or older who require an intermediate level of care in a nursing facility. The community-based services offered through the ElderChoices Home and Community-Based 2176 Waiver, described herein as ElderChoices, are as follows:

A. Adult Family Homes

B. Homemaker Services

C. Chore Services

D. Home-Delivered Meals

E. Personal Emergency Response System

F. Adult Day Care

G. Adult Day Health Care

H. Respite Care

I. Adult Companion Services

These services are designed to maintain Medicaid eligible ~~persons~~ beneficiaries at home in order to preclude or postpone institutionalization of the individual.

In accordance with 42 CFR 441.301(b)(1)(ii) ElderChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions.

212.000 Eligibility ~~Assessment~~for the ElderChoices Program ~~2-1-061-1-~~ 13

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

The ~~client~~ beneficiary in take and assessment process for the ElderChoices Program includes a determination of categorical eligibility, a nursing facility level of care determination, the development of a ~~plan~~ Plan of ~~care~~ Care and the ~~client's~~ beneficiary's notification of ~~their~~ his or her choice between home and community-based services and institutional services. ~~Costs effectiveness of the waiver program is determined annually in the aggregate and submitted to the Center for Medicare and Medicaid Services (CMS).~~

B. Candidates 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 County Office and is based on non-medical and medical criteria. Income and resources comprise the non-medical criteria. Medically, the candidate must be an individual with a functional disability.

C. To be determined an individual with a functional disability, an individual must meet at least one 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. Medical assessment results in a score of three or more on Cognitive Performance Scale; or

3. Medical assessments results in a Changes in Health, End-Stage Disease and Symptoms and Signs (CHESS) score of three or more.

D. 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. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the ElderChoices program unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.

F. Eligibility for the ElderChoices waiver program is determined as the latter of the date of application for the program or the date the plan of care is signed by the DAAS RN and beneficiary. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.)

G. The ElderChoices waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once individuals meet all medical and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated participants who can be served in any waiver year. Once the maximum number of unduplicated participants 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 ElderChoices 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.

212.100 ~~Financial Eligibility Determination~~Reserved ~~7-15-09~~1-1-13

~~Financial eligibility for the Arkansas Medicaid Program must be verified as part of the beneficiary intake and assessment process for admission into the ElderChoices Program. Medicaid eligibility is determined by the DHS County Office located in the beneficiary's resident county.~~

212.200 Level of Care Determination ~~7-15-09~~1-1-13

A prospective ElderChoices beneficiary must require a nursing facility intermediate level of care. Registered Nurses employed by the Division of Aging and Adult Services (DAAS RNs) perform a comprehensive assessment of each applicant to determine his or her personal assistance and health care needs. The assessment tool is ArPath, the electronic interRAI home care instrument, which evaluates the candidate's level of care need.

The intermediate level of care determination is ~~performed~~ made by medical staff ~~assigned to~~with the Department of Human Services (DHS) Utilization Review Team with the Office of Long Term Care. The determination is based on the comprehensive assessment performed by the DAAS RN, using standard criteria for functional disability in~~The intermediate level of care criteria provides an objective and consistent method for~~ evaluating ~~the~~ an individual's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance ~~to~~ with nursing home admission criteria, must be completed and the individual deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving ElderChoices services.

~~Reevaluations will be performed annually by the Department of Human Services medical team to determine the beneficiary's continuing need for an intermediate level of care. The DAAS RN performs a comprehensive assessment periodically (at least annually), and the Office of Long Term Care re-determines level of care annually.~~ The results of the level of care determination and the reevaluation are documented on form DHS-704, Decision for Nursing Home Placement.

NOTE: While federal guidelines require level of care reassessment at least annually, DAAS may reassess a beneficiary's level of care and/or need any time it is deemed appropriate by the DAAS RN to ensure that a beneficiary is appropriately placed in the ElderChoices program and is receiving services suitable to his or her needs.

212.300 Plan of Care ~~7-15-09~~1-1-13

A. Each beneficiary ~~eligible for~~in the ElderChoices program must have an individualized ElderChoices ~~plan~~ Plan of ~~care~~Care. The authority to develop an ElderChoices ~~plan~~ Plan of ~~care~~ Care is given to the Medicaid State ~~Agency's~~ agency's designee, the ~~Department of Human Services Division of Aging and Adult Services~~ Registered Nurse (~~DHS~~DAAS RN). ~~At the discretion of the beneficiary, t~~The ElderChoices ~~plan~~ Plan of ~~care~~ Care developed with the ElderChoices beneficiary, representative, the participant's family, or anyone requested by the participant, by the DHS RN supersedes all other plans of care developed for an ElderChoices beneficiary. The information in the plan of care must include:

B. When developing the waiver Plan of Care, 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 Plan of Care. The representative may participate in choosing the provider(s) for the beneficiary. If anyone other than the beneficiary chooses the provider, the DAAS RN will identify that individual on the Plan of Care.

C. The ElderChoices Plan of Care developed by the DAAS RN includes, but is not limited to:

1. ~~A.~~ Beneficiary identification and contact information, including full name and address, phone number, date of birth, Medicaid number and the effective date of ElderChoices waiver eligibility;

2. Primary and secondary diagnosis;

3. Contact person;

4. Physician's name and address;

5. The amount, frequency and duration of ElderChoices waiver services to be provided, and the name of the service provider chosen by the beneficiary or representative to provide the services;

6. Other services outside the ElderChoices services, regardless of payment source, identified and/or ordered to meet the beneficiary's needs;

7. The election of community services by the waiver beneficiary or representative; and,

8. The name and title of the DAAS RN responsible for the development of the beneficiary's Plan of Care.

~~B. The medical and other services to be provided, their frequency and duration and the name of the service provider chosen by the beneficiary to provide each service;~~

~~C. The election of community services by the waiver participant and~~

~~D. The name and title of the DHS RN responsible for the development of the beneficiary's plan of care.~~

D. If waiver eligibility is approved by the DHS county office, A a copy of the ~~plan~~ Plan of ~~care~~ Care signed by the ~~DHS~~ DAAS RN, and the waiver ~~participant~~ beneficiary or representative will be forwarded to the beneficiary or representative and the Medicaid enrolled~~ElderChoices~~ service provider(s) included in the Plan of Care. ~~chosen by the~~

~~beneficiary, family member, or DHS RN, according to policy. Each provider is responsible for developing an implementation plan in accordance with the beneficiary's plan of care. The service provider and the ElderChoices beneficiary must review and follow the signed authorized Plan of Care. Services cannot begin until the Medicaid provider receives the authorized Plan of Care from the DAAS RN.~~ The original plan of care will be maintained by the ~~DHS~~ DAAS RN.

~~_____~~The implementation ~~plan of the~~ Plan of Care ~~by a provider~~ must ~~be designed to~~ ensure that services are:

~~A~~1. Individualized to the beneficiary's unique circumstances;

~~B~~2. Provided in the least restrictive environment possible;

~~C~~3. Developed within a process ensuring participation of those concerned with the beneficiary's welfare;

~~D~~4. Monitored and adjusted as needed, based on changes ~~authorized and reported by the DAAS RN regarding~~to the waiver ~~P~~plan of ~~C~~care~~, as reported by the DHS RN~~;

~~E~~5. Provided within a system that safeguards the beneficiary's rights ~~to quality services as authorized on the waiver Plan of care~~; and;

~~F~~6. Documented carefully, with assurance that ~~appropriate records will be~~required information is recorded and maintained.

NOTE: Each service included on the ElderChoices ~~plan~~ Plan of ~~care~~ Care must be justified by the ~~DHS~~ DAAS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary, ~~cost effectiveness~~ and other factors deemed appropriate by the ~~DHS~~ DAAS RN.

~~Each ElderChoices service must be provided according to the beneficiary Plan of Care. For services included in the waiver Plan of Care, Medicaid reimbursement is limited to the amount and frequency that is authorized in the Plan of Care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.~~

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

~~Each ElderChoices service must be provided according to the beneficiary plan of care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.~~

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

212.305 Targeted Case Management Services (Non-Waiver Service) ~~7-15-09~~1-1-13

Each ElderChoices ~~plan of care~~Plan of Care will include Targeted Case Management, unless refused by the waiver ~~participant~~beneficiary. The Targeted Case Manager is responsible for managing the ElderChoices Plan of care, 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 ~~DHS~~ DAAS RN or ~~Program Administrator Nurse Manager and reporting any changes to the DHS RN.~~ The waiver provider

and the Targeted Case Manager are responsible for reporting any changes in services or changes in the beneficiary status to the DHS RN immediately upon learning of the change.

In addition to the monitoring performed by Targeted Case Managers, the DHS DAAS RN is also routinely monitor caseloads on an as-needed basis, as required through the Quality Management Strategies established for the waiver program.

212.310 Provisional Plan of Care ~~11-15-101-~~ 1-13

The ElderChoices registered nurse (DHS DAAS RN) will may develop a provisional plan Plan of careCare prior to establishment of Medicaid eligibility, based on information obtained during the in-home medical assessment, when recommending medical approval based on the following nursing home criteria. The DAAS RN must discuss the provisional Plan of Care policy and have the approval of the applicant prior to completing and processing the provisional Plan of Care. The Plan of Care will be developed by the applicant and the DAAS RN, and signed by the applicant or the applicant's representative, and the DAAS RN.

To be determined a functionally disabled elderly individual, the individual must meet at least one of the following criteria, as determined by a licensed medical professional. The individual is:

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

B. At least two (2) of the three (3) ADLs of transferring/locomotion, eating or toileting without limited assistance from or total dependence upon another person

Applicable definitions of limited and extensive assistance remain unchanged.

Extensive Assistance: 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.

Limited Assistance: 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.

The provisional plan Plan of care Care will include all current plan of care information, except for the waiver eligibility date and, the Medicaid beneficiary ID number and diagnosis.

The provisional plan of care will expire after 60 days. The provisional plan of care expiration date will be entered on page 1 of the plan of care and will be calculated as 60 days from the date the provisional plan of care is signed by the DHS RN and the applicant.

A signed copy of tThe provisional plan Plan of care Care will be mailed toto the waiver applicant and each provider included on the plan Plan of careCare. If the beneficiary and the provider chooses to implement the provisional plan of careaccept 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) and notify the DHS DAAS RN via Start Services form AAS-9510 that services have started. The DHS DAAS RN will continue the current practice of tracking the start of care dates and giving give the applicant options when services are not started.

The provisional Plan of Care will expire 60 days from the date signed by the applicant and the DAAS RN. A Plan of Care 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 Plan of Care.

A. A provisional ~~plan~~ Plan of ~~care~~ Care ~~will~~ may be developed and sent to providers only when the assessment outcome indicates medical eligibility and the ~~DHS~~ DAAS RN believes, in his or her professional judgment, that the applicant meets the level of care criteria for an adult with a functional disability, as explained in Section 212.000, Eligibility for the ElderChoices Program, ~~recommends the applicant for medical approval and only when the recommendation is based on the medical criteria shown above.~~

The waiver eligibility date will be established retroactively, effective on the day the provisional ~~plan~~ Plan of ~~care~~ Care was signed by the applicant or applicant's representative, and the ~~DHS~~ DAAS RN, if:

1. At least one waiver service begins within 30 days of the development of the provisional ~~plan~~ Plan of ~~care~~Care

   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 ~~plan~~ Plan of ~~care~~Care, 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 ~~plan~~ Plan of ~~care~~ Care is signed by the ~~DHS~~ DAAS RN, the county office 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.

212.311 Denied Eligibility Application ~~7-15-09~~1-1-13

A. If the DHS county office 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 county office will notify the ~~DHS~~ DAAS RN. The ~~DHS~~ DAAS 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 ~~beneficiary~~ 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 county office are as follows:

1. If the individual has no unpaid ElderChoices 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 county office completes the case.
2. If the individual has unpaid waiver charges and services were authorized by the ~~DHS~~ DAAS 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 ~~plan~~ Plan of ~~care~~ Care is signed by the ~~DHS~~ DAAS RN, and the applicant or the applicant's representative, whichever is later.

212.312 Comprehensive Plan ~~Of~~ of Care ~~7-15-09~~1-1-13

Prior to the expiration date of the provisional ~~plan~~ Plan of ~~care~~Care, the ~~DHS~~ DAAS RN will mail the comprehensive ~~plan~~ Plan of ~~care~~ Care to the waiver beneficiary and all providers included on the ~~plan~~ Plan of ~~care~~Care. The comprehensive ~~plan~~ Plan of ~~care~~ Care will replace the provisional ~~plan~~ Plan of ~~care~~Care. ~~If the DHS county office has approved the application, t~~The comprehensive ~~plan~~ Plan of ~~care~~ Care will include the Medicaid beneficiary ID number, the waiver eligibility date established according to policy and the comprehensive ~~plan~~ Plan of ~~care~~ Care expiration date.

The comprehensive ~~plan~~ Plan of ~~care~~ Care expiration date will be 365 days from the date of the ~~DHS~~ DAAS RN's signature on form AAS-9503, the ElderChoices ~~plan~~ Plan of ~~care~~Care. ~~If the application is still pending at the county office when the comprehensive plan of care is mailed to the providers, the waiver eligibility date and the Medicaid beneficiary ID number will not be included.~~ Once the application is either approved or denied by the DHS county office, the providers will be notified by the ~~DHS~~ DAAS RN. The notification for the approval will be in writing via a ~~plan~~ Plan of ~~care~~ Care 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 ElderChoices Applicants Leaving an Institution ~~7-15-09~~1-1-13

The ~~revised~~ 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 ~~plan~~ Plan of ~~care~~ Care 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 county office prior to discharge AND if a provisional ~~plan~~ Plan of ~~care~~ Care is developed by the ~~DHS~~ DAAS 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.

If no waiver application is filed and no medical assessment or provisional ~~plan~~ Plan of ~~care~~ Care is completed by the ~~DHS~~ DAAS 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.

Medical assessments and plans of care may be completed during a period of institutionalization; however, a discharge date must be scheduled. Since the purpose of the assessment and the ~~plan~~ Plan of ~~care~~Care is to depict the applicant's condition and needs in the home, premature assessments and plan of care development do not meet the intent of the program.

This policy applies to applicants leaving hospitals or nursing facilities.

212.314 Optional Participation ~~6-1-05~~1-1-13

Neither waiver providers nor waiver applicants are required to begin or receive services prior to an eligibility determination by the Division of County Operations. When services are started based on the receipt of a provisional ~~plan~~ Plan of ~~care~~Care, it is the responsibility of each provider to explain the process and financial liability to the applicant and/or ~~family member~~representative **prior to beginning services**. The decision to begin services prior to an eligibility determination must be a joint decision between the provider and the applicant, both of whom must understand the financial liability of the applicant if eligibility is not established.

NOTE: Regardless of the reason for the denial and regardless of when a new waiver application may be filed, a provisional ~~plan~~ Plan of ~~care~~ Care will only be utilized on a current waiver application. Once an application is denied, a new provisional ~~plan~~ Plan of ~~care~~ Care must be developed if a subsequent waiver application is filed.

212.320 ~~Physician~~ Authorization Of The ElderChoices Plan Of Care with Personal Care Services 1-1-13~~7-15-09~~

The following applies to individuals receiving both personal care services and ElderChoices services.

A. The ~~DHS~~ DAAS RN is responsible for developing an ElderChoices plan of care that includes both waiver and non-waiver services. Once developed, the plan of care ~~is~~may be ~~sent to the applicant's physician of choice for signature, signed by the DAAS RN~~ authorizing the services ~~listed if required~~.

B. ~~If a physician's signature is obtained on an ElderChoices plan of care and personal care services are included on the ElderChoices plan of care when the physician signs it and returns it to the DHS RN, T~~the ~~signed~~ ElderChoices plan of care signed by the DAAS RN will suffice as the "~~Physician~~ Personal Care Authorization" for services required in the Personal Care Program. ~~The signature on the ElderChoices plan of care only replaces the need for the physician's signature authorizing personal care services. No other requirements under the Personal Care Program regarding the personal care service plan are modified.~~ 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 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 ElderChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the ElderChoices plan of care, signed by a DAAS RN, will serve as the authorization for personal care services for one year from the date of the DAAS RN's signature, as described above.~~

~~C. If a physician's signature is not obtained on an ElderChoices plan of care, the personal care provider will be required to secure a signed authorization from a physician, meeting Medicaid Personal Care Program policy regarding personal care service plans.~~

~~D~~C. ~~The ElderChoices Plan of Care is effective for one year, once signed by the DAAS RN, the authorization for personal care services, when included on the ElderChoices Plan of Care, 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 ElderChoices Plan of Care, a new service plan is not required at the 6-month interval. The~~

~~ElderChoices plan of care is effective for one year, from the date of the DHS RN's signature. This signature does not meet the requirements of the Medicaid Personal Care Program. If the ElderChoices plan of care does include an MD's signature, the authorization for personal care services, included on the ElderChoices plan of care, is for one year from the date of the physician's signature, unless revised by the DHS RN. This policy supersedes information currently found in the Arkansas Medicaid Personal Care provider manual.~~

~~This policy does not place the responsibility of developing a personal care service plan with the DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care provider manual.~~

212.321 Internal Procedures ~~7-15-091-1-13~~

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

B. If the ~~DHS-~~DAAS RN is aware that personal care services are currently being provided when the ElderChoices ~~plan-~~Plan of ~~care-~~Care is developed, the ~~DHS-~~DAAS RN will contact the personal care provider to obtain information regarding the amount of personal care services currently being provided. It is the personal care provider's responsibility to provide this information to ~~the~~ DHS-DAAS RN immediately upon receipt of the request. If this information is not received within five working days of the request, the ~~DHS-~~DAAS RN will take necessary steps to submit the ElderChoices ~~plan-~~Plan of ~~care~~Care, as developed by the ~~DHS-~~DAAS RN. ~~The DAAS RN will not alter the current number of personal care units unless a waiver Plan of Care cannot be developed without duplicating services or a change in services is necessary in order to establish eligibility. If personal care units must be altered, the DAAS RN will contact the personal care provider to discuss available alternatives prior to making any revisions. The ElderChoices Plan of Care and the required justification for each service remain the responsibility of the DAAS RN. Therefore, final decisions regarding services included on the ElderChoices Plan of Care rest with the DAAS RN.~~

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 ~~DHS-~~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 ~~DHS-~~DAAS RN.

~~C. The personal care service plan provided to the DHS RN must meet all requirements as detailed in the personal care provider manual. These include, but are not limited to, the amount of personal care services, personal care tasks, frequency and duration. The DHS RN will not alter the~~

current number of personal care units unless a waiver plan of care cannot be developed without duplicating services or a change in services is necessary in order to establish eligibility. If personal care units must be altered, the DHS RN will contact the personal care provider to discuss available alternatives prior to making any revisions. The ElderChoices plan of care and the required justification for each service remain the responsibility of the DHS RN. Therefore, final decisions regarding services included on the ElderChoices plan of care rest with the DHS RN.

212.322 Revisions when the Plan Of Care Contains Personal Care Services 7-15-091-1-13

Requested changes to the personal care services included on the ElderChoices Plan of Care may originate with the personal care RN or the DAAS RN, based on the recipient's circumstances. Unless requested by an IndependentChoices beneficiary, the individual or agency requesting revisions to the Personal Care services on the ElderChoices Plan of Care is responsible for securing any required signatures authorizing the change prior to the ElderChoices Plan of Care being revised. The DAAS RN will obtain electronic signatures for dates of service on or after January 1, 2013.

If revised by the DAAS RN, a copy of the revised ElderChoices Plan of Care 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 ElderChoices Plan of Care will be revised accordingly within 10 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, as stated above, rests with the DAAS RN. Requested changes to the personal care services included in the plan of care may originate with the personal care RN or the DHS DAAS RN, depending on the beneficiary's circumstances.

Regardless of the origin of the request, if the ElderChoices Plan of care is revised If the change is requested by the DHS RN, a copy of the revised ElderChoices plan Plan of care Care and form AAS 9510 will be mailed to the personal care provider. The signature of the DAAS RN on the revised Plan of Care authorizes the services as listed. The personal care agency is responsible for securing the required physician's order, according to Arkansas Medicaid Personal Care policy. Once the revised personal care service begins, the DHS DAAS RN must be notified via the AAS 95119510. If any problems are encountered with implementing the requested revisions, the DHS 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's narrative. The final decision, as stated above, rests with the DHS DAAS RN.

212.323 Medicaid Audit Requirements 6-1-051-1-13

When the Medicaid Program, as authorized by the ElderChoices plan Plan of careCare, reimburses for personal care services, all Medicaid audits will be performed based on that authorization. Therefore, all documentation by the personal care provider must tie services rendered to authorized services as reflected on the ElderChoices plan Plan of careCare.

These deviations from personal care policy are being implemented in an effort to eliminate the need for the personal care service plan to be submitted to the physician for signature when that practice duplicates a signature already secured through the ElderChoices Program. These revisions are NOT intended to change any other current policy regarding personal care or ElderChoices services.

212.400 Temporary Absences From from the Home 7-15-091-1-13

Once an ElderChoices eligibility application has been approved, waiver services must be provided in the home for eligibility to continue. Unless stated otherwise below, the county Department of Human Services (DHS) office will must be notified immediately by the DHS DAAS RN when waiver services are discontinued, and action will be initiated by the DHS county office to close the waiver case. Providers will be notified by the DHS DAAS RN.

A. Absence from the Home due to Institutionalization

An individual cannot receive ElderChoices 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 DHS 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 RN will notify the DHS county office and action will be initiated by the DHS county office to close the waiver case.

2. If the DHS 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 ElderChoices 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 ElderChoices 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 within 10 working days of receiving a request for verification.**

If providers are unable to provide proof that ElderChoices services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. ElderChoices 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 DHS 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 prescribed by the Plan of Care (e.g., the beneficiary has left the state and the return date is unknown), the DAAS RN will notify the county office. Action will be taken by the county office to close the waiver case.

NOTE: It is the responsibility of the provider to notify the DAAS RN immediately via form AAS-9511 upon learning of a change in the beneficiary's status.

212.410 ~~Institutionalization~~Reserved ~~7-1-11~~1-1-13

An individual cannot receive ElderChoices waiver services while in an institution. However, the following policy will apply 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 individual is hospitalized or enters a nursing facility.

A. Hospitalization

When a waiver beneficiary enters a hospital, the DHS 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 the beneficiary has not returned home after 30 days, the DHS RN will notify the county office via form DHS-3330 and action will be initiated by the county office to close the waiver case. It is the responsibility of the provider to notify the DHS RN immediately via form AAS-9511 upon learning of a change in the beneficiary's status.

NOTE: The Arkansas Medicaid Program considers an individual an inpatient beginning with the date of admission to an inpatient facility. 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 ElderChoices 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 within 10 working days of receiving a request for verification.

If providers are unable to provide proof that ElderChoices services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. ElderChoices 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. Nursing Facility Admission

When an ElderChoices beneficiary has entered a nursing facility and it is anticipated that the stay will be short, the waiver case will be closed effective the date of admission, but the Medicaid case may be left open until the DHS county office is notified that the individual has returned home. When the individual returns home, the ElderChoices case may be reopened effective the date of the return home if the DHS RN has provided the DHS county office with a copy of Page 2 of the plan of care, showing the election of ElderChoices. 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 ElderChoices beneficiaries admitted to a nursing facility to receive facility-based respite services.

212.420 Non-InstitutionalizationReserved 7-15-091-1-13

When a waiver beneficiary is absent from the home for reasons other than institutionalization, the 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 prescribed by the plan of care (e.g., the beneficiary has left the state and the return date is unknown), the DHS RN will notify the county office and action will be taken by the county office to close the waiver case.

NOTE: It is the responsibility of the provider to notify the 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 7-15-091-1-13

Because the provider has more frequent contact with the clientbeneficiary, many times the provider becomes aware of changes in the beneficiary's status sooner than the DHS DAAS RN, Targeted Case Manager, or DHS county office. It is the provider's responsibility to report these changes immediately so that proper action may be taken. Providers are required tomust complete the Waiver Provider Communication – Change of Participant Status Fform (AAS-9511) and send it to the DHS DAAS RN. A copy should must be retained in the provider's beneficiary's case record. Regardless of whether the change will may result in action by the DHS county office, providers must immediately report all changes in the beneficiary's status to the DHS DAAS RN.

The TCM 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 RN or Nurse Manager immediately upon learning of the change.

212.600 Relatives Providing ElderChoices Services 1-1-13

All ElderChoices 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 AFH 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:

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

All providers, including relatives, are required to meet all ElderChoices provider certification requirements, Arkansas Medicaid enrollment requirements, and provider services according to the beneficiary's plan of care and any established benefit limits for that specific service.

213.100 Adult Family Homes ~~10-1-08~~1-1-13

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., homemaker, chore, attendant care, companion, 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 Homes services provide a family living environment for adults who are functionally impaired and who, due to the severity of their functional impairments, are considered to be at imminent risk of death or serious bodily harm and, as a consequence, are not capable of fully independent living.

~~There are three (3) different reimbursement rates for Adult Family Homes based on the Level of Care required for the individual participant. Level of Care is indicated by using a modifier with CPT Code **S5140**.~~

The number of ~~participants~~ beneficiaries served by an Adult Family Home may not exceed three (3) and ~~participants~~ 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 AFH provider, immediate immediate family members or caregivers residing in the adult family home with the waiver ~~participant~~ beneficiary are prohibited from receiving Medicaid reimbursement for direct provision of any ElderChoices services.

Adult Family Home services shall be included in the plan of care only when it is necessary to prevent the permanent institutionalization of a beneficiary as determined by the 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 ~~participant~~ beneficiary in the life of the family as much as possible. The provider must assist the ~~participant~~ beneficiary in becoming or remaining active in the community.

Services must be provided according to the participant's written ElderChoices plan of care.

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 ~~participant~~beneficiary.

For any given year of the ElderChoices 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 ElderChoices waiver, ElderChoices waiver ~~participants~~ 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, and Medicaid will cover the 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 recipients in long term care facilities.

The Adult Family Home waiver beneficiary may receive up to 2,400 units (600 hours) 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.

~~PARTICIPANTS~~ BENEFICIARIES RECEIVING ADULT FAMILY HOMES SERVICES ARE NOT ELIGIBLE TO RECEIVE ANY OTHER ELDERCHOICES SERVICE, EXCEPT FOR LONG-TERM FACILITY-BASED RESPITE.

213.110 Adult Family Homes Certification Requirements ~~10-1-08~~1-1-13

Enrollment as an ElderChoices Adult Family Homes provider requires certification by the Department of Human Services, Division of Aging and Adult Services (DAAS), as an Adult Family Home. Providers must recertify with DAAS annually.

An Adult Family Home, for the purpose of the ElderChoices 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 ~~client~~ beneficiary an admission agreement specifying services to be provided, the ~~client's~~ beneficiary's cost for room and board, conditions and rules governing the ~~client~~ beneficiary and grounds for termination of residency. Each Adult Family Homes provider will also be required to develop and maintain written program policies.

213.210 Homemaker Services

~~7-15-09~~1-1-13

Procedure Code	Description
S5130	Homemaker Services

In-home 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.

Homemaker services provide basic upkeep and management of the home and household assistance, such as:

A. Menu planning,

B. Meal preparation,

C. Laundry,

D. Essential shopping and errands and

E. Simple household tasks.

Simple household tasks may include, but are not limited to, washing windows, cleaning ceiling fans and light fixtures, cleaning the refrigerator and washing inside walls.

Medically oriented personal care tasks are not included as a part of this service.

Homemaker services must be provided according to the beneficiary ElderChoices written plan of care.

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.

One (1) unit of service equals 15 minutes. Homemaker services are limited to a maximum of 4 hours (16 units) per day, not to exceed an overall benefit limit of 172 units per month.

An ElderChoices beneficiary who spends more than five (5) hours at an adult day care or adult day health care facility or who is receiving short-term, facility-based respite care will not be eligible for homemaker services on the same date of service unless authorized by the ~~DHS~~ DAAS RN.

An ElderChoices beneficiary receiving long-term, facility-based respite care is not eligible for homemaker services on the same date of service.

213.220 Chore Services

~~7-15-09~~1-1-13

Procedure Code	Description
S5120	Chore Services

Chore services provide heavy cleaning and/or yard and sidewalk maintenance only in extreme, specific and individual circumstances when lack of these services would make the home uninhabitable.

Chore services do not include small outside painting jobs, routine lawn mowing or trimming, raking or mulching of leaves for aesthetic purposes.

Chore services must be provided according to the beneficiary's written ElderChoices plan of care.

When justified and included on the plan of care by the DHS DAAS RN, the chore service must be specific, naming the chore authorized and the estimated amount of time for completion.

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. Family members of the beneficiary may not be reimbursed by Medicaid for chore services. ~~Family members are not eligible for consideration as chore specialists.~~ Section 214.000 contains information regarding additional documentation requirements.

One (1) unit of service equals 15 minutes. Chore services are limited to a maximum of 80 units (20 hours) per month.

An ElderChoices beneficiary who spends more than five (5) hours at an adult day care or adult day health care facility or who is receiving short-term, facility-based respite care will not be eligible for chore services on the same date of service unless authorized by the DHS DAAS RN.

An ElderChoices beneficiary receiving long-term, facility-based respite care is not eligible for chore services on the same date of service.

An individual living in the home with the beneficiary is prohibited from serving as a Chore Services provider for the beneficiary.

213.230 Homemaker ~~And/Or~~and/or Chore Certification Requirements ~~10-13-03~~1-1-13

The following requirements must be met prior to certification by the Division of Aging and Adult Services (DAAS) by providers of homemaker and/or chore services. The provider must:

A. Hold a current Arkansas State Board of Health Class A and/or Class B license,

or

Be a private or public incorporated entity whose stated purpose is to provide homemaker and/or chore services and

B. Employ and supervise direct care staff who:

1. Prior to providing an ElderChoices service, have received instruction regarding the general needs of the elderly;
2. Possess the necessary skills to perform the specific services required to meet the needs of the ~~client~~ 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 meet the training and, as applicable, testing requirements according to licensure, agency policy and DAAS certification.

Homemaker and/or Chore providers who hold a current Arkansas State Board of Health Class A and/or Class B license must recertify with DAAS every three years, however, DAAS must maintain a copy of the agency's current Home Health license at all times.

Homemaker and/or Chore providers who are a private or public incorporated entity whose stated purpose is to provide homemaker and/or chore services must recertify with DAAS annually.

213.310 Hot Home-Delivered Meals ~~11-15-101-~~ 1-13

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 Nutrition Services Program Policy Number 206.

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible ~~clients~~ 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 ~~client~~ beneficiary must:

A. Be unable to prepare some or all of his or her own meals, and

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 plan of care

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 ~~client~~ beneficiary each time a meal is delivered to document receipt of the meal.

Hot Home-Delivered Meals must be provided according to the ~~client's~~ beneficiary's written ElderChoices plan of care.

213.311 Hot Home-Delivered Meal Provider Certification Requirements ~~11-15-101-~~ 1-13

To be certified by the Division of Aging and Adult Services (DAAS) 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 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. Notify the ~~DHS~~ DAAS RN immediately if:

1. There is a problem with delivery of service
2. The ~~client~~ 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 ~~DHS~~ DAAS RN who is responsible for the individual's plan of care. Requests must be submitted in writing to the ~~DHS~~ DAAS RN. Any changes in the individual's circumstances must be reported to the ~~DHS~~ DAAS RN via form AAS-9511.

F. The provider must contact the individual either in person or by phone daily, Monday through Friday, to ensure the individual's safety and well being. This is not required for individuals receiving only the weekend Frozen Home-Delivered Meals service.

NOTE: This requirement DOES NOT apply to those ElderChoices beneficiaries whose ElderChoices plan of care includes homemaker 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 plan of care 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 a copy of the agency's current Food Establishment Permit at all times.~~

~~Re-assessment of all beneficiaries of waiver services shall be completed at least annually, using form DHS-703 in a manner similar to the initial assessment process.~~

213.320 Frozen Home-Delivered Meals ~~11-15-101-~~ 1-13

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 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 ~~DHS~~ DAAS RN developing the plan of care 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 ~~DHS~~ DAAS RN. The service must be included on the plan of care. If the individual responsible for developing the plan of care 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. 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 ~~11-15-101-~~ 1-13

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.

E. Have the provision of frozen meals included on his or her plan of care, as developed by the appropriate ~~DHS-DAAS~~ RN.

Frozen Home-Delivered Meals must be documented on the ElderChoices plan of care by the ~~DHS-DAAS~~ RN, and must be provided in accordance with the beneficiary's written ElderChoices plan of care.

213.323 Frozen Home-Delivered Meal Provider Certification Requirements ~~11-15-101-~~ 1-13

In order to become approved providers of frozen meals, ~~they~~ providers must meet all applicable requirements of DAAS Nutrition Services Program Policy Number 206.

To be certified by DAAS 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 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. Provide frozen meals that:

1. Were prepared or purchased according to the Department of Health and DAAS 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 ElderChoices beneficiary), menu analysis as required by DAAS Nutrition Services Program Policy if other than 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. 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. 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 senior ~~participant~~ beneficiary and

9. Are discarded after 30 days.

H. Verify quarterly that all individuals 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. Any changes in the individual's circumstances must be reported to the ~~DHS~~ DAAS RN via form AAS-9511.

I. Notify the appropriate ~~DHS~~ DAAS 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 ~~DHS~~ DAAS RN who is responsible for the individual's plan of care. Requests must be submitted in writing to the ~~DHS~~ DAAS RN. Any changes in the individual's circumstances must be reported to the ~~DHS~~ DAAS RN via form AAS-9511.

J. Contact individuals either in person or by phone daily, Monday through Friday, to ensure the individual's safety and well being. This is not required for individuals receiving only the weekend Frozen Home-Delivered Meals service.

NOTE: This requirement DOES NOT apply to those ElderChoices beneficiaries whose ElderChoices plan of care includes Homemaker services and/or Personal Care services at least three (3) times per week.

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's plan of care only when they are necessary to prevent the institutionalization of an individual.

~~Frozen Home-Delivered Meals providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Food Establishment Permit at all times.~~

~~Re-assessment of all beneficiaries of waiver services shall be completed at least annually, using form DHS-703 in a manner similar to the initial assessment process.~~

213.330 Limitations on Home-Delivered Meals ~~11-15-101-~~ 1-13

One unit of service equals one meal. The maximum number of Home-Delivered Meals 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 SFY is four (4). This includes hot, frozen or a combination of the two. There is no separate benefit limit for frozen emergency meals.

Frozen Home-Delivered Meals may be provided daily to eligible beneficiaries. A maximum of seven (7) meals may be delivered at one time.

Home-Delivered Meal providers may deliver more than seven meals at one time, if:

A. The waiver ~~participant~~ beneficiary receives Homemaker, Respite or Personal Care at least three (3) times per week,

B. Frozen Home-Delivered Meals are ordered on the plan of care,

C. The waiver ~~participant~~ beneficiary has the means of storing 14 frozen meals (as verified by the ~~DHS~~ DAAS RN).

Home-Delivered Meal providers delivering frozen meals may deliver 14 at one time if the DHS RN enters 14 meals delivery approved in the comments section of the HDM entry on the plan of care. If this statement is not on the plan of care, 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 ElderChoices individual may not be provided with a Hot or Frozen Home-Delivered Meal ~~or a Hot Home-Delivered Meal~~ 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 Care or Adult Day Health Care. (Licensure mandates that providers of these services provide a meal or meals; therefore, a Home-Delivered Meal on these dates is a duplicative service and prohibited under waiver guidelines.)

NOTE: Medicaid reimbursement for Home-Delivered Meals is not allowed on the same day to individuals who are also attending Adult Day Care, Adult Day Health Care, or facility-based Respite care for more than five (5) hours. When applying this policy, the time of day the ~~client~~ beneficiary receives day care or respite services is 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 Home-Delivered Meal is billable for an individual receiving day care, or facility-based Respite services, on a specific date of service, the following must be applied:

If an ElderChoices ~~client~~ beneficiary is receiving day care 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 Home-Delivered meal is not allowable on the same date of service. This is true **regardless of the total number of day care or Respite hours provided.**

213.340 Combination of Hot and Frozen Home-Delivered Meals ~~7-15-09~~1-1-13

In instances where the ElderChoices beneficiary wishes to receive a combination of hot and frozen meals, the ~~DHS~~ DAAS 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 ~~DHS~~ DAAS RN may prescribe on the plan of care a combination of hot and frozen meals to be delivered.

213.350 Emergency Meals ~~11-15-10~~1-1-13

~~Clients~~ 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 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

D. Be replaced by the provider after the ~~participant~~ beneficiary has been instructed to use it to ensure that participants consistently have emergency meals on hand.

213.400 Personal Emergency Response System ~~7-15-09~~1-1-13

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 individuals 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 ~~DHS~~ DAAS 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 ElderChoices plan of care.

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. PERS is limited to a maximum of thirty-one (31) units per month.

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 ElderChoices beneficiaries who are accessing PERS services for their first time or for the current period of re-eligibility for ElderChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging and Adult Services for extension of the benefit.

View or print Division of Aging and Adult Services contact information.

213.410 Personal Emergency Response System Certification Requirements ~~10-13-03~~1-1-13

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of personal emergency response services, a provider must:

A. Provide, install and maintain 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 ~~client~~ beneficiary and ensure responders receive necessary instruction and training and

D. Ensure that equipment is installed by qualified individuals who also provide instruction and training to ~~clients~~beneficiaries.

~~PERS providers must recertify annually with DAAS.~~

213.500 Adult Day Care ~~7-15-09~~1-1-13

Procedure Code	Required Modifier	Description
S5100	U1	Adult Day Care, 4-5 Hours Per Date of Service
S5100	—	Adult Day Care, 6-8 Hours Per Date of Service

Adult day care facilities are licensed by the Office of Long-Term Care (OLTC) 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 ElderChoices plan of care, ElderChoices beneficiaries may receive adult day care services for four (4) or more hours per day, not to exceed eight (8) hours per day, when the services are prescribed by the beneficiary's attending physician and provided according to the beneficiary's written plan of care. Adult day care services of less than four (4) hours per day are not reimbursable by Medicaid. Adult day care may be utilized up to forty (40) hours per week, not to exceed one hundred eighty-four (184) hours per month. One (1) unit of service equals fifteen (15) minutes.

As required, beneficiaries who are present in the facility for more than five (5) hours a day (procedure code **S5100**) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, ElderChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day care. Additionally, beneficiaries who attend an adult day care for more than five (5) hours are not eligible to receive homemaker or chore services on the same date of service unless authorized by the ~~DHS~~ DAAS 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 care, adult day health care, or facility-based respite care for more than 5 hours. The time of day the beneficiary is receiving day care 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 ~~DHS~~ DAAS RN and/or DHS audit staff and considered when determining any duplication in services for individuals participating in the ElderChoices Program.

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day care or facility-based respite services on a specific date of service.

If an ElderChoices beneficiary is receiving day care 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 care or respite hours provided.**

Adult day care providers are required to maintain a daily attendance log of ~~participants~~beneficiaries. Section 214.000 contains information regarding additional documentation requirements.

213.510 Adult Day Care Certification Requirements ~~7-15-091-1-~~13

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of adult day care 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 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.

Adult Day Care providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Adult Day Care license at all times.

213.600 Adult Day Health Care (ADHC) ~~7-15-091-1-~~13

Procedure Code	Required Modifier	Description
S5100	TD, U1	Adult Day Health Care, 4-5 Hours Per Date of Service
S5100	TD	Adult Day Health Care, 6-8 Hours Per Date of Service

Adult day health care facilities are licensed to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to individuals who are functionally impaired and who, due to the severity of their functional impairment, are not capable of fully independent living.

Adult day health care 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 care is appropriate only for individuals 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.

ElderChoices beneficiaries may receive adult day health care services for four (4) or more hours per day, not to exceed eight (8) hours per day when the service is provided according to the beneficiary's written ElderChoices plan of care. Adult day health care services of less than four (4) hours per day are not reimbursable by Medicaid. Adult day health care may be utilized up to forty (40) hours (160 units) per week, not to exceed one hundred eighty-four (184) hours (736 units) per month.

Beneficiaries who are present in the facility for more than five (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, ElderChoices 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 care. Additionally, beneficiaries who attend an adult day health care for more than five (5) hours are not eligible to receive homemaker or chore services on the same date of service unless authorized by the ~~DHS~~ DAAS RN.

Adult day health care providers are required by licensure to maintain a daily attendance log of participants. 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 care, adult day health care, or facility-based respite care for more than 5 hours. The time of day the beneficiary is receiving day care 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 DHS DAAS RN and/or DHS audit staff and considered when determining any duplication in services for individuals participating in the ElderChoices Program.

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day care or facility-based respite services on a specific date of service.

If an ElderChoices beneficiary is receiving day care 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 care or respite hours provided.**

213.610 Adult Day Health Care Provider Certification Requirements

~~7-15-09~~1-1-13

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of adult day health care services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by Arkansas Department of Human Services, Office of Long-term Care as a long-term 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.

Adult Day Health Care providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Adult Day Health Care license at all times.

NOTE: Adult day care and adult day health care are not allowed on the same date of service.

213.700 Respite Care

~~7-15-09~~1-1-13

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 ~~participants~~ beneficiaries in their homes. Respite care may be provided outside of the ~~participant's~~ 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 prescribed by the ~~participant's~~ beneficiary's physician.

In the event the in-home medical assessment performed by the DHS DAAS RN substantiates a need for respite care services, the service will be prescribed as needed, via the ~~participant's~~ beneficiary's plan of care, not to exceed an hourly maximum. The DHS DAAS RN will establish the service limitation based on the ~~participant's~~ beneficiary's medical need, other services included on the plan of care and support services available to the beneficiary. Respite care services must be provided according to the ~~participant's~~ beneficiary's written plan of care.

An individual living in the home with the beneficiary is prohibited from serving as a Respite Services provider for the beneficiary.

213.710 In-Home Respite Care ~~8-1-07~~1-1-13

In-home respite care may be provided by licensed personal care or home health agencies and certified homemaker agencies. Reimbursement will be made for direct care rendered according to the ~~client's~~ beneficiary's plan of care by trained respite workers employed and supervised by certified in-home respite providers.

Providers rendering respite care services in the ~~client's~~ beneficiary's home must bill procedure code **S5150**. One (1) unit of service for procedure code **S5150** equals 15 minutes. Eligible ~~clients~~ beneficiaries may receive up to 96 units of in-home respite care per date of service. For the state fiscal year (SFY), July 1 through June 30 each year, eligible ~~participants~~ beneficiaries may receive up to 4800 units (1200 hours) of In-Home Respite Care, Facility-Based Respite Care, Adult Companion Service or a combination of the three services.

When respite care is provided, the provision of or payment for other duplicate services under the waiver is prohibited. When a respite care provider is in the home to provide respite care services, the provider is responsible for all other in-home ElderChoices services included on the ~~client's~~ beneficiary's plan of care. For example, if homemaker, chore and/or home-delivered meals or meal preparation are included on the plan of care, the respite provider must provide these services while in the home. No other ElderChoices service, other than PERS, may be reimbursed for the same time period.

213.711 Facility-Based Respite Care ~~8-1-07~~1-1-13

Facility-based respite care may be provided outside the ~~participant's~~ beneficiary's home on a short- or long-term basis by licensed adult foster care 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 ~~participants~~ beneficiaries may receive up to 32 units of short-term, facility-based respite care per date of service.

Facility-based providers rendering services for ~~more than 8 hours/day a full twenty four (24) hours per date of service~~ must bill **T1005** for long-term, facility-based respite care. One (1) unit of service for procedure code **T1005** equals 15 minutes. A beneficiary ~~must~~ may receive up to 96 units 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 ~~client~~beneficiary.

Eligible participants may receive up to 4800 units (1200 hours) per SFY of Facility-Based Respite Care, In-Home Respite Care, Adult Companion Services or a combination of the three. ~~Adult Family Home beneficiaries are limited to 2,400 units (600 hours) of long-term facility-based respite per state fiscal year.~~

~~Participants~~ Beneficiaries receiving long-term, facility-based respite care services may receive only ElderChoices 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 ~~10-13-03~~1-1-13

To be certified by the 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 license to provide personal care and/or home health services as issued by the state licensing authority; or

B. Hold a current DAAS Homemaker certification; and

C. Employ and supervise direct care staff trained and qualified to provide respite care services and

D. Agree to the minimum Assurances of Providers of ElderChoices Waiver Services.

In-Home Respite Care providers as described in A. above must recertify with DAAS every three years, however, DAAS must maintain a copy of the agency's current Home Health license at all times. In-Home Respite Care providers as described in B. above must recertify with DAAS annually.

213.713 Facility-Based Respite Care Certification Requirements ~~7-1-07~~1-1-13

To be certified by the Division of Aging and Adult Services 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 ~~foster family~~ home

B. A licensed adult day care facility

C. A licensed adult day health care facility

D. A licensed nursing facility

E. A licensed residential care facility

F. A licensed Level I or Level II Assisted Living Facility

G. 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, however, 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.

213.800 Adult Companion Services ~~10-1-08~~1-1-13

Procedure Code	Required Modifier	Description
S5135	U1	Adult Companion Services

Adult companion services include non-medical care, supervision and socialization services provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities

as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not diversionary in nature. When required and in accordance with a therapeutic goal in the plan of care, a companion who meets state standards for providing assistance with bathing, eating, dressing and personal hygiene may provide these services when they are essential to the health and welfare of the individual and in the absence of the individual's family. Companion services must be furnished outside the timeframe of other waiver services and state plan personal care. An individual receiving Adult Family Homes services cannot receive waiver adult companion services or any other waiver services, with the exception of Long-Term Facility-Based Respite services.

Services must be provided according to the ~~participant's~~ beneficiary's written ElderChoices plan of care.

Providers of Adult Companion Services must bill procedure code **S5135 and the required modifier U1**. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible ~~participants~~ beneficiaries may receive up to 4800 units (1200 hours) per SFY of Adult Companion Services, In-Home Respite, Facility Based Respite Care or any combination of the three.

213.810 Adult Companion Services Certification Requirements ~~11-15-10~~1-1-13

Providers who hold a current Class A or Class B Home Health Agency license from the Arkansas Department of Health and are certified by the Arkansas Department of Human Services, Division of Aging and Adult Services (DAAS) as an ElderChoices waiver provider of Adult Companion Services may apply to enroll as a Medicaid Adult Companion Services provider. To be certified, providers must provide a copy of their current class A or Class B Home Health Agency license through the Arkansas Department of Health.

Private Care agencies licensed by the Arkansas Department of Health as a Private Care Agency-Medicaid Personal Care and certified by the Arkansas Department of Human Services, Division of Aging and Adult Services as an ElderChoices waiver provider of Adult Companion Services may apply to enroll as a Medicaid Adult Companion Services provider. To be certified, providers must provide a copy of their current private care agency-Medicaid personal care license through the Arkansas Department of Health.

Adult Companion Services providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Home Health Agency license or Private Care – Medicaid Personal Care license at all times.

214.000 Documentation ~~7-1-07~~1-1-13

In addition to the service-specific documentation requirements previously listed, ElderChoices 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 ~~participant's~~ beneficiary's plan of care

B. A brief description of the specific service(s) provided

C. The signature and title of the individual rendering the service(s)

D. The date and actual time the service(s) was rendered

If more than one category of service is provided on the same date of service, such as homemaker, personal care, and respite care, the documentation must specifically delineate

items A through D above for each service billed. For audit purposes, the auditor must readily be able to discern which service was billed in a particular time period based upon supporting documentation for that particular billing.

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 ElderChoices services, as with all Medicaid services, may be made in pencil.

215.000 ElderChoices Forms ~~7-15-09~~1-1-13

ElderChoices 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. These forms include but are not limited to:

A. Plan of Care — AAS–9503

~~B. Quarterly Monitoring — AAS–9506~~

~~C~~B. Start Services — AAS–9510

~~D~~C. Beneficiary Change of Status — AAS–9511

Providers may request form~~s AAS–9506 and~~ AAS–9511 by writing to the Division of Aging and Adult Services. **View or print the Division of Aging and Adult Services contact information.**

Forms AAS–9503 and AAS–9510 will be mailed to the provider by the ~~DHS~~ DAAS RN.

Instructions for completion and retention are included with each form. If there are questions regarding any ElderChoices form, providers may contact the ~~DHS~~ DAAS RN in your area.