FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Craig Cloud

TELEPHONE NO. 320-6439 **FAX NO.** 501-404-4619 **EMAIL:** craig.cloud@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE State Plan Amendment #2015-004; State Plan Amendment #2015-007; Targeted Case Management 2-15; IndependentChoices 2-15; Personal Care 3-15; and ARChoices-New-15

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year SFY 2016 (Jan – June)		**Next Fiscal Year** SFY 2017	
General Revenue	$2,500,000	General Revenue	$ 7,530,000
Federal Funds	$6,000,000	Federal Funds	$17,570,000
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$8,500,000	Total	$25,100,000

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ 2,500,000

Next Fiscal Year
$ 7,530,000

$6.2 million of the increase is based on a rate increase of State Plan Personal Care from $16.76/hr to $18/hr. $1.3 million of the increase is due to 554 persons on the waiver waiting list and expected growth.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

The Personal Care rate has not been increased in more than five years. Providers are challenged with meeting their financial obligations under the current rate. The Arkansas Department of Health, a large provider of Personal Care in Arkansas, determined in 2014

that it costs $19 to provide an hour of Personal Care. Increasing the rate to $18 will help support providers in providing this much needed service.

Merging the two waivers into one waiver will improve administrative efficiencies and provide a consistent set of services across the individual's span of care.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

These changes are not required by statute. The rate increase is being made so providers can continue providing this service. The waivers are being merged to improve efficiencies in state administration of the services, which will benefit the client.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

Personal Care has not received a rate increase in more than five years. The rate has not kept up with inflation. ADH determined in 2014 that it costs $19 to provide an hour of personal care. The amount settled upon in this proposal, $18/hr., was a negotiated amount made between providers and DHS in 2014.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

Providers will be able to continue providing quality care.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

The only alternative would be to provide less of an increase or no increase. This would not be practical based on the actual cost for providers in providing the care.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

There were no alternatives provided as part of public comment.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

Not applicable.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

DHS will review the rate periodically to determine if the rate meets current needs.

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Targeted Populations:

TCM services, when prescribed by a physician or other medical professional designated by the Division of Medical Services, are available to beneficiaries age 60 and older **as well as beneficiaries age 21 and older with a physical disability or aged 65 and older who participate in the ARChoices In Homecare (ARChoices)** 1915(c) waiver program who:

- have limited functional capabilities in two or more ADLs or IADLs, resulting in a need for coordination of multiple services and/or other resources; OR
- are in a situation or condition which poses imminent risk of death or serious bodily harm and one who demonstrates the lack of mental capacity to comprehend the nature and consequences of remaining in that situation or condition.

___ Case-management services will be made available for up to ____ consecutive days of a covered stay in a medical institution for individuals age 21 and over transitioning from an institution to a community setting. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_x_ Entire State
___ Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_x_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.

State: Arkansas
Date Received: 01 Sept, 2015
Date Approved: 19 Nov, 2015
Date Effective: 1 Jan, 2016
Transmittal Number: AR15-0004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers, according to established program guidelines.

Monitoring visits may be as frequent as necessary, within established Medicaid maximum allowable limitations.

Monitoring is allowed through regular contacts with service providers at least every other month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least monthly, that the beneficiary continues to participate in the service plan and is satisfied with services.

Face to face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case management providers must be certified by the Division of Aging and Adult Services on an annual basis, unless approved otherwise by the Division of Medical Services, based on performance evaluations or other approved data.

State: Arkansas
Date Received: 01 Sept, 2015
Date Approved: 19 Nov, 2015
Date Effective: 1 Jan, 2016
Transmittal Number: AR15-0004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES

[Target Group] In order to be certified by the Division of Aging and Adult Services, the provider must meet the following qualifications:

A. Be located in the state of Arkansas

B. Be licensed as a Class A or Class B Home Health Agency by the Arkansas Division of Health, or a unit of state government or an agency **or be a private public incorporated agency whose stated purpose is to provide case management to the elderly or those adults with physical disabilities.**

C. Is able to demonstrate one year of experience in performing case management services (experience must be within the past 3 years);

D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group (experience must be within the past 3 years);

E. Have an administrative capacity to insure quality of services in accordance with state and federal requirements;

F. Have the financial management capacity and system that provides documentation of services and costs;

G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements;

H. Be able to demonstrate that the provider has current liability coverage, and

I. Employ qualified case managers who must:

1. Reside in or near the area of responsibility; and
2. Be licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Social Worker **or Licensed Certified Social Worker**), a registered nurse or a licensed practical nurse; or
3. Have a bachelor's degree from an accredited institution in a health and human services field, plus two years' experience in the delivery of human services to the elderly.
4. Have performed satisfactorily as a case manager serving the targeted group for a period of two (2) years (experience must be within the past 3 years).

A copy of the current certification must accompany the provider application and Medicaid contract.

State: Arkansas
Date Received: 01 Sept, 2015
Date Approved: 19 Nov, 2015
Date Effective: 1 Jan, 2016
Transmittal Number: AR15-0004

1. Case Management Services (continued)

B. Persons Sixty years of Age and Older

TCM services, when prescribed by a physician or other medical professional designated by the Division of Medical Services, are available to beneficiaries age 60 and older **as well as beneficiaries age 21 and older with a physical disability or aged 65 and older who participate** in the **ARChoices In Homecare (ARChoices)** 1915 (c) waiver, who:

- have limited functional capabilities in two or more ADLs or IADLs, resulting in a need for coordination of multiple services and/or other resources; OR
- are in a situation or condition which poses imminent risk of death or serious bodily harm and one who demonstrates the lack of mental capacity to comprehend the nature and consequences of remaining in that situation or condition.

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure. Case management services are billed on a per unit basis. One unit equals 15 minutes.

The agency's targeted case management fee schedule rates were set as of October 1, 2012 and are effective for services on or after that date. All targeted case management fee schedule rates are published on the agency's website (www.medicaid.state.ar.us). A uniform rate for these services is paid to all governmental and non-governmental providers unless otherwise indicated in the state plan.

Cost per 15 minute unit = $7.50

State: Arkansas
Date Received: 01 Sept, 2015
Date Approved: 19 Nov, 2015
Date Effective: 1 Jan, 2016
Transmittal Number: AR15-0004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Program of All-Inclusive Care for the Elderly (PACE) Reimbursement Methodology

The PACE rates are based on the Upper Payment Limit methodology. The historical fee-for-service population data is extracted for claims and eligibility for a PACE eligible populations for more than one fiscal period. Data for recipient aged, blind and disabled aid categories for those 55 or greater is used in the UPL and rate calculations. The level of care codes are limited to nursing facility level of care eligible or **ARChoices** Waiver level of care eligible.

The data includes both those that are eligible only for Medicaid and those that are eligible for both Medicaid and Medicare. In addition, this data includes only QMB-Plus and SLMB-Plus populations. The claims data includes all categories of service. The UPL and base rate information is also inclusive of patient liability.

The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. The recent trend rates are compared to linear regression model trend rates to determine comparability, and to determine if any adjustments are necessary. The trend rates for future periods are expected to be consistent with historical rate changes rather than the more recent experience.

The following rate category groupings were developed for Arkansas: Pre-65 Medicaid Only, Pre-65 Dual Eligible, Post-65, and QMB Only. The UPL for QMB Only is based on actual expenditures for co-payments and deductibles for the base year period trended forward for inflation, and adjusted for investment income and administration expense. Due to the limited size population in the post-65 age group that was not Medicare eligible, it was determined that a Medicare eligibility rate for those over 65 would not improve predictability. The data did not reflect a necessity for a rate grouping for either geographic region or gender.

Claims completion factors are developed from the fee-for-service paid claims experience with the most recently available paid dates. Claims completion factors were developed for fourteen (14) primary groupings with comparable categories of service grouped for improved predictability. The completion factors were adjusted to exclude low and high outliers for each specific lag month.

The following adjustments are necessary in the development of the rates:

- Prescription Drug (PD) Rebate – Reduce PD expenditure data to reflect the rebate received by Arkansas.
- Investment Income – Reduce expenditure data by 0.2% for all Categories of Services (COS) to reflect an average payment lag of 2.49 months.
- Administration Expense – Increase expenditure data for all COS by 0.3% to reflect the cost of administration of the fee-for-service program.

State: Arkansas
Date Received: 5 August, 2015
Date Approved: 30 November, 2015
Date Effective: 1 January, 2016
Transmittal Number: AR 15-0007

OMB Approved 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. __X__ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. __X__ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. __X__ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. __X__ Services included in the following Section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

ARChoices Attendant Care

iii. Payment Methodology

A. ____ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) as that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

State: Arkansas
Date Received: 5 August, 2015
Date Approved: 30 November, 2015
Date Effective: 1 January, 2016
Transmittal Number: AR 15-0007

OMB Approved 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Each active and pending record contained within the database only includes data fields that are used in reporting. Each participant record may include the following:

- representative information, if applicable,
- participant's employee,
- participant's back-up worker,
- directions to the participant's home,
- nurse tracking,
- counselor tracking,
- contact notes,
- HCBS **ARChoices** service plan for persons receiving both **ARChoices** and IndependentChoices.

These data elements will assist the counselors and nurses in performing their duties by allowing timely management and monitoring of each participant's case. The HCBS service plan is used to determine if an extension of benefits is warranted, as all community resources are considered when requesting an extension of benefits. The database allows nurses, counselors or contractors to set health risk indicators identifying program participants who may require more frequent monitoring.

The data allows nurses and counselors to run reports from their case load. Automated highlights on specific data elements draw the nurse or counselor's attention to areas that require special attention. Highlighted data fields represent the following:

- assessment performed by the nurse but not received by DAAS,
- counselor's request for authorization by a physician not received after four or more days,
- date enrollment forms sent to a potential enrollee but not returned.

State: Arkansas
Date Received: 5 August, 2015
Date Approved: 30 November, 2015
Date Effective: 1 January, 2016
Transmittal Number: AR 15-0007

State: ARKANSAS

Citation	Condition or Requirement
1905(t)	The following PCCM exempt services do not require PCP authorization: Dental Services Emergency hospital care DDS Alternative Community Services Family Planning Anesthesia Alternative Waiver Programs Developmental Day Treatment Services Core Services only Disease Control Services for Communicable Diseases Domiciliary care **ARChoices** waiver services Gynecological care Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment Mental health services as follows: a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner b. Rehabilitative services for persons with mental illness aged 21 or older or for specified procedures for persons under age 21 c. Rehabilitative Services for Youth and Children Nurse Midwife services ICF/IID services Nursing Facility services Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment. Ophthalmology and Optometry services Obstetric (antepartum, deliver and postpartum) services Pharmacy Physician Services for inpatients acute care. Transportation Sexual Abuse Examination. Targeted case management provided by the Division of Youth Services or the Division of Children and Family services under an interagency agreement with the Division of Medical Services.
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

State: Arkansas
Date Received: 5 August, 2015
Date Approved: 30 November, 2015
Date Effective: 1 January, 2016
Transmittal Number: AR 15-0007

Citation	Condition or Requirement

1. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
DDS Alternative Community Services
Family Planning
Anesthesia
Alternative Waiver Programs
Developmental Day Treatment Services Core Services only
Disease Control Services for Communicable Diseases
Domiciliary care
ARChoices waiver services
Gynecological care
Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment
Mental health services as follows:

a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
b. Rehabilitative services for persons with mental illness aged 21 or older or for specified procedures for persons under age 21
c. Rehabilitative Services for Youth and Children

Nurse Midwife services
ICF/IID Services
Nursing Facility services
Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.
Ophthalmology and Optometry services
Obstetric (antepartum, deliver and postpartum) services
Pharmacy
Physician Services for inpatients acute care.
Transportation

26. Personal care furnished in accordance with the requirements at 42 CFR §440.167 and with regulations promulgated, established and published for the Arkansas Medicaid Personal Care Program by the Division of Medical Services.

(a) Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of personal care services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Medicaid website at www.medicaid.state.ar.us.

(b) Reimbursement for Personal Care Program Services is by fee schedule, at the lesser of the billed charge or the Title XIX (Medicaid) maximum allowable fee per unit of service. Effective for dates of service on and after July 1, 2004, one unit equals fifteen minutes of service.

(c) Effective for dates of service on and after July 1, 2007, reimbursement to enrolled Residential Care Facilities (RCFs) for personal care services furnished to Medicaid eligible residents (i.e., clients) is based on a multi-hour rate system not to exceed one day, based on the individual clients' levels of care. A client's level of care is determined from the service units required by his or her service plan. Rates will be recalculated as needed to maintain parity with other Personal Care providers when revisions of the Title XIX maximum allowable fee occur. The effective date of any such revised rates shall be the effective date of the revised fee.

(d) **Reimbursement to enrolled Assisted Living Facilities (ALF) for personal care services furnished to Medicaid eligible residents (i.e., clients) is based on a multi-hour rate system not to exceed one day, based on the individual clients' level of care. A client's level of care is determined from the service units required by his or her service plan. Rates will be recalculated as needed to maintain parity with other Personal Care providers when revisions of the Title XIX maximum allowable fee occur. The effective date of such revised rates shall be the effective date of the revised fee.**

(e) Agencies rates are set as of January 1, 2016 and are effective for services on or after that date. All rates are published at the agency's website, (http://www.medicaid.state.ar.us/).

State: Arkansas
Date Received: 5 August, 2015
Date Approved: 30 November, 2015
Date Effective: 1 January, 2016
Transmittal Number: AR 15-0007

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Personal Care**

EFFECTIVE DATE: **January 1, 2016**

SUBJECT: **Provider Manual Update Transmittal PERSCARE-3-15**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
200.130	8-1-04	200.130	1-1-16
213.000	1-1-13	213.000	1-1-16
214.300	1-1-13	214.300	1-1-16
214.310	1-1-13	214.310	1-1-16
214.320	1-1-13	214.320	1-1-16
214.330	10-13-03	214.330	1-1-16
214.400	1-1-13	—	—
215.100	7-1-13	215.100	1-1-16

Explanation of Updates

Sections 200.130, 213.000, 214.300, 214.310, 214.320, 214.330 and 215.100 are updated to change ElderChoices to ARChoices.

Section 214.400, Reporting Personal Care Services Provided to Beneficiaries in the Alternatives for Adults with Physical Disabilities Waiver Program, is removed.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Targeted Case Management**

EFFECTIVE DATE: **January 1, 2016**

SUBJECT: **Provider Manual Update Transmittal TCM-2-15**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
204.000	10-1-12	204.000	1-1-16
212.100	3-1-08	212.100	1-1-16
212.200	10-1-12	212.200	1-1-16
212.300	3-1-08	212.300	1-1-16
212.400	3-1-08	212.400	1-1-16
212.410	10-1-12	212.410	1-1-16
215.000	1-1-13	215.000	1-1-16
218.100	10-1-12	218.100	1-1-16
218.200	10-1-12	218.200	1-1-16
218.300	10-1-12	218.300	1-1-16
220.000	10-1-12	220.000	1-1-16
240.000	10-13-03	240.000	—
—	—	240.010	1-1-16
241.000	3-1-08	241.000	1-1-16
262.100	10-1-12	262.100	1-1-16

Explanation of Updates

Sections 204.000, 212.100, 212.200, 212.300, 212.400, 212.410, 215.000, 218.100, 218.200, 218.300, 220.000, 241.000 and 262.100 are updated to change ElderChoices to ARChoices in Homecare and to change mental retardation to intellectual disability.

Section 240.000 is updated to delete policy and the effective date since it is a primary section header. Section 240.010 is added to include policy for Prior Authorization (PA) for beneficiaries under the age of 21.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

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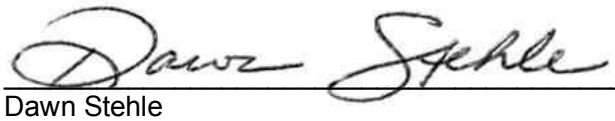
Thank you for your participation in the Arkansas Medicaid Program.



Dawn Stehle
Director

SECTION II - TARGETED CASE MANAGEMENT
CONTENTS

204.000 Participation Requirements for Providers of Targeted Case Management for Beneficiaries Ages Sixty (60) and Older Including ARChoices in Homecare Waiver Participants 1-1-16

Providers of targeted case management who are restricted to serving persons sixty (60) years of age and older or serving persons ages twenty-one (21) and older with a physical disability and those sixty-five (65) and older who participate in the ARChoices in Homecare (ARChoices) 1915(c) waiver must be certified by the Division of Aging and Adult Services as an organization qualified to provide targeted case management services.

In order to be certified by the Division of Aging and Adult Services, the provider must meet the following qualifications:

A. Be located in the state of Arkansas;

B. Be licensed as a Class A or Class B Home Health Agency or Private Care Agency by the Arkansas Department of Health or a unit of state government or be a private or public incorporated agency whose stated purpose is to provide case management to the elderly or adults with physical disabilities;

C. Be able to demonstrate one year of experience in performing case management services. (Experience must be within the past 3 years);

D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group. (Experience must be within the past 3 years);

E. Have an administrative capacity to insure quality of services in accordance with state and federal requirements;

F. Have the financial management capacity and system that provides documentation of services and costs;

G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements;

H. Be able to demonstrate that the provider has current liability coverage; and

I. Employ qualified case managers who must:

    1. Reside in or near the area of responsibility; and
    2. Be licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Certified Social Worker), a registered nurse or a licensed practical nurse; or
    3. Have a bachelor's degree from an accredited institution in a health and human services field, plus two years' experience in the delivery of human services to the elderly; or
    4. Have performed satisfactorily as a case manager serving the targeted population for a period of two (2) years (experience must be within the past 3 years).

A copy of the current certification must accompany the provider application and Medicaid contract.

212.100 Beneficiaries Ages Twenty-One (21) and Younger Who Are Not Receiving DDS ACS Waiver Services 1-1-16

This target population consists of beneficiaries who are ages twenty-one (21) and younger who:

A. Experience developmental delays;

B. Have diagnosed physical or mental conditions with a high probability of resulting in a developmental delay;

C. Are determined at risk of having substantial developmental delay if early intervention services are not provided;

D. Are diagnosed with a developmental disability attributable to an intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy, autism or any other medical condition considered to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability or requires treatment and services similar to those required for such persons; and

E. Are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

212.200 Beneficiaries Ages Twenty-One (21) and Younger Eligible for Developmental Disabilities Services 1-1-16

This target population consists of beneficiaries who are ages twenty-one (21) and younger and who:

A. Experience developmental delays;

B. Have a diagnosed physical or mental condition with a high probability of resulting in developmental delay;

C. Are determined to be at risk of having substantial developmental delay if early intervention services are not provided; and

D. Are diagnosed as having a developmental disability which is attributable to an intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy, autism or any other medical condition considered closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability or requires treatment and services similar to those required for such persons.

DDS certified case managers enrolled as Medicaid targeted case managers must obtain written verification that any beneficiary they wish to bill for has been certified as eligible to receive services from the Division of Developmental Disabilities Services. This documentation must be obtained from the DDS service coordinator responsible for the beneficiary's county of residence and must be maintained in the beneficiary's record. Providers may request a list of DDS service coordinators and their locations from the local DHS county office.

212.300 Beneficiaries Ages Twenty-Two (22) and Older with a Developmental Disability Who Are Not Receiving DDS ACS Waiver Services 1-1-16

This target population consists of beneficiaries who are ages twenty-two (22) and older and who: are:

A. Diagnosed as having a developmental disability of an intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy, autism or any other condition of a person found to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability or requires treatment and services similar to those required for such persons. (Refer to Section 203.000 for more information.)

B. Not receiving DDS ACS waiver services.

212.400 Beneficiaries Ages Sixty (60) and Older including ARChoices in Homecare Waiver Participants 1-1-16

This target population consists of beneficiaries ages sixty (60) and older as well as beneficiaries ages twenty-one (21) and older with a physical disability or ages sixty-five (65) and older who participate in the ARChoices waiver who have limited functional capabilities in two or more ADLs or IADLs resulting in a need for coordination of multiple services and/or other resources or are in a situation or condition that poses imminent risk of death or serious bodily harm and who demonstrates the lack of mental capacity to comprehend the nature and consequences of remaining in that situation or condition.

212.410 Regulations for Participants Ages Sixty (60) and Older and including ARChoices in Homecare Waiver Participants Case Management Providers 1-1-16

A. A plan of care developed by the DAAS RN for the ARChoices in Homecare (ARChoices) Program replaces any other plan of care. The ARChoices plan of care must include all appropriate ARChoices services and certain non-waiver services appropriate for the beneficiary.

B. If services are currently provided to an ARChoices client, the provider must report these services to the DAAS RN. Before beginning or revising services to an ARChoices client, the DAAS RN must be contacted to ensure that the plan of care is revised and approved. All changes in service or client circumstances must be reported to the DAAS RN immediately. Certain services provided to an ARChoices client that are not included in the plan of care may be subject to recoupment by the Medicaid Program.

C. An ARChoices plan of care may not be revised by anyone other than the DAAS RN. All services, regardless of the funding source, must be documented by the TCM provider in the beneficiary's TCM case file. Non-Medicaid funded services, such as food stamps, housing, etc., must be included in the overall TCM assessment and on the TCM service plan. These type services that are not required on the waiver plan of care may be implemented without prior approval by the DAAS RN.

D. If a temporary situation arises based on a filled position becoming temporarily vacant and the hiring of the position is in process, a case manager may exceed the maximum of 90 active cases for no more than 60 consecutive days. The maximum number of active cases during a temporary situation, as described above, may not exceed 110 Medicaid beneficiaries. If the TCM agency temporarily stops accepting referrals, written notification must be sent to the DAAS RN with an effective date. Once referrals are being accepted again, written notification must be sent to the DAAS RN with an effective date. This will ensure all TCM agencies are fairly represented and it will avoid unnecessary referrals, which would ultimately delay services being provided to the beneficiary.

215.000 Physician's Role 1-1-16

A physician must prescribe all services provided by an enrolled targeted case management provider unless the participant is in the ARChoices waiver and the service is authorized by the DAAS RN. However, the physician is not medically responsible for the services and does not supervise the TCM provider or the service provider.

Targeted case management services for beneficiaries under age twenty-one (21) who are not eligible for DDS must be prescribed as a result of a Child Health Services/EPSDT screen. The prescription must be renewed within the applicable periodicity schedule, not to exceed a maximum of twelve (12) months. The original and all subsequent renewed prescriptions must be signed and dated by the physician (no stamped signatures will be accepted) and must be filed

and retained by the targeted case manager in the beneficiary's record. Obtaining the physician's orders and prescriptions is not a covered TCM service.

Targeted case management services for all other target groups must be prescribed after the physician examines the beneficiary. The prescription must be renewed every 12 months. The initial and all subsequent renewed or revised prescriptions must be signed and dated by the physician (no stamped signature will be accepted) and must be filed and retained by the targeted case manager in the beneficiary's record. It is the responsibility of the TCM provider to ensure the MD order for TCM services is complete, signed and dated.

If a beneficiary is required to participate in the ConnectCare Primary Care Case Management (PCCM) Program, the beneficiary's PCP must write the prescription for targeted case management services after the physician has examined the beneficiary. Additional information regarding the PCP Program may be found in Section I.

NOTE: As stated in this manual, an ARChoices in Homecare (ARChoices) waiver plan of care developed by the DAAS RN for the ARChoices Program replaces any other plan of care. The ARChoices plan of care must include all appropriate ARChoices services and certain non-waiver services appropriate for the beneficiary. This most often includes Targeted Case Management. The service providers and the ARChoices beneficiary must review and follow the signed authorized plan of care. Each service included on the ARChoices plan of care must be justified by the DAAS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DAAS RN.

For ARChoices participants whose waiver plan of care includes TCM at the time the DAAS RN signs the plan of care, the ARChoices plan of care, signed by a DAAS RN, will serve as the authorization for TCM services for one year from the date of the DAAS RN's signature. No additional TCM order signed by a physician is required.

218.100 Assessment/Service Plan Development 1-1-16

This component is an annual face-to-face contact with the beneficiary and contact with other professionals, caregivers or other parties on behalf of the beneficiary. Assessment is performed for the purpose of collecting information about the beneficiary's situation and functioning and to determine and identify the beneficiary's problems and needs.

The TCM assessment is a comprehensive assessment that includes medical, social, educational, and other services. It goes beyond the assessment process used in determining eligibility for the 1915(c) waiver program(s). It addresses all facets of the individual's everyday life in determining how any problem or need might be met and what services are available in the individual's community.

For TCM beneficiaries ages 60 and older or the ARChoices participants, the maximum units allowed for this service may not exceed twelve (12) units per assessment/service plan visit. All references to units are in 15 minute increments.

This component includes activities that focus on needs identification. Activities, at a minimum, include:

A. The assessment of an eligible beneficiary to determine the need for any medical, educational, social and other services. Specific assessment activities include:

1. Taking beneficiary history
2. Identifying the needs of the beneficiary
3. Completing related documentation

4. Gathering information from other sources, such as family members, medical providers and educators, if necessary, to form a complete assessment of the Medicaid eligible beneficiary

B. An assessment may be completed between annual assessments, if the TCM deems it necessary.

1. Documentation in the beneficiary's case file must support the assessment, such as life-changing diagnoses, major changes in circumstances, death of a spouse, change in primary caregiver, etc.

2. Any time an assessment is completed, the circumstances resulting in a new assessment rather than a monitoring visit must be documented and must support the activity billed to Medicaid.

3. **For beneficiaries ages twenty-one and older, reassessments performed between annual assessment visits are limited to eight (8) units per reassessment.** Documentation in the beneficiary's case file must support the reassessment, such as a life-changing diagnosis, major changes in circumstances, death of a spouse, change in a primary caregiver, etc. Any time an assessment is completed, the circumstances resulting in a new assessment rather than a monitoring visit must be documented and must support the activity billed to Medicaid.

C. Service plan development builds on the information collected through the assessment phase and includes ensuring the active participation of the Medicaid-eligible beneficiary or their authorized representative. The goals and actions in the care plan must address medical, social, education, and other services needed by the Medicaid-eligible beneficiary. Service plans must:

1. Be specific and explain each service needed by the beneficiary

2. Include all services, regardless of payment source

3. Include support services available to the beneficiary from family, community, church or other support systems and what needs are met by these resources

4. Identify immediate, short term and long term ongoing needs as well as how these needs/goals will be met

5. Assess the beneficiary's individualized need for services and identify each service to be provided along with goals

NOTE: The TCM service plan is a comprehensive care plan that includes medical, social, educational, and other services that have been identified and included on the service plan for purposes in meeting the identified goals. The TCM service plan goes beyond the ARChoices waiver plan of care developed by the DAAS RN. The TCM service plan addresses all facets of the individual's everyday life in determining how a problem or need will be met and what services are available in the individual's community.

D. The assessment and the service plan may be accomplished at the same time, during the same visit, or separately.

1. However, for the assessment and the service plan for beneficiaries age 21 and over, **the total time in completing the assessment and developing the service plan may not exceed 12 units per beneficiary, regardless of whether the two are completed on the same date of service or different dates of service.**

2. **For beneficiaries ages 21 and older, the total time spent on the assessment and service plan development process may not exceed 12 units.**

NOTE: Annual reassessments and service plan development are allowed, in fact, encouraged. This policy does not prohibit annual reassessments and service plan development. Reassessments may be conducted any time the

case manager deems it appropriate, however, when reassessments are performed more frequently than annually, justification for conducting a full reassessment, rather than a monitoring visit, must be included in the documentation contained in the case record.

TCM service plans must be renewed, at least, annually.

218.200 Service Management/Referral and Linkage 1-1-16

This component includes activities that help link Medicaid eligible beneficiaries with medical, social, educational providers and/or other programs and services that are capable of addressing identified needs and achieving goals specified in the service plan. For example, making referrals to providers for needed services and scheduling appointments may be considered case management. This component details:

A. Functions and processes that include contacting service providers selected by the beneficiary and negotiation for the delivery of services identified in the service plan. Contacts with the beneficiary and/or professionals, caregivers or other parties on behalf of the beneficiary may be a part of service management.

B. For beneficiaries participating in a DAAS HCBS waiver program, the transfer of information to the DAAS RN via the AAS-9511, AAS-9510, or other communication form is not a covered service.

See Section 262.100 for the appropriate procedure code.

218.300 Service Monitoring/Service Plan Updating 1-1-16

This component includes activities and contacts that are necessary to ensure the TCM care plan is effectively implemented and adequately addressing the needs of the Medicaid-eligible beneficiary.

The maximum units allowed for this service may not exceed six (6) units per monitoring visit when providers are dealing with beneficiaries ages 21 and older.

A. The activities and contacts may be with the Medicaid-eligible beneficiary, family members, providers or other entities.

B. They may be as frequent as necessary, within established Medicaid maximum allowable limitations, to help determine such things as:

1. Whether services are being furnished in accordance with a Medicaid eligible beneficiary's plan of care
2. The adequacy of the services in the plan of care
3. Changes in the needs or status of the Medicaid-eligible beneficiary

C. Monitoring is allowed through regular contacts with service providers at least every month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least monthly, that the beneficiary continues to participate in the service plan and is satisfied with services.

1. A face-to-face monitoring contact with the beneficiary must be completed once every three months. Required contacts with the service providers may be conducted through face-to-face contact or by telephone. Communication with service providers by email or fax are allowed as described in Section 213.000, F.1.

2. A face-to-face contact is not considered a covered monitoring contact unless the required monitoring form is completed according to instructions, dated, signed by the targeted case manager, and filed in the beneficiary's case record.

D. Updating includes:

1. Reexamining the beneficiary's needs
2. Identifying changes that have occurred since the previous assessment
3. Identifying hospitalizations or other extended absences from the home
4. Altering the TCM service plan
5. Measuring the beneficiary's progress toward service plan goals. Service plans should not be updated more than quarterly unless there is a significant change in the beneficiary's needs.

Monitoring and follow-up activities include making necessary adjustments in the TCM care plan and service arrangements with providers, according to established program guidelines.

Face-to-face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

E. Non-Covered Services include:

1. The updating of a tickler system
2. A case management agency is not allowed to monitor or update an activity when the service being monitored or updated is provided to the beneficiary by the same agency.
3. However, the same agency is allowed to be both the TCM agency and the agency providing a direct service, such as personal care, home delivered meals, or PERS.
4. However, the agency is not allowed to bill for a TCM monitoring contact when monitoring the **quality of care or the quality of the service** provided by the same agency or when the purpose of the contact is to monitor the progress of a service being in place, delivered, having started, effective date, etc.
5. In addition, TCM is not allowed when monitoring is required through the direct service policy, such as with PERS providers.
6. Monitoring the PERS service is a part of the certification policy for all PERS providers. Additional monitoring of the PERS service by a TCM is not a covered TCM service.

F. Examples of case monitoring and service plan updating are shown below:

1. Example # 1

Provider "A" has been chosen by the beneficiary to provide home delivered meals. The beneficiary has also chosen provider "A" for case management services. Case management by provider "A" may not be billed for any activity associated with the provision of home delivered meals. It is the responsibility of the direct service provider to ensure quality services are provided. In this example, the home delivered meal provider is responsible for ensuring meals are delivered timely and to the beneficiary's satisfaction. Case management activity does not include monitoring the provision of home delivered meals by the same agency.

This same policy applies to any service where the case management agency is the same agency providing the in-home service.

2. Example # 2

Provider "B" has been chosen by the beneficiary to provide personal care. The beneficiary has also chosen provider "B" for targeted case management services. Case management by provider "B" may not be billed for any activity associated with the quality of the personal care services being provided by the same agency. It is the responsibility of the direct service provider to ensure quality services are provided.

In this example, the personal care provider is responsible for ensuring personal care services are provided to the satisfaction of the beneficiary and according to the plan of care (POC) that includes the personal care service. This includes whether or not the aide performs the duties assigned, arrives timely, stays the assigned period of time, is courteous and meets the requirements established for the Personal Care Program by the Arkansas Medicaid Program.

G. A TCM provider is allowed to bill a monitoring contact when the monitoring is for the purpose of verifying the services included on the POC are sufficient based on the beneficiary's current condition. This is also true when the case manager is contacted by the beneficiary.

1. If the monitoring contact is billed, based on this purpose, documentation must support the reason for the contact, the results of the contact and any changes requested to the POC.

   a. **NOTE:** This type activity, when based on the beneficiary's condition and the sufficiency of the services in place, may be billed regardless of whether or not the case manager and the direct service provider are the same agency.

   b. If the monitoring contact, whether initiated by the case manager or the beneficiary, is not addressing **quality of care**, the monitoring contact is billable, if it meets the definition described in this manual.

2. The same policy applies to the personal emergency response system (PERS) service. The TCM provider may test the PERS unit when completing a monitoring visit, if the PERS unit is not provided by the same agency as the TCM service.

   a. Since the PERS providers are required to test their units monthly, if they choose to meet that requirement by having their targeted case managers test the units while in the home, this is not considered a covered TCM service.

   b. It does, however, meet the requirement established for the PERS providers, if results of the testing are documented by the PERS provider and available for audit.

H. All requests from case managers to increase or decrease services or change service providers will be verified by the DHS RN and justified by the DHS RN prior to any changes being made to the waiver plan of care. This applies when the beneficiary is a participant in a home and community based waiver program.

See Section 262.100 for the appropriate procedure code and modifier.

220.000 Benefit Limits 1-1-16

Based on the state fiscal year (SFY) July through June, beneficiaries ages twenty-one (21) and older are limited to fifty (50) hours (200 units) of targeted case management services per year.

Regardless of the overall SFY benefit limit, each waiver plan of care must specify the number of units being authorized and documentation must reflect how those units are utilized. Utilization must be reasonable, documented, and justified in the case record, based on the beneficiary's overall medical condition, support services available to the beneficiary, and in-home services currently in place.

If a TCM beneficiary is also a home and community based waiver beneficiary, such as ARChoices, the waiver plan of care supersedes any other plan of care. Therefore, the number

of units authorized on the waiver plan of care may not be exceeded unless prior approved by the DHS RN. **Approval will not be granted after the services are already provided**.

For audit purposes, the authorization must be in writing, placed in the beneficiary's file, and available for auditors.

240.000 PRIOR AUTHORIZATION

240.010 Prior Authorization (PA) Required for Beneficiaries Under 21 1-1-16

Prior authorization (PA) is required and must be obtained before providing targeted case management services for Medicaid eligible beneficiaries under the age of 21.

241.000 Individuals Exempt from Prior Authorization (PA) 1-1-16

Prior authorization (PA) is not applicable for targeted case management (TCM) services for those beneficiaries who are twenty-one (21) years of age and older, who have been diagnosed with a developmental disability, nor for beneficiaries sixty (60) years of age and older, nor beneficiaries ages 21 and older or 65 and older who are participating in the ARChoices Program.

262.100 Targeted Case Management Procedure Codes 1-1-16

The procedure code in this section must be billed either electronically or on paper with the proper modifier indicated. Prior authorization is required when billing for beneficiaries under age 21. There are benefit limits for TCM services for beneficiaries ages 21 and older. See Section 242.000 for prior authorization requirements and Section 220.000 for information about benefit limits.

The column labeled U21, 21+, and 60+ indicates that the procedure code or the procedure code along with a particular modifier must be used when billing for beneficiaries under age 21, for those ages 21 and older who have been diagnosed with a developmental disability, or for those ages 60 and older.

The following procedure codes and modifiers must be used to bill for targeted case management services:

⁂ (…) This symbol, along with text in parenthesis, indicates the Arkansas Medicaid description of the service.

National Code	Modifier	U21 21+ 60+	Local Code Description
T1017		U21	⁂ (Assessment/Service Plan Development)
T1017	U2	21+	⁂ (Assessment/Service Plan Development)
T1017	U5	60+	⁂ (Assessment/Service Plan Development)
T1017	UA	21+ in ARChoices	⁂ (Assessment/Service Plan Development)
T1017	U4	U21, 21+	⁂ (Service Management/Referral and Linkage)
T1017	U6	60+	⁂ (Service Management/Referral and Linkage)
T1017	UB	21+ in ARChoices	⁂ (Service Management/Referral and Linkage)
T1017	U1	U21	⁂ (Service Monitoring/Service Plan Updating)

National Code	Modifier	U21 21+ 60+	Local Code Description
T1017	U3	21+	⁂ (Service Monitoring/Service Plan Updating)
T1017	U7	60+	⁂ (Service Monitoring/Service Plan Updating)
T1017	UC	21+ in ARChoices	⁂ (Service Monitoring/Service Plan Updating)

SECTION II - PERSONAL CARE

CONTENTS

200.130 Private Care Agencies 1-1-16

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

B. Private care agencies must hold current licensure from the Arkansas Department of Labor.

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

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

213.000 Scope of the Program 1-1-16

A. Personal care services are primarily based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Hands-on assistance in at least one of these areas is required. This type of assistance is provided by a personal care aide based on a beneficiary's physical dependency needs (as opposed to purely housekeeping services). A plan of care is developed through the assessment process and is based on a beneficiary's dependency in at least one of the above-listed activities of daily living. While not a part of the eligibility criteria, the need for assistance with other tasks and IADLs (Instrumental Activities of Daily Living) are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized. Routines or IADLs include meal preparation, incidental housekeeping, laundry, medication assistance, etc. These tasks are also defined and described in this section of this provider manual.

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

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

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

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

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

1. Authorized for the individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a service plan approved by the State, e.g., ARChoices, IndependentChoices;

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

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

E. Personal care for Medicaid-eligible individuals under the age of 21 requires prior authorization. See Sections 240.000 through 246.000.

F. Only Class-A Home Health agencies, Class-B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, education service cooperatives and DDS facilities may provide

personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the beneficiary's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

214.300 Authorization of ARChoices Plan of Care and Personal Care Service Plan 1-1-16

The DAAS RN is responsible for developing an ARChoices Plan of Care that includes both waiver and non-waiver services. Once developed, the Plan of Care is signed by the DAAS RN authorizing the services listed.

The signed ARChoices Plan of Care will suffice as the "Personal Care Authorization" for services required in the Personal Care Program. The signature of the DAAS RN on the ARChoices Plan of Care simply replaces the need for the physician's signature authorizing personal care services. The personal care service plan, developed by the Personal Care provider, is still required.

As the ARChoices Plan of Care is effective for one year, once signed by the DAAS RN; the authorization for personal care services, when included on the ARChoices Plan of Care, will be for one year from the date of the DAAS RN's signature, unless revised by the DAAS RN or the personal care service plan needs to be revised, whichever occurs first. If personal care services continue unchanged as authorized on the ARChoices Plan of Care, a new service plan is not required at the 6-month interval.

NOTE: For ARChoices participants who receive personal care through traditional agency services or have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices 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.

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.

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

214.310 Development of ARChoices Plan of Care 1-1-16

If personal care services are not currently being provided when the DAAS RN develops the ARChoices Plan of Care, the DAAS RN will determine if personal care services are needed. If so, the service, amount, frequency, duration and the recipient's provider of choice will be included on the ARChoices Plan of Care. A copy of the ARChoices Plan of 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 DAAS RN within 10 working days from mailing or action may be taken by the DAAS RN to secure another personal care provider or modify the ARChoices Plan of Care. (The ARChoices Plan of Care is dated the date it is mailed.) Before taking action to secure another provider or modifying the Plan of Care, the applicant and/or family members will be contacted to discuss possible alternatives. Communications related to participation in the IndependentChoices program will be conveyed electronically through "tasks" communicated through Med Compass software, a new data system used to help manage waiver and IndependentChoices services.

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

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

If the DAAS RN is aware that personal care services are currently being provided when the ARChoices Plan of Care is developed, the DAAS RN will contact the personal care provider to verify the current order and amount of personal care services in place. If requested verbally, the request must be documented in the ARChoices nurse narrative. It is the personal care provider's responsibility to provide the requested information to the DAAS RN immediately upon receipt of the request. If a copy is not received within 10 working days of the request, the DAAS RN will process the ARChoices Plan of Care, as developed by the DAAS RN.

NOTE: It is the IndependentChoices employer or personal care provider's responsibility to place information regarding their presence in the home in a prominent location so that the DAAS RN will be aware that they are serving the beneficiary. Preferably, the provider will place the information on the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will place the information in a location satisfactory to the applicant, as long as it is readily available and easily accessible by the DAAS RN.

The personal care service plan developed by the personal care provider must meet all requirements as detailed in the personal care provider manual. This includes, but is not limited to, the amount of personal care services, personal care tasks, frequency and duration. The DAAS RN will not alter the current number of personal care units, unless a waiver Plan of Care cannot be developed without duplicating services. 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 ARChoices Plan of Care and the required justification for each service remains the responsibility of the DAAS RN. Therefore, final decisions regarding services included on the ARChoices Plan of Care rest with the DAAS RN.

NOTE: For the IndependentChoices program, services are effective the date of the DAAS RN's signature on the assessment tool or the waiver plan of care, whichever is the latter of the two.

214.320 Revisions to the ARChoices Plan of Care 1-1-16

Requested changes to the personal care services included on the ARChoices 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 ARChoices Plan of Care is responsible for securing any required signatures authorizing the change prior to the ARChoices 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 ARChoices 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 ARChoices 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.

214.330 Medicaid Audit Requirements for the ARChoices Plan of Care 1-1-16

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

215.100 Assessment and Service Plan Formats 1-1-16

A. The Division of Medical Services (DMS), in some circumstances and for certain specified providers, requires exclusive use of form DMS-618 (**View or print form DMS-618.**) to satisfy particular Program documentation requirements.

1. Whether Medicaid does or does not require exclusive use of form DMS-618, all documentation required by the Personal Care Program must meet or exceed DMS regulations as stated in this manual and other official communications.

2. When using form DMS-618, attachments may be necessary to complete assessments and service plans and/or to comply with other rules.

   a. An assessing Registered Nurse (RN) must sign or initial and date each attachment he or she adds to a required personal care document.

   b. The authorizing physician must sign (or initial) and date each attachment he or she adds to a service plan or other required document.

B. The Division of Medical Services requires Residential Care Facility (RCF) Personal Care providers to use exclusively form DMS-618 and to comply with all rules applicable to RCFs regarding the use of form DMS-618.

C. For assessments completed on individuals participating in the IndependentChoices Program, the following applies:

For IndependentChoices participants, the DMS-618 is not required. Only the AR Path assessment will be used by the DAAS RN.

For IndependentChoices participants who are also active waiver participants in the ARChoices Program, the assessment tool used for waiver level of care determination and the waiver plan of care will suffice to support authorization for personal care services, if signed by the DAAS RN. Eligibility for personal care services is based on the same criteria as state plan personal care services. Services are effective the date of the DAAS RN's signature on the waiver assessment tool or the waiver plan of care, whichever is the latter of the two. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver plan of care must include, at least, the information included on the DMS-618 that is utilized to support the medical necessity, eligibility and amount of personal care services provided through IndependentChoices or agency personal care services. This information is required in documentation whether or not an extension of benefits is requested. As with all required documentation, this information must be available in the participant's chart or electronic record and available for audit and Quality Management Strategy reviews.

TOC required

105.100 ARChoices 1-1-16

ARChoices is designed for beneficiaries ages 21 and older who, without the waiver's services, would require an intermediate level of care in a nursing home. Individuals ages 21 through 64 must have a physical disability as determined through Social Security Railroad Retirement or DHS's Medical Review Team. The services listed below are designed to maintain beneficiaries at home and preclude or postpone institutionalization.

A. Adult family home

B. Attendant care services

C. Home delivered meals

D. Personal emergency response system

E. Adult day services

F. Adult day health services

G. Respite care

H. Environmental accessibility/adaptations/adaptive equipment

ARChoices eligibility requires a determination of categorical eligibility, a determination of level of care, the development of a plan of care and a cost comparison to determine the cost-effectiveness of the plan of care. ARChoices requires notifying the beneficiary that he or she may freely choose between waiver services and institutional services.

Refer to the ARChoices provider manual for more detailed information.

124.230 Working Disabled 1-1-16

The Working Disabled category is an employment initiative designed to enable people with disabilities to gain employment without losing medical benefits. Individuals who are ages 16 through 64, with a disability as defined by Supplemental Security Income (SSI) criteria and who meet the income and resource criteria may be eligible in this category.

There are two levels of cost sharing in this aid category, depending on the individual's income:

A. Regular Medicaid cost sharing.

Beneficiaries with gross income below 100% of the Federal Poverty Level (FPL) are responsible for the regular Medicaid cost sharing (pharmacy, inpatient hospital and prescription services for eyeglasses). They are designated in the system as "WD RegCO."

B. New cost sharing requirements.

Beneficiaries with gross income equal to or greater than 100% FPL have cost sharing for more services and are designated in the system as "WD NewCo".

The cost sharing amounts for the "WD NewCo" eligibles are listed in the chart below:

Program Services	New Co-Payment*
ARChoices Waiver Services	None
Ambulance	$10 per trip

Program Services	New Co-Payment*
Ambulatory Surgical Center	$10 per visit
Audiological Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Child Health Management Services	$10 per day
Chiropractor	$10 per visit
Dental	$10 per visit (no co-pay on EPSDT dental screens)
Developmental Disability Treatment Center Services	$10 per day
Diapers, Underpads and Incontinence Supplies	None
Domiciliary Care	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Emergency Department: Emergency Services	$10 per visit
Emergency Department: Non-emergency Services	$10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals ages 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient	25% of the hospital's Medicaid per diem for the first Medicaid-covered inpatient day
Hospital: Outpatient	$10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per encounter, regardless of the number of services per encounter
Medical Supplies	None
Inpatient Psychiatric Services for Under Age 21	25% of the facility's Medicaid per diem for the first Medicaid-covered day
Outpatient Behavioral Health	$10 per visit

Program Services	New Co-Payment*
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Certified Nurse Midwife	$10 per visit
Orthodontia (not covered for individuals ages 21 and older)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of the first covered day's Medicaid inpatient per diem
Rural Health Clinic	$10 per core service encounter
Targeted Case Management	10% of Medicaid maximum allowable rate per unit
Occupational Therapy (Age 21 and older have limited coverage**)	$10 per visit
Physical Therapy (Age 21 and older have limited coverage**)	$10 per visit
Speech Therapy (Age 21 and older have limited coverage**)	$10 per visit
Transportation (non-emergency)	None
Ventilator Services	None
Visual Care	$10 per visit

*** Exception:** Cost sharing for nursing facility services is in the form of "patient liability" which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD beneficiaries (Aid Category 10) who temporarily enter a nursing home and continue to meet WD eligibility criteria will be exempt from the co-payments listed above.

**** Exception:** This service is NOT covered for individuals within the Occupational, Physical and Speech Therapy Program for individuals ages 21 and older.

NOTE: Providers must consult the appropriate provider manual to determine coverage and benefits.

172.100 Services not Requiring a PCP Referral 1-1-16

The services listed in this section do not require a PCP referral.

A. ARChoices waiver services

B. Anesthesia services, excluding outpatient pain management

C. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP)

D. Dental services

E. DDS Alternative Community Services (ACS) Waiver services

F. Developmental Day Treatment Clinic Services (DDTCS) core services

G. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS

H. Domiciliary care

I. Emergency services in an acute care hospital emergency department, including emergency physician services

J. Family Planning services

K. Gynecological care

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner.
2. Rehabilitative services for persons with mental illness (RSPMI Program) ages 21 or older, or for specified procedures for persons under age 21 as listed in the RSPMI provider manual, Section 216.000.
3. Rehabilitative Services for Youth and Children (RSYC) Program.

N. Obstetric (antepartum, delivery and postpartum) services.

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement.
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications.
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider.

O. Nursing facility services and intermediate care facility for mentally retarded (ICF/MR) services

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye

Q. Optometry services

R. Pharmacy services

S. Physician services for inpatients in an acute care hospital. This includes:

1. Direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and

2. Indirect care (pathology, interpretation of X-rays, etc.)

T. Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.

U. Physician visits (except consultations) in the outpatient departments of acute care hospitals:

1. Medicaid will cover these services without a PCP referral only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations.

2. Consultations require PCP referral.

V. Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid covers these services without a PCP referral only:

1. If the Medicaid beneficiary is enrolled with a PCP and

2. The services are within applicable benefit limitations.

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services

X. Transportation (emergency and non-emergency) to Medicaid-covered services

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity, or would create unnecessary hardship.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – All Providers**

EFFECTIVE DATE: **January 1, 2016**

SUBJECT: **Provider Manual Update Transmittal SecI-1-15**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
105.100	7-15-12	105.100	1-1-16
105.150	10-1-12	—	—
124.230	1-1-13	124.230	1-1-16
172.100	9-15-09	172.100	1-1-16

Explanation of Updates

Section 105.100 is updated to change the Alternatives for Adults with Physical Disabilities waiver and the ElderChoices waiver to the ARChoices waiver and to include current waiver services offered to eligible beneficiaries.

Section 105.150, ElderChoices, is removed.

Section 124.230 is updated to change the Alternatives for Adults with Physical Disabilities waiver services to ARChoices waiver services.

Section 172.100 is updated to change Alternatives for Adults with Physical Disabilities and ElderChoices waiver services to ARChoices waiver services.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – All Providers**

EFFECTIVE DATE: **January 1, 2016**

SUBJECT: **Provider Manual Update Transmittal SecV-6-15**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
500.000	—	500.000	—
—	—	DMS-690	1/16

Explanation of Updates

Section 500.000 is updated to add the Targeted Case Management Contact Monitoring Form (form DMS-690).

This transmittal and the enclosed form are for informational purposes only. **Please do not complete the enclosed form.**

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

SECTION V – FORMS

500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J430	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adverse Effects Form	DMS-2704

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	DMS-844
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	DMS-845
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	DMS-846
ARKids First Behavioral Health Services Provider Qualification Form	DMS-612
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693

Form Name	Form Link
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	Application Packet
Quarterly Monitoring Form	AAS-9506
Referral for Audiology Services – School-Based Setting	DMS-7783

Form Name	Form Link
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request for Molecular Pathology Laboratory Services	DMS-841
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Targeted Case Management Contact Monitoring Form	DMS-690
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-690
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-831
DMS-840
DMS-841
DMS-844
DMS-845
DMS-846
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Finance Administration, Sales and Tax Use Unit
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit
Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit

HP Enterprise Services Manual Order

HP Enterprise Services Provider Assistance Center (PAC)

HP Enterprise Services Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

First Connections Infant & Toddler Program, Developmental Disabilities Services, Appeals

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

Immunizations Registry Help Desk

Magellan Pharmacy Call Center

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Partners Provider Certification

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

Select Optical

Standard Register

Table of Desirable Weights

UAMS College of Pharmacy Evidence-Based Prescription Drug Program Help Desk

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

TOC required

200.100 IndependentChoices 1-1-16

The IndependentChoices program is a state plan service under 1915(j) of the Social Security Act. IndependentChoices is operated by the Division of Aging and Adult Services (DAAS). The program offers Medicaid-eligible individuals who are elderly and individuals with disabilities an opportunity to self-direct their personal assistant services.

IndependentChoices seeks to increase the opportunity for consumer direction and control for Medicaid beneficiaries receiving or needing personal assistant services. Personal Assistant services in IndependentChoices include state plan personal care for Medicaid beneficiaries and attendant care services for ARChoices beneficiaries in Homecare (ARChoices). IndependentChoices offers an allowance and counseling services in place of traditional agency-provided personal assistance services and items related to personal assistance needs.

The participant or designee is the employer and accepts the responsibility in directing the work of their employee to the degree necessary to meet their individual needs for assistance with activities of daily living and instrumental activities of daily living.

If the IC participant can make decisions regarding his or her care but does not feel comfortable reading and filling out forms or talking on the phone, he or she can appoint a Communications Manager. The Communications Manager can act as the participant's voice and complete and sign forms, but will not make decisions for the participant. The Communications Manager will not hire, train, supervise or fire the personal assistant for the IC participant.

If the participant needs someone to hire and supervise the personal assistant, make decisions about care and administer the cash expenditure plan as well as complete all forms, a Decision-Making Partner will be appointed.

IndependentChoices participants or their Decision-Making Partners must be able to assume the responsibilities of becoming an employer by hiring, training, supervising and firing if necessary their directly hired workers. In doing so the program participant accepts the risks, rights and responsibilities of directing their care and having their health care needs met.

The IndependentChoices program respects the employer authority of the participant who chooses to direct his or her care by hiring an employee who will be trained by the employer or Decision-Making Partner to provide assistance how, when, and where the employer or Decision-Making Partner determines will best meet the participant's individual needs. The Medicaid beneficiary assumes the risks, rights and responsibilities of having their health care needs met in doing so.

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

200.200 Eligibility 1-1-16

To be eligible for IndependentChoices, a participant must:

A. Be 18 years of age or older

B. Be eligible for Medicaid, as determined by the DHS Division of County Operations, in a category that covers personal care, or be eligible for Supplemental Security Income (SSI) through the Social Security Administration, or be eligible for ARChoices and determined in need of attendant care services or personal care by the DAAS Registered Nurse (RN).

C. Be receiving personal assistance services or be medically eligible to receive personal assistance services. Personal assistance services include state plan personal care and ARChoices attendant care services.

1. **Personal Care:** In determining eligibility and level of need for personal care, IndependentChoices follows policy found in the Arkansas Medicaid Personal Care Provider Manual.

2. **Attendant Care:** The DAAS RN must determine and authorize attendant care services based on ARChoices policy.

D. Not be living in a home or property owned, operated or controlled by a provider of services unless the provider is related by blood or marriage to the participant. This includes single family homes, group homes, adult family homes, congregate settings, a living situation sponsored or staffed by an agency provider, etc.

E. Be willing to participate in IndependentChoices and understand the rights, risks and responsibilities of managing his or her own care with an allowance; or, if unable to make decisions independently, have a willing representative decision-maker who understands the rights, risks and responsibilities of managing the care of the participant with an allowance.

202.300 Enrollment 1-1-16

The Division of Aging and Adult Services (DAAS) is the point of entry for all enrollment activity for IndependentChoices. The program is limited based on an approved number through the Medicaid State Plan.

The individual or their designee will first call the IndependentChoices toll-free number at 888-682-0044 or 866-710-0456. Information about the program is provided to the individual and verification made that the individual is currently enrolled in a Medicaid category that covers personal assistance services. If the individual is currently enrolled in an appropriate Medicaid category and has an assessed physical dependency need for “hands on” assistance with personal care needs, DAAS will enter the participant’s information into a DAAS database. If the individual is not currently enrolled in an appropriate Medicaid category, the individual will be referred to the DHS County Office for eligibility determination.

The IndependentChoices counselor, nurse and fiscal agent will then work with the individual to complete the enrollment forms either by mail and telephone contact or by a face-to-face meeting. The individual will be provided with a program manual, which explains the individual’s responsibilities regarding enrollment and continuing participation. The individual must complete the forms in the Enrollment Packet, which consists of the Participant Responsibilities and Agreement, the Backup Personal Assistant and the Authorization to Disclose Health Information. The individual must also complete the forms in the Employer Packet, which includes the Limited Power of Attorney, IRS and direct deposit forms related to being a household employer. Each personal assistant must complete the forms in the Employee Packet which include the standard tax withholding forms normally completed by an employee, the Employment Eligibility Verification Form (I-9), a Participant/Personal Assistant Agreement, Employment Application and a Provider Agreement. Each packet includes step-by-step instructions on how to complete the above forms. Assistance is available to the individual, Decision-Making Partner/Communications Manager and the personal assistant to help complete the forms and answer any questions.

As part of the enrollment process, the DAAS RN will complete an assessment using the Home and Community Based Services (HCBS) Level of Care Assessment Tool. The DAAS RN will determine, through the completed assessment and professional judgment, the level of medical necessity. This determination creates the budget for self-directed services. Eligibility for personal care services is based on the same criteria as state plan personal care services. **NOTE:** For ARChoices beneficiaries, the DAAS RN will determine the need for personal care and attendant care hours needed. The ARChoices plan of care will reflect that the beneficiary chooses IndependentChoices as the provider. DAAS-HCBS staff will obtain physician authorization for persons not receiving ARChoices waiver services.

After the in-home assessment, the DAAS RN will complete the paperwork and coordinate with the IndependentChoices counselor. The counselor will process all of the completed enrollment forms. The assessment is sent to the beneficiary's physician for authorization if the beneficiary is not authorized for services through a waiver plan of care for ARChoices. State and IRS tax forms will be retained by the fiscal agent. Disbursement of funds to a beneficiary or their employee will not occur until all required forms are accurately completed and in the possession of the fiscal agent.

Personal care assessments for beneficiaries aged 21 years or older and authorized by the beneficiary's physician in excess of 14.75 hours per week are forwarded to DAAS for coordination with Utilization Review in the Division of Medical Services for approval. **View or print Utilization Review contact information.** For beneficiaries under age 21, all personal care hours must be authorized through Medicaid's contracted Quality Improvement Organization (QIO). **View or print AFMC contact information.**

IndependentChoices follows the rules and regulations found in the Arkansas Medicaid Personal Care Provider Manual in determining and authorizing personal care hours. The initial authorization for personal assistance services may not begin until the beneficiary's primary care physician or an advanced practice nurse enrolled in the Arkansas Medicaid APN program seeing patients in an Arkansas Medicaid enrolled Rural Health Clinic or Federally Qualified Health Center signs and dates the Home and Community Based Services (HCBS) Level of Care Assessment Tool. For beneficiaries receiving services through the ARChoices waiver program, the APN or physician's signature is not required. The signature of the DAAS RN is sufficient to authorize personal care services. After the service plan is authorized, the actual day services begin is dependent upon all of the following conditions:

A. DAAS issues a seven-day notice to discontinue service to any agency personal care, ARChoices provider currently providing services to the individual.

B. The date the beneficiary's worker is able to begin providing the necessary care. It can be no earlier than the date the physician authorized the service plan for the non-waiver eligible participant, if an agency provider is not providing the personal care services.

C. The fiscal agent is in possession of all required employer and employee documents.

If the beneficiary is not a recipient of ARChoices services, then continuation of personal assistance services requires reauthorization prior to the end of the current service plan end date.

When required for non-waiver beneficiaries, the earlier of the two following conditions will suffice for the face-to-face visit required sixty days prior to the begin date of the new service plan:

A. The beneficiary's primary care physician or eligible nurse practitioner (as described in this manual) signature on the HCBS Level of Care Assessment Tool attests that he or she has examined the patient within the past 60 days.

B. The beneficiary has a face-to-face visit with their primary care physician or eligible nurse practitioner 60 days prior to the service plan begin date.

When the approval by Utilization Review is received, or the beneficiary needs 14.75 hours or less per week, the IndependentChoices Counselor will contact the beneficiary or Decision-Making Partner/Communications Manager to develop the cash expenditure plan. The Medicaid beneficiary as the employer and the counselor will determine when IndependentChoices services can begin, but may not commence prior to the date authorized by the physician. The beneficiary is required to have a face-to-face visit with their physician within 60 days of the date that the physician signs the Assessment Tool or 60 days prior to the service plan begin date and each subsequent reassessment. At no time will services begin prior to the first day of the previous month unless authorized by the Division of Aging and Adult Services.

The cash allowance allows the program participant to purchase those services that help the program participant receive assistance at times of the day that best meet his or her individual preferences. The allowance also supports the purchase of goods and services that lessen the need for human assistance while increasing the participant's ability to maintain independence in the community.

Primarily the allowance is used to pay the participant's employee's salary. The list of services listed below was developed by the IndependentChoices Advisory Committee comprised of representatives from Area Agencies on Aging, Department of Health, Spinal Cord Commission and advocates. Not all of these services are widely used, but the availability of these services on an individual basis has impacted the quality of life of individual program participants.

Following is a list of possible uses of the cash allowance:

A. Personal Assistance Services including personal care and attendant care services for ARChoices beneficiaries

B. Medical related transportation not provided through the Non-Emergency Transportation (NET) Waiver

C. Prescription Medication Not Covered by Insurance, Medicaid or Medicare Part D

D. Over-the-counter Drugs

E. Adaptive Equipment (Purchase or Rental)

F. Communication Devices

G. Discretionary Cash used to purchase personal hygiene items

H. Home Modifications

I. Emergency Food and Clothing

J. Safety Devices

K. Technology (Computers)

L. Environmental Equipment

M. Emergency Pest Control

N. Emergency Housing

O. Emergency Utilities

P. Education

Q. Service Animal Purchase and Maintenance

R. Other, with approval by the Division of Aging and Adult Services

220.210 Personal Care/Hospice Policy Clarification 1-1-16

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

A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication

and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in home providers.

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

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

Extension of benefits for personal care for beneficiaries receiving both hospice services and personal care services will be considered based on the individual beneficiary's physical dependency needs. Requests for increased personal care hours will be reviewed for medical necessity; duplication of services will be adjusted accordingly.

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

220.300 Attendant Care Services 1-1-16

In-home services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible participant's function in his or her own home. IndependentChoices allows ARChoices participants the choice of self-directed attendant care services rather than receiving attendant care services through a certified agency.

The DAAS RN will determine the number of hours of attendant care services needed by the participant as indicated on the ARChoices Plan of Care. If the participant chooses to self-direct attendant care services, the DAAS RN will refer the participant to the IndependentChoices program by sending the plan of care to IndependentChoices, notating that IndependentChoices was selected.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
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TO: **Arkansas Medicaid Health Care Providers – IndependentChoices**

EFFECTIVE DATE: **January 1, 2016**

SUBJECT: **Provider Manual Update Transmittal INCHOICE-2-15**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
200.100	1-1-13	200.100	1-1-16
200.200	1-1-13	200.200	1-1-16
202.300	7-1-15	202.300	1-1-16
220.100	11-1-09	220.100	1-1-16
220.210	1-1-13	220.210	1-1-16
220.300	1-1-13	220.300	1-1-16
220.400	1-1-13	—	—

Explanation of Updates

Sections 200.100, 200.200 and 220.100 are updated to change ElderChoices to ARChoices and to change adult companion services and homemaker services to attendant care services.

Section 202.300 is updated to change ElderChoices and Alternatives for Adults with Physical Disabilities to ARChoices.

Section 220.210 is updated to change homemaker services to attendant care services.

Section 220.300 is updated to change ElderChoices to ARChoices and homemaker services to attendant care services.

Section 220.400, Adult Companion Services, is removed.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – ARChoices In Homecare Home and Community-Based 2176 Waiver**

EFFECTIVE DATE: **January 1, 2016**

SUBJECT: **Provider Manual Update Transmittal ARCHOICES-NEW-15**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
——	——	ALL	1-1-16

Explanation of Updates

A new ARChoices In Homecare Home and Community-Based 2176 Waiver policy manual is available for all ARChoices providers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

SECTION II –ARCHOICES IN HOMECARE (ARCHOICES) HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER

CONTENTS

200.000 ARCHOICES IN HOMECARE (ARCHOICES) HCBS WAIVER PROGRAM GENERAL INFORMATION

201.000 Arkansas Medicaid Certification Requirements for ARChoices HCBS Waiver Program 1-1-16

All ARChoices Home and Community-Based Services (HCBS) Waiver providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

ARChoices HCBS Waiver providers must be 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 Hewlett Packard Enterprise Provider Enrollment Unit by submitting current certification, licensure, all DAAS-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider, etc.

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 Provider Certification. **View or print the Division of Aging and Adult Services Provider Certification contact information.** Payment cannot be authorized for services provided beyond the certification period.

201.100 Providers of ARChoices HCBS Waiver Services in Bordering and Non-Bordering States 1-1-16

An ARChoices provider must be physically located in the State of Arkansas or physically located in a bordering state and serving a trade-area city. The trade-area cities are limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas.

All providers must be licensed and/or certified by their states' appropriate licensing/certifying authorities. Copies of all appropriate licenses and certifications must be submitted to DAAS for certification as a potential ARChoices provider.

Arkansas Medicaid does not provide ARChoices Waiver services in non-bordering states.

201.105 Provider Assurances 1-1-16

A. Agency Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted an ARChoices Waiver Person-Centered Service Plan (PCSP).

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to an ARChoices beneficiary.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:
    a. Description of the purpose and philosophy of the ARChoices Waiver Program;
    b. Discussion and distribution of the provider agency's written code of ethics;
    c. Discussion of activities which shall and shall not be performed by the employee;
    d. Discussion, including instructions, regarding ARChoices Waiver record keeping requirements;
    e. Discussion of the importance of the PCSP;
    f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
    g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality;
    h. Discussion of the beneficiary's rights regarding HCBS Settings as discussed in 201.000.

B. Code of Ethics

The Provider agrees to follow and/or enforce for each employee providing services to an ARChoices Waiver beneficiary a written code of ethics that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized beneficiaries are to accompany the employee to beneficiary's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the beneficiary's residence;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

C. Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
    a. Choice must be identified/included in the person-centered service plan.
    b. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services and supports and who provides them.
5. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.
6. In a provider-owned or controlled residential setting (e.g., Adult Family Homes), in addition to the qualities specified above, the following additional conditions must be met:
    a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord

tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

b. Each individual has privacy in their sleeping or living unit:
   i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
   ii. Beneficiaries sharing units have a choice of roommates in that setting.
   iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

c. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.

d. Beneficiaries are able to have visitors of their choosing at any time.

e. The setting is physically accessible to the individual.

f. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
   i. Identify a specific and individualized assessed need.
   ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
   iii. Document less intrusive methods of meeting the need that have been tried but did not work.
   iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
   vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   vii. Include the informed consent of the individual.
   viii. Include an assurance that interventions and supports will cause no harm to the individual.

210.000 PROGRAM COVERAGE

211.000 Scope 1-1-16

The Arkansas Medical Assistance (Medicaid) Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to persons age 21 through 64 who are determined to have a physical disability through the Social Security Administration or the DHS Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or are 65 years of age or older and require an intermediate level of care in a nursing facility. The community-based services offered through the ARChoices Home and Community-Based Waiver, described herein as ARChoices, are as follows:

A. Adult Family Homes

B. Attendant Care Services

C. Home-Delivered Meals

D. Personal Emergency Response System

E. Adult Day Services

F. Adult Day Health Services

G. Respite Care

H. Environmental Accessibility Adaptations/Adaptive Equipment

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

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

212.000 Eligibility for the ARChoices Program 1-1-16

A. To qualify for the ARChoices Program, a person must be age 21 through 64 and who are determined to have a physical disability through the Social Security Administration or the DHS Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or be 65 years of age or older and require an intermediate level of care in a nursing facility. Persons determined to meet the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the ARChoices Program.

The beneficiary intake and assessment process for the ARChoices Program includes a determination of categorical eligibility, financial eligibility, a nursing facility level of care determination, the development of a PCSP and the beneficiary's notification of his or her choice between home and community-based services and institutional services.

B. Applicants for participation in the program (or their representatives) must make application for services at the DHS office in the county of their residence. Medicaid eligibility is determined by the DHS County Office and is based on non-functional and functional criteria. Income and resources comprise the non-functional criteria. The individual must be an individual with a functional need.

C. To be determined an individual with a functional need; an individual must meet at least one of the following three criteria, as determined by a licensed medical professional:

1. The individual is unable to perform either of the following:
    a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon another person; or
    b. At least 2 of the 3 ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or
2. Medical assessment results in a score of three or more on Cognitive Performance Scale; or
3. Medical assessments results in a Change in Health, End-Stage Disease and Signs and Symptoms (CHESS) score of three or more.
4. Definitions:
    a. CHESS means the changes in Health, End-Stage Disease, Signs and Symptoms Scale was designed to identify individuals at risk of serious decline. It can serve as an outcome where the objective is to minimize problems related to declines in function, or as a pointer to identify persons whose conditions are unstable.

    CHESS, originally developed for use with nursing home residents, has been

adapted for use with other instruments in the interRAI suite. It creates a 6- point scale from 0 = not at all unstable to 5 = highly unstable, with higher levels predictive of adverse outcomes such as mortality, hospitalization, pain, caregiver stress and poor self-rated health. (RE: **http://www.interrai.org/scales.html**)

b. COGNITIVE PERFORMANCE SCALE (CPS) combines information on memory impairment, level or consciousness and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment). The CPS has been shown to be highly correlated with the MMSE in a number of validation studies. (RE: **http://www.interrai.org/scales.html**)

c. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.

d. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.

e. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.

f. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.

g. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.

h. MENTAL RETARDATION means a level of retardation as described in the American Association on Mental Retardation's Manual on Classification on Mental Retardation. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals.

i. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals.

j. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.

   i. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.

   ii. Intravenous injections and hypodermoclysis or intravenous feedings.

   iii. Levin tubes and nasogastric tubes.

   iv. Nasopharyngeal and tracheostomy aspiration.

   v. Application of dressings involving prescription medication and aseptic techniques.

vi. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.

vii. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.

viii. Initial phases of a regimen involving administration of medical gases.

ix. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.

x. Ventilator care and maintenance.

xi. The insertion, removal and maintenance of gastrostomy feeding tubes.

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

l. TOILETING means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.

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

n. TRANSFERRING means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.

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

F. Eligibility for the ARChoices Waiver program is determined as the latter of the date of application for the program or the date the PCSP 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 ARChoices Waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once beneficiaries meet all functional and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:

1. Each ARChoices application will be accepted and medical and financial eligibility will be determined.
2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled and that the applicant is number X in line for an available slot.
3. Entry to the waiver will then be prioritized based on the following criteria:
   a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;
   b. Waiver application determination date for persons being discharged from a nursing facility after a 90- day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;
   c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
   d. Waiver application determination date for all other persons.

212.100 Reserved 1-1-16

212.200 Level of Care Determination 1-1-16

To be determined eligible for the ARChoices Waiver, an applicant 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 individual's level of care need.

The intermediate level of care determination is based on the comprehensive assessment performed by the DAAS RN, using standard criteria for functional need in evaluating an individual's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance with nursing home admission criteria, must be completed and the individual deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving ARChoices services.

The DAAS RN performs a comprehensive assessment at least annually. The results of the level of care determination and the reevaluation are documented on form DHS-704, Decision for Nursing Home Placement.

Providers may submit relevant medical, social and personal information concerning beneficiaries to the DAAS RN prior to reassessments. Providers may upload information to **http://www.daas.ar.gov/provrequest.html** so that it can be received immediately by the appropriate DAAS RN. It is up to providers to submit the information in a timely manner. DAAS RNs schedule reassessments 6 to 10 weeks ahead of the expiration date. To ensure that the DAAS RN receives the information prior to the reassessments, providers need to submit the information no later than 12 weeks prior to the expiration date of the PCSP. DAAS will not provide providers with any special alerts or reminders of the expiration date. It is up to the provider to keep track of this date and submit the information in a timely manner.

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 ARChoices program and is receiving services suitable to his or her needs.

212.300 Person-Centered Service Plan (PCSP) 1-1-16

A. Each beneficiary in the ARChoices program must have an individualized ARChoices PCSP. The authority to develop an ARChoices PCSP is given to the Medicaid State agency's designee, the Division of Aging and Adult Services Registered Nurse (DAAS RN). At the discretion of the beneficiary, the ARChoices PCSP is developed with the ARChoices beneficiary, representative, the participant's family or anyone requested by the participant, including the provider, if requested by the beneficiary. At the request of the beneficiary or their representative, the DAAS RN can assist in coordinating and inviting any requested beneficiaries.

B. When developing the waiver PCSP, the beneficiary may freely choose a family member or individual to appoint as a representative. The beneficiary and representative may participate in all decisions regarding the types, amount and frequency of services included in the PCSP. The representative may participate in choosing the provider(s) for the beneficiary. If anyone other than the beneficiary chooses the provider, the DAAS RN will identify that individual on the PCSP. Should the self-directed service delivery model be selected by an individual other than the beneficiary, that individual may not be the paid employee for one year unless the DAAS approves a release based upon extenuating circumstances and in the best interest of the beneficiary.

C. The ARChoices PCSP developed by the DAAS RN includes, but is not limited to:

1. Beneficiary identification and contact information, including full name and address, phone number, date of birth, Medicaid number and the effective date of ARChoices Waiver eligibility;
2. Primary and secondary diagnosis;
3. Contact person;
4. Physician's name and address;
5. The amount, frequency and duration of ARChoices Waiver services to be provided and the name of the service provider chosen by the beneficiary or representative to provide the services. **Note: There will not be a frequency ordered with Attendant Care. The monthly hours will be established using the RUG score. The provider and client will establish the frequency.**
6. Other services outside the ARChoices services, regardless of payment source, identified and/or ordered to meet the beneficiary's needs including the option for the self-directed service delivery model;
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 PCSP.

D. If waiver eligibility is approved by the DHS county office, a copy of the PCSP signed by the DAAS RN and the waiver beneficiary or representative, will be forwarded to the beneficiary or representative and the Medicaid enrolled service provider(s) included in the PCSP. The service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Services cannot begin until the Medicaid provider receives the authorized PCSP from the DAAS RN. The original PCSP will be maintained by the DAAS RN.

The implementation of the PCSP by a provider must ensure that services are:

1. Individualized to the beneficiary's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the beneficiary's welfare;

4. Monitored and adjusted as needed, based on changes authorized and reported by the DAAS RN regarding the waiver PCSP;
5. Provided within a system that safeguards the beneficiary's rights to quality services as authorized on the waiver PCSP; and,
6. Documented carefully, with assurance that required information is recorded and maintained.

NOTE: Each service included on the ARChoices PCSP must be justified by the DAAS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DAAS RN.

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

NOTE: PCSPs are updated annually by the DAAS RN and sent to the ARChoices provider prior to the expiration of the current PCSP. However, the provider has the responsibility for monitoring the PCSP expiration date and ensuring that services are delivered according to a valid PCSP. At least 30 and no more than 45 days before the expiration of each PCSP, the provider shall notify the DAAS RN via email and copy the RN supervisor of the PCSP expiration date.

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

REVISIONS TO A BENEFICIARY PERSON-CENTERED SERVICE PLAN MAY ONLY BE MADE BY THE DHS RN.

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

212.305 Targeted Case Management Services (Non-Waiver Service) 1-1-16

Each ARChoices PCSP will include Targeted Case Management, unless refused by the waiver beneficiary. The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in their service need, referring the beneficiary for reassessment, if necessary, and reporting any beneficiary complaints and changes in status to the DAAS RN or Nurse Manager immediately upon learning of the change.

NOTE: As stated in this manual, the service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Each service included on the ARChoices PCSP must be justified by the DAAS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DAAS RN.

For ARChoices beneficiaries whose waiver PCSP includes TCM at the time the DAAS RN signs the PCSP, the ARChoices PCSP, signed by a DAAS RN, will serve as the authorization for TCM services for one year from the date of the DAAS RN's signature, as described above.

212.310 Provisional Person-Centered Service Plan (PCSP) 1-1-16

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

The provisional PCSP will include all current PCSP information, except for the waiver eligibility date and the Medicaid beneficiary ID number.

The provisional PCSP will be mailed to the waiver applicant and each provider included on the PCSP. If the beneficiary and the provider accept the risk of ineligibility, the provider must begin services within an established time frame as determined by the Division of Aging and Adult Services (DAAS) and notify the DAAS RN, via Start Services form AAS-9510, that services have started. The DAAS RN will track the start of care dates and give the applicant options when services are not started.

The provisional PCSP will expire 60 days from the date signed by the applicant and the DAAS RN. A PCSP that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional PCSP.

A. A provisional PCSP may be developed and sent to providers only when the assessment outcome indicates functional eligibility and the DAAS RN believes, in his or her professional judgment, that the applicant meets the level of care criteria for an adult with a functional need, as explained in Section 212.000, Eligibility for the ARChoices Program.

   The waiver eligibility date will be established retroactively, effective on the day the provisional PCSP was signed by the applicant or applicant's representative and the DAAS RN, if:

   1. At least one waiver service begins within 30 days of the development of the provisional PCSP

      AND

   2. The waiver application is approved by the Division of County Operations.

B. If waiver services begin within 31 through 60 days of the development of the provisional PCSP, the retroactive eligibility date will be the effective date that a waiver service is started.

C. If waiver services do not begin within 60 days from the date the provisional PCSP is signed by the DAAS 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.

D. Provisional Person-Centered Service Plans may not include the non-waiver self-directed service delivery model.

212.311 Denied Eligibility Application 1-1-16

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 DAAS RN. The 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 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 ARChoices Waiver charges, Medicaid coverage will begin on the date of the appeal decision. However, the waiver portion of the case will not be approved until the date the DHS county office completes the case.
2. If the individual has unpaid waiver charges and services were authorized by the 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 PCSP is signed by the DAAS RN and the applicant or the applicant's representative, whichever is later.

212.312 Comprehensive Person-Centered Service Plan (PCSP) 1-1-16

Prior to the expiration date of the provisional PCSP, the DAAS RN will send the comprehensive PCSP to the waiver beneficiary and all providers included on the PCSP. The comprehensive PCSP will replace the provisional PCSP. The comprehensive PCSP will include the Medicaid beneficiary ID number, the waiver eligibility date established according to policy and the comprehensive PCSP expiration date.

The comprehensive PCSP expiration date will be 365 days from the date of the DAAS RN's signature on form AAS-9503, the ARChoices PCSP. Once the application is either approved or denied by the DHS county office, the providers will be notified by the DAAS RN. The notification for the approval will be in writing via a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.

212.313 ARChoices Applicants Leaving an Institution 1-1-16

The policy regarding retroactive eligibility applies to applicants entering the waiver program from the community and to applicants entering the program from an institution. The same process and the same policy determining the waiver eligibility date will apply to applications of each type.

EXCEPTION: No waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a provisional PCSP is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest waiver eligibility date will be the day the applicant is discharged from the facility.

NOTE: For inpatients, if a waiver application is filed at the local DHS county office prior to discharge AND if a provisional PCSP is developed by the 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. (Note: Medicaid beneficiaries in nursing facilities do not have to complete a new application when applying for ARChoices. Their signature on the PCSP electing waiver services serves as the application.)

If no waiver application is filed and no functional assessment or provisional PCSP is completed by the 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.

Functional assessments and PCSPs may be completed during a period of institutionalization; however, a discharge date must be scheduled. Since the purpose of the assessment and the PCSP is to depict the applicant's condition and needs in the home, premature assessments and PCSP development do not meet the intent of the program.

This policy applies to applicants leaving hospitals or nursing facilities.

212.314 Optional Participation 1-1-16

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 PCSP, it is the responsibility of each provider to explain the process and financial liability to the applicant and/or 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 PCSP will only be utilized on a current waiver application. Once an application is denied, a new provisional PCSP must be developed if a subsequent waiver application is filed.

212.320 Authorization Of The ARChoices Person-Centered Service Plan (PCSP) with Personal Care Services 1-1-16

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

A. The DAAS RN is responsible for developing an ARChoices PCSP that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DAAS RN authorizing the services.

B. The ARChoices PCSP signed by the DAAS RN will suffice as the "Personal Care Authorization" for services required in the Personal Care Program. The personal care service plan developed by the Personal care provider is still required.

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

NOTE: For ARChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a DAAS 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. The ARChoices PCSP is effective for one year, once signed by the DAAS RN; the authorization for personal care services, when included on the ARChoices PCSP, will be for one year from the date of the DAAS RN's signature, unless revised by the DAAS RN. If personal care services continue unchanged as authorized on the ARChoices PCSP, a new service plan is not required at the 6-month interval.

NOTE: It is the personal care provider's responsibility to place information regarding the agency's presence in the home in a prominent location so that the DAAS RN will be aware that the provider is serving the beneficiary.

Preferably, the provider will place the information atop the refrigerator or under the phone the beneficiary uses, unless the beneficiary objects. If so, the provider will place the information in a location satisfactory to the beneficiary, as long as it is readily available to and easily accessible by the DAAS RN.

212.322 Revisions when the Person-Centered Service Plan (PCSP) Contains Personal Care Services 1-1-16

Requested changes to the personal care services included on the ARChoices PCSP may originate with the personal care RN or the DAAS RN, based on the recipient's circumstances. Unless requested by an IndependentChoices beneficiary, the individual or agency requesting revisions to the Personal Care services on the ARChoices PCSP is responsible for securing any required signatures authorizing the change prior to the ARChoices PCSP being revised. 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 ARChoices PCSP and a Start of Care Form (AAS-9510) will be mailed to the personal care provider within 10 working days after being revised. If authorization is secured by the Personal Care agency, a copy of the revised personal care order, signed by the physician, must be sent to the DAAS RN prior to implementing any revisions. Once received, the ARChoices PCSP will be revised accordingly within 10 days of its receipt. If any problems are encountered with implementing the requested revisions, the DAAS RN will contact the personal care provider to discuss possible alternatives. These discussions and the final decision regarding the requested revisions must be documented in the nurse narrative. The final decision rests with the DAAS RN.

212.323 Medicaid Audit Requirements 1-1-16

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

212.324 Personal Care/Hospice Policy Clarification 1-1-16

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

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

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

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

Extension of benefits for personal care for beneficiaries receiving both hospice services and personal care services will be considered based on the individual beneficiary's physical dependency needs. Requests for increased personal care hours will be reviewed for medical necessity; duplication of services will be adjusted accordingly.

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

212.400 Temporary Absences from the Home 1-1-16

Once an ARChoices eligibility application has been approved, waiver services must be provided in a home and community-based services setting for eligibility to continue. Unless stated otherwise below, the county Department of Human Services (DHS) office must be notified immediately by the 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 DAAS RN.

A. Absence from the Home due to Institutionalization

An individual cannot receive ARChoices Waiver services while in an institution. The following policy applies to any inpatient stay where Medicaid pays the facility for the date of admission, i.e., hospitals, nursing homes, rehab facilities, etc., for active waiver cases when the beneficiary is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver beneficiary is admitted to a hospital, the 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 ARChoices beneficiaries admitted to a nursing facility to receive facility-based respite services.

NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.

Payment for ARChoices services may be allowed for the date of a beneficiary's admission to an inpatient facility if the provider can provide verification that services were provided before the beneficiary was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:

- **Copies of claim forms or timesheets listing the times that services were provided**
- **A statement from the inpatient facility showing the time that the beneficiary was admitted**
- **This information must be submitted to DAAS within 10 working days of receiving a request for verification.**

If providers are unable to provide proof that ARChoices services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. ARChoices services provided on the same day the beneficiary is discharged from the inpatient facility are billable when provided according to policy and after the beneficiary was discharged.

B. Absence due to Reasons Other than Institutionalization

When a waiver beneficiary is absent from the home for reasons other than institutionalization, the 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 OCSO (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.

212.500 Reporting Changes in Beneficiary's Status 1-1-16

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

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

212.600 Relatives Providing ARChoices Services 1-1-16

All ARChoices services, except for Adult Family Homes, may be provided by a beneficiary's relative, unless stated otherwise in this manual. No Adult Family Home provider, employee or family member of the provider may be related to the Adult Family Home waiver beneficiary.

For the purposes of this section, a relative or family member shall be defined as all persons related to the beneficiary by virtue of blood, marriage, or adoption. The following is applicable for all waiver services:

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 ARChoices provider certification requirements, Arkansas Medicaid enrollment requirements and provide services according to the beneficiary's PCSP and any established benefit limits for that specific service.

213.000 Description of Services

213.100 Adult Family Homes 1-1-16

Procedure Code	Modifier	Description
S5140	U1	Adult Family Homes Level A
S5140	U2	Adult Family Homes Level B
S5140	U3	Adult Family Homes Level C

Adult Family Homes services are personal care and supportive services (e.g., attendant care, transportation and medication oversight (to the extent permitted under State Law)), provided in a certified private home by a principal care provider who lives in the home.

Payment for Adult Family Home services is not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for Adult Family Home services does not include payments made, directly or indirectly, to members of the beneficiary's immediate family.

Adult Family Home services provide a family living environment for adults who are functionally impaired and who, due to the severity of their functional 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.

The number of beneficiaries served by an Adult Family Home may not exceed three (3) and beneficiaries must be unrelated to the adult family home provider. "Unrelated" is defined as any person who is not related to the provider by virtue of blood, marriage, or adoption. Other than the Adult Family Home provider, immediate family members or caregivers residing in the adult family home with the waiver beneficiary are prohibited from receiving Medicaid reimbursement for direct provision of any ARChoices services.

Adult Family Home services shall be included in the PCSP 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 beneficiary in the life of the family as much as possible. The provider must assist the beneficiary in becoming or remaining active in the community.

Services must be provided according to the participant's written ARChoices PCSP.

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

One (1) unit of service equals one (1) day. Adult Family Homes are limited to a maximum of thirty-one (31) units per month. Room and board costs are not included as a part of this service. Service payments are for the provision of daily living care to the beneficiary.

For any given year of the ARChoices Waiver, Adult Family Homes shall charge waiver residents no more than 90.8% of the current Individual SSI Benefit amount rounded to the nearest dollar for room and board. For any given year of the ARChoices Waiver, ARChoices Waiver beneficiaries shall receive 9% of the current Individual SSI Benefit amount rounded to the nearest dollar for personal needs allowance.

The waiver eligible person will cover the cost of room and board in the Adult Family Home. In addition, the DHS County Office will determine individual liability for care services based on the waiver eligible person's available resources. Medicaid will cover the remaining cost of waiver services provided to the waiver eligible person. The personal needs allowance is adequate to meet the other expenses of the waiver eligible person in the Adult Family Home and exceeds the personal needs allowance for beneficiaries in long term care facilities.

The Adult Family Home waiver beneficiary may receive up to 600 hours (2,400 units) of long-term facility-based respite per state fiscal year. The service of Adult Family Home is not allowed on the same date of service as respite service.

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

213.110 Adult Family Homes Certification Requirements 1-1-16

Enrollment as an ARChoices Adult Family Homes provider requires certification by the Department of Human Services, Division of Aging and Adult Services (DAAS), as an Adult

Family Home. Adult Family Homes providers must complete an application packet, including Medicaid Provider forms; be tested over designated training materials and achieve a passing score and submit the home for inspection by designated DAAS staff. If substitute caregivers are identified, these beneficiaries must meet the same training and testing requirements as the Adult Family Homes provider. In addition, drug screens and background checks are required for the provider, substitute care givers and provider family members residing in the home and who are over the age of sixteen. Providers must recertify with DAAS annually. This requires submission of a renewal application packet and home inspection, as well as documentation of at least twelve hours of related training activities.

An Adult Family Home, for the purpose of the ARChoices Program, does not include any house, institution, hotel or other similar living situation that supplies room and board only, room only, or board only.

As a condition of certification, each Adult Family Homes provider shall execute with and provide to each beneficiary an admission agreement specifying services to be provided, the beneficiary's cost for room and board, conditions and rules governing the beneficiary and grounds for termination of residency. Each Adult Family Homes provider will also be required to develop and maintain written program policies. Program policies must include and comply with the HCBS Settings rules found in section 201.000.

NOTE: The Adult Family Home provider's ElderChoices certification will be valid as an ARChoices Adult Family Home provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

NOTE: At the next annual certification, the Adult Family Home provider must have policies in place that include and comply with the HCBS Settings rules found in section 201.000.

213.210 Attendant Care Services 1-1-16

Procedure Code	Modifier	Description
S5125	U2	Attendant Care Services
S5125		Attendant Care Self-Directed Model

Attendant Care services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible beneficiary's functioning in his or her own home or elsewhere in the community where the beneficiary engages in activities, including work-related activities.

Attendant care services consists of assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks through hands-on assistance, supervision and/ or cueing.

Hands-on assistance, supervision and/or cueing are defined as:

A. "Hands-on assistance" means a provider physically performs all or part of an activity because the individual is unable to do so.

B. "Set-up", a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.

C. "Supervision" means a provider must be near the individual to observe how the individual is completing a task.

D. “Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the individual complete activities without hands-on assistance.

E. "Monitoring", a form of supervision, means a provider must observe the individual to determine if intervention is needed.

F. “Stand-by", a form of supervision, means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

G. "Support", a form of supervision, means to enhance the environment to enable the individual to be as independent as possible.

H. The following forms of assistance combine elements of Hands-on assistance, supervision and/or cueing:

I. "Redirection”, a form of supervision or cueing, means to divert the individual to another more appropriate activity.

J. “Memory care support”, a blend of supervision, cueing and hands-on assistance. Includes services related to observing behaviors, supervision and intervening as appropriate in order to safeguard the service beneficiary against injury, hazard or accident. These specific supports are designed to support beneficiaries with cognitive impairments.

Activities of daily living include:

A. Eating

B. Bathing

C. Dressing

D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, etc.)

E. Toileting

F. Mobility/ambulating, including mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

A. Meal planning and preparation

B. Managing finances

C. Laundry

D. Shopping and errands

E. Communication

F. Traveling and participation in the community

G. Light housekeeping: attendant services and supports may include Homemaker services that consist of general household tasks and are intended to ensure that the individual’s home is safe and allows for independent living. Examples of “general household tasks” may include, but are not limited to, meal preparation, routine household care and laundry.

H. Chore services

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

The provision of ADLs and IADLs does not entail nursing care.

Beneficiaries may choose to self-direct this service through Arkansas's IndependentChoices program under 1915(j) authority; or may receive services through an agency. The IndependentChoices Medicaid Provider Manual describes the self-directed service delivery model.

Attendant Care services must be provided according to the beneficiary ARChoices written PCSP.

A brief description of the service(s) provided, including the signature and title of the individual rendering the service, must be documented in the beneficiary's case record. See Section 214.000 for additional documentation requirements.

Benefit limits will be determined on a client basis based on the assessed level of need by the DAAS RN. The highest RUG level allows a maximum allocation of 81 hours per week (324 units), 359 hours per month (1,436 units), or 4,212 hours per year (16,848 units).

Fifteen (15) minutes of service equals one (1) unit.

An ARChoices beneficiary who spends more than five (5) hours (20 units) at an adult day services or adult day health services facility or who is receiving short-term, facility-based respite care will not be eligible for attendant care services on the same date of service unless authorized by the DAAS RN.

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

213.230 Attendant Care Services Certification Requirements 1-1-16

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

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

B. Employ and supervise direct care staff who:

1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
2. Possess the necessary skills to perform the specific services required to meet the needs of the beneficiary the direct care staff member is to serve; and
3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and DAAS certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DAAS every three years; however, the provider must submit a copy the agency's current license to DAAS each year when the license is renewed.

Providers are required to submit copy of renewed license to DAAS.

NOTE: The Class A, Class B or Private Care Agency license provider's ElderChoices and AAPD certification will be valid as an Attendant Care services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices and AAPD.

213.240 Environmental Accessibility Adaptations/Adaptive Equipment 1-1-16

Environmental Accessibility Adaptations/Adaptive Equipment services enable the individual to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise. Environmental Accessibility Adaptations/Adaptive Equipment is physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, to function with greater independence in the home and preclude or postpone institutionalization. Adaptive equipment also enables the Alternatives beneficiary to increase, maintain and/or improve his/her functional capacity to perform daily life tasks that would not be possible otherwise and perceive, control or communicate with the environment in which he or she lives.

Excluded are adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes. All dwellings that receive adaptations must be in good repair and have the appearance of sound structure.

Permanent fixtures are not allowed on rented or leased properties.

213.250 Benefit Limit - Environmental Accessibility Adaptations/Adaptive Equipment 1-1-16

The overall cap for Environmental Accessibility Adaptations/Adaptive Equipment is $7,500 per the lifetime of the eligible waiver beneficiary, including this service if received under the Alternatives for Adults with Physical Disabilities (AAPD) waiver. If a waiver beneficiary is receiving Environmental Accessibility Adaptations and Adaptive Equipment, the combined cost cannot exceed the $7,500 overall cap. A waiver beneficiary may access through the waiver several occurrences of Environmental Accessibility Adaptations or for several items of Adaptive Equipment over a span of years, or he/she may access the whole $7,500 at one time. Once the $7,500 per eligible beneficiary is reached, no further Environmental Accessibility Adaptations/Adaptive Equipment can be accessed through the waiver by the eligible waiver beneficiary during his/her remaining lifetime.

213.260 Examples of Acceptable Environmental Accessibility Adaptations/Adaptive Equipment 1-1-16

Acceptable environmental accessibility adaptations/adaptive equipment must be necessary for the welfare of the beneficiary and may include, but are not limited to:

A. Installing and/or repairing ramps and grab-bars

B. Widening doorways

C. Modifying bathroom facilities

D. Installing specialized electronic and plumbing systems

E. Installing an electrical entry door to the home – if based on need and accessibility

F. Installing overhead tracks for transferring

G. Durable Medical Equipment not payable by Medicare/Medicaid

H. Generators for ventilator-dependent beneficiaries

213.270 Examples of Unacceptable Environmental Accessibility Adaptations/Adaptive Equipment 1-1-16

Unacceptable environmental accessibility adaptations/adaptive equipment to the home include, but are not limited to:

A. Those that are of general utility

B. Those not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

C. Those that add to the total square footage of the home

D. Purchase of any vehicle, such as automobile/van, regardless of previously installed modifications or adaptations

E. Vehicle modifications or purchase of a vehicle

F. Replacement of all carpeting when door widening is completed

G. Repairs or updates necessary in order to complete the environment accessibility adaptations/adaptive equipment

Examples:

1. In order to install a ramp, repairs to the porch or deck must be made to support the ramp. The ramp could be approved; the repairs to the existing porch or deck could not be approved.
2. Bathroom needs adaptation to install a new commode for disabled individual. In order to replace the commode, the flooring must be replaced due to dry rot or decay. The new commode could be approved. The sub-flooring, etc., could not be approved.

H. Permanent fixtures to leased or rented homes.

213.280 Provider Qualifications Environmental Accessibility Adaptations/Adaptive Equipment 1-1-16

Individuals or businesses seeking certification by the Division of Aging and Adult Services and enrollment as Medicaid providers of environmental accessibility adaptations/adaptive equipment services must meet the following criteria:

A. The provider of services must be a builder, tradesman or contractor.

B. The provider must be licensed (where applicable) as appropriate for home improvement contracting or adaptation and equipment provided.

C. The provider must certify that his or her work meets state and local building codes.

D. The provider must obtain all applicable permits.

E. The provider must be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines.

F. Contractors are required to adhere to the Uniform Federal Accessibility Standards.

NOTE: All environmental modifications requiring electrical or plumbing work must be completed by a licensed professional. If a contractor subcontracts with an electrician or plumber, the contractor must submit a copy of the subcontractor's license with the claim form.

213.290 Environmental Modifications/Adaptive Equipment 1-1-16

Prior to payment for this service, the waiver beneficiary is required to secure 3 separate itemized bids for the same service. The bids are reviewed by the DAAS RN or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided.

Each claim must be signed by the provider, the waiver beneficiary and DAAS RN, or designee. A statement of satisfaction form must be signed by the waiver beneficiary prior to any claim being submitted.

Note: The Environmental Modification provider's AAPD certification will be valid as an ARChoices Environmental Modification provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under AAPD.

213.310 Hot Home-Delivered Meals 1-1-16

Hot Home-Delivered Meals provide one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with the DAAS Nutrition Services Program Policy Number 206.

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible beneficiaries who are homebound. Homebound is defined as a person with normal inability to leave home without assistance (physical or mental) from another person; a person who is frail, homebound by reason of illness or incapacitating disability or otherwise isolated; or for whom leaving home requires considerable and taxing effort by the individual and absences from the home are infrequent, relatively short in duration or are attributable to the need to receive medical treatment.

Additionally, the beneficiary must:

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

B. Have no other individual to prepare his or her own meals; and

C. Have the provision of the Home-Delivered Meals included on his or her PCSP.

The provision of a Home-Delivered Meal is the most cost-effective method of ensuring a nutritiously adequate meal.

The Home-Delivered Meals provider must maintain a log sheet signed by the beneficiary that includes date and time of delivery each time a meal is delivered to document receipt of the meal.

Hot Home-Delivered Meals must be provided according to the beneficiary's written ARChoices PCSP.

Procedure Code	Required Modifier	Description
S5170	U2	Hot Home-Delivered Meal
S5170	—	Frozen Home-Delivered Meal
S5170	U1	Emergency Home-Delivered Meal

213.311 Hot Home-Delivered Meal Provider Certification Requirements 1-1-16

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 DAAS RN immediately if:

1. There is a problem with delivery of service
2. The beneficiary is not consuming the meals
3. A change in the individual's condition is noted

NOTE: Changes in service delivery must receive prior approval by the DAAS RN who is responsible for the individual's PCSP. Requests must be submitted in writing to the DAAS RN. Any changes in the individual's circumstances must be reported to the 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 beneficiaries receiving only the weekend Frozen Home-Delivered Meals service.

NOTE: This requirement DOES NOT apply to those ARChoices beneficiaries whose ARChoices PCSP includes attendant care services or personal care services at least three (3) times per week.

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

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.

NOTE: The Home-Delivered Meals provider's ElderChoices certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.320 Frozen Home-Delivered Meals 1-1-16

Frozen Home-Delivered Meals service provides one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with DAAS Nutrition Services Program Policy Number 206.

The goal of the Frozen Home-Delivered Meals service is to supplement, not replace, the Hot Home-Delivered Meal service by providing one daily nutritious meal to homebound persons at risk of being institutionalized who:

A. Reside in remote areas where daily hot meals are not available;

B. Choose to receive a frozen meal rather than a hot meal; or

C. Are at nutritional risk and are certified to receive a meal for use on weekends or holidays when the hot meal provider is not in operation.

NOTE: While the individual has freedom of choice regarding this service, it is the responsibility of the DAAS RN developing the PCSP to ensure the appropriateness of the service. A hot meal delivered daily remains the food service of choice, when available. Therefore, a frozen meal must be approved by the DAAS RN. The service must be included on the PCSP. If the individual responsible for developing the PCSP does not think the frozen meals are appropriate for the individual, other options will be considered. Those options include removing the Home-Delivered Meal service rather than authorizing a frozen meal.

It is the certified provider's responsibility to deliver the meals regardless if they are hot or frozen. Meals may not be left on the doorstep. The meals cannot be mailed to the individual via United States Postal Service or delivered by paid carrier such as Fed Ex or UPS.

213.321 Beneficiary Requirements for Frozen Home-Delivered Meals 1-1-16

The beneficiary must:

A. Be homebound, which is defined by the following requirements:

1. The person is normally unable to leave home without assistance (physical or mental) from another person;
2. The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
3. Leaving home requires considerable and taxing effort by the individual; and
4. Absences of the individual from home are infrequent, of relatively short duration or attributable to the need to receive medical treatment.

B. Be unable to prepare some or all of his or her meals or require a special diet and be unable to prepare it.

C. Have no other individual available to prepare his or her meals and the provision of a Frozen Home-Delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal.

D. Have adequate and appropriate storage and be able to perform the simple tasks associated with storing and heating a Frozen Home-Delivered Meal or have made other appropriate arrangements approved by DAAS.

E. Have the provision of frozen meals included on his or her PCSP as developed by the appropriate DAAS RN.

Frozen Home-Delivered Meals must be documented on the ARChoices PCSP by the DAAS RN and must be provided in accordance with the beneficiary's written ARChoices PCSP.

213.322 Reserved 1-1-16

213.323 Frozen Home-Delivered Meal Provider Certification Requirements 1-1-16

In order to become approved providers of frozen meals, 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 ARChoices 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 beneficiary; and
9. Are discarded after 30 days.

H. Verify quarterly that all beneficiaries receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks unless other appropriate arrangements have been made and approved by DAAS. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.

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

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

NOTE: This requirement DOES NOT apply to those ARChoices beneficiaries whose ARChoices PCSP includes Attendant Care 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 PCSP 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.

NOTE: The Home-Delivered Meals ElderChoices provider's certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

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).

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 beneficiary receives Attendant Care services or Personal Care at least three (3) times per week;

B. Frozen Home-Delivered Meals are ordered on the PCSP; and

C. The waiver beneficiary has the means of storing 14 frozen meals as verified by the DAAS RN.

   Home-Delivered Meal providers delivering frozen meals may deliver 14 at one time if the DAAS RN enters 14 meals delivery approved in the comments section of the HDM entry on the PCSP. If this statement is not on the PCSP, or if any of the other factors above are not in place, the meal providers cannot deliver more than seven (7) meals at one time.

An ARChoices individual may not be provided with a Hot or Frozen 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 Services or Adult Day Health Services. (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 beneficiaries who are also attending Adult Day Services, Adult Day Health Services, or facility-based Respite care for more than five (5) hours. When applying this policy, the time of day the beneficiary receives day services or respite services 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 Adult Day Services, Adult Day Health Services or facility-based Respite services, on a specific date of service, the following must be applied:

If an ARChoices beneficiary is receiving Adult Day Services, Adult Day Health Services or facility-based Respite at any time between the hours of 11:00 a.m. and 1:30 p.m. **and** the noon meal is routinely served to others at the facility during this timeframe, the noon meal must also be served to this individual. A Home-Delivered meal is not allowable on the same date of service. This is true **regardless of the total number of Adult Day Services, Adult Day Health Services, or Respite hours provided.**

213.340 Combination of Hot and Frozen Home-Delivered Meals 1-1-16

In instances where the ARChoices beneficiary wishes to receive a combination of hot and frozen meals, the DAAS RN shall evaluate the beneficiary's situation based on the criteria set forth in Section 213.320, Frozen Home-Delivered Meals. If the criteria are met, the DAAS RN may prescribe on the PCSP a combination of hot and frozen meals to be delivered.

213.350 Emergency Meals 1-1-16

Beneficiaries may receive up to four (4) emergency meals per state fiscal year. The meals must:

A. Contain 33 1/3 percent of the Dietary Reference intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and 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 beneficiary has been instructed to use it to ensure that beneficiaries consistently have emergency meals on hand.

213.400 Personal Emergency Response System 1-1-16

Procedure Code	Required Modifier	Description
S5161	UA	PERS Unit
S5160	—	PERS Installation

The Personal Emergency Response System (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. PERS enables an elderly, infirm or homebound individual to secure immediate help in the event of a physical, emotional or environmental emergency.

PERS is specifically designed for high-risk beneficiaries whose needs have been carefully determined based on their level of medical vulnerability, functional impairment and social isolation. PERS is not intended to be a universal benefit. The DAAS RN must verify that the individual is capable, both physically and mentally, of operating the PERS unit.

PERS must be included in the beneficiary’s written ARChoices PCSP.

PERS providers must contact each beneficiary at least once per month to test the system’s operation. The provider shall maintain a log of test calls that includes the date and time of the test, specific test results, corrective actions and outcomes.

A log of all beneficiary calls received must be maintained by the emergency response center. The log must reflect the date, time and nature of the call and the response initiated by the center. All calls must be documented in the beneficiary’s record. See Section 214.000 for other documentation requirements.

One (1) unit of service equals one (1) day. 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 ARChoices beneficiaries who are accessing PERS services for their first time or for the current period of re-eligibility for ARChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging 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 1-1-16

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 beneficiary and ensure responders receive necessary instruction and training; and

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

PERS providers must recertify annually with DAAS.

NOTE: The PERS ElderChoices provider's certification will be valid as an ARChoices PERS provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.500 Adult Day Services 1-1-16

Procedure Code	Required Modifier	Description
S5100	U1	Adult Day Services, 8 – 16 Units Per Date of Service
S5100	—	Adult Day Services, 20 – 40 Units Per Date of Service

Adult day services 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 ARChoices PCSP, ARChoices beneficiaries may receive adult day services for two (2) or more hours per day (8 units), not to exceed ten (10) hours per day (40 units), when the services are prescribed by the beneficiary's attending physician and provided according to the beneficiary's written PCSP. Adult day services of less than two (2) hours per day (8 units) are not reimbursable by Medicaid. Adult day services may be utilized up to fifty (50) hours per week (200 units), not to exceed two hundred thirty (230) hours per month (920 units). One (1) unit of service equals 15 minutes.

As required, beneficiaries who are present in the facility for more than five (5) hours a day (20 units, procedure code **S5100**) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours (20 units) of adult day services. Additionally, beneficiaries who attend an adult day service for more than five (5) hours (20 units) are not eligible to receive attendant care services on the same date of service unless authorized by the 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 services, adult day health services, or facility-based respite care for more than 5 hours (20 units). The time of day the beneficiary is receiving day services, day health services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the DAAS RN and/or DHS audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.

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

If an ARChoices beneficiary is receiving day services, day health services or **facility-based** respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to this individual. A home-delivered meal is not allowable on the same date of service. This is true **regardless of the total number of day services or respite units provided**.

Adult day services and day health services providers are required to maintain a daily attendance log of beneficiaries. Section 214.000 contains information regarding additional documentation requirements.

213.510 Adult Day Services Certification Requirements 1-1-16

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of adult day services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by the Arkansas Department of Human Services, Office of Long-Term Care as a long-term adult day care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Care Facility.

In order to be certified by DAAS, Adult Day Services providers must meet the HCBS Settings rules found in section 201.000.

Adult Day Services 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.

In order to be recertified by DAAS, Adult Day Services providers must meet the HCBS Settings rules found in section 201.000.

Providers are required to submit copy of renewed license to DAAS.

NOTE: The Adult Day Services ElderChoices provider's certification will be valid as an ARChoices Adult Day Services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.600 Adult Day Health Services (ADHS) 1-1-16

Procedure Code	Required Modifier	Description
S5100	TD, U1	Adult Day Health Services, 8 – 16 units Per Date of Service
S5100	TD	Adult Day Health Services, 20 – 40 units Per Date of Service

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

Adult day health services programs provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary that cannot be provided by adult day care programs. Adult day health services are appropriate only for beneficiaries whose facility-developed care plans specify one or more of the following health services:

A. Rehabilitative therapies (e.g., physical therapy, occupational therapy),

B. Pharmaceutical supervision,

C. Diagnostic evaluation, or

D. Health monitoring

ARChoices beneficiaries may receive adult day health services for two (2) or more hours per day (8 units), not to exceed ten (10) hours per day (40 units) when the service is provided according to the beneficiary's written ARChoices PCSP. Adult day health services of less than two (2) hours per day (8 units) are not reimbursable by Medicaid. Adult day health services may be utilized up to fifty (50) hours per week (200 units), not to exceed two hundred thirty (230) hours per month (920 units).

Beneficiaries who are present in the facility for more than five (5) hours a day (20 units, procedure code **S5100**, modifier **TD**) must be served a nutritious meal that equals one-third of the Recommended Daily Dietary Allowances. Therefore, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day health services. Additionally, beneficiaries who attend an adult day health services for more than five (5) hours (20 units) are not eligible to receive attendant care services on the same date of service unless authorized by the DAAS RN.

Adult day health services providers are required by licensure to maintain a daily attendance log of beneficiaries. See Section 214.000 for additional documentation requirements.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day services, adult day health services, or facility-based respite care for more than 5 hours (20 units). The time of day the beneficiary is receiving day services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the DAAS RN and/or DHS audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.

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

If an ARChoices beneficiary is receiving day services or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to the individual. A home-delivered meal is not allowable on the same date of service. **This is true regardless of the total number of day services or respite hours provided.**

213.610 Adult Day Health Services (ADHS) Provider Certification Requirements 1-1-16

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

In order to be certified by DAAS, Adult Day Health Services providers must meet the HCBS Settings rules found in section 201.000.

Adult Day Health Services 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. In order to be recertified, Adult Day Health Services providers must meet the HCBS Settings rules found in section 201.000.

Providers are required to submit copy of renewed license to DAAS.

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

NOTE: The Adult Day Health Services ElderChoices provider's certification will be valid as an ARChoices Adult Day Health Services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.700 Respite Care 1-1-16

Procedure Code	Description
T1005	Long-Term Facility-Based Respite Care
S5135	Short-Term Facility-Based Respite Care
S5150	In-Home Respite Care

Respite care services provide temporary relief to persons providing long-term care for beneficiaries in their homes. Respite care may be provided outside of the beneficiary's home to meet an emergency need or to schedule relief periods in accordance with the regular caregiver's need for temporary relief from continuous care giving. If there is no primary caregiver, respite care services will not be deemed appropriate and subsequently will not be prescribed by the beneficiary's physician.

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

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 1-1-16

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

Providers rendering respite care services in the beneficiary's home must bill procedure code **S5150**. One (1) unit of service for procedure code **S5150** equals 15 minutes.

Eligible beneficiaries may receive up to 24 hours (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 beneficiaries may receive up to 1200 hours (4800 units) of In-Home Respite Care, or Facility-Based Respite Care or a combination of the two 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 ARChoices services included on the beneficiary's PCSP. For example, if attendant care services and/or home-delivered meals are included on the PCSP, the respite provider must provide these services while in the home. No other ARChoices service, other than PERS, may be reimbursed for the same time period.

213.711 Facility-Based Respite Care 1-1-16

Facility-based respite care may be provided outside the beneficiary's home on a short- or long-term basis by certified adult family homes, residential care facilities, nursing facilities, adult day care facilities, adult day health care facilities, Level I and Level II Assisted Living Facilities and hospitals.

Facility-based providers rendering services for eight (8) hours or less per date of service must bill **S5135** for short-term, facility-based respite care. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible beneficiaries may receive up to 8 hours (32 units) of short-term, facility-based respite care per date of service.

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

Eligible beneficiaries may receive up to 1200 hours (4800 units) per SFY of Facility-Based Respite Care- or In-Home Respite Care, or a combination of the two. Adult Family Home beneficiaries are limited to 600 hours (2400 units) of long-term facility-based respite per state fiscal year.

Beneficiaries receiving long-term, facility-based respite care services may receive only ARChoices PERS services concurrently.

Please refer to the NOTE found in Section 213.500 regarding Home-Delivered Meals and facility-based respite services.

213.712 In-Home Respite Care Certification Requirements 1-1-16

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

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

C. Agree to the minimum Assurances of Providers of ARChoices Waiver Services.

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

Providers are required to submit copy of renewed license to DAAS.

NOTE: The Class A, Class B or Private Care Agency license ElderChoices provider's certification will be valid as a Respite services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.713 Facility-Based Respite Care Certification Requirements 1-1-16

To be certified by the Division of Aging and Adult Services as a provider of facility-based respite care services, a provider must be licensed in their state as one or more of the following:

A. A certified adult family home

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.

NOTE: The Class A, Class B or Private Care Agency facility-based respite ElderChoices provider's license certification will be valid as a facility-based respite services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

214.000 Documentation 1-1-16

In addition to the service-specific documentation requirements previously listed, ARChoices providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the beneficiary's PCSP

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

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

1. For records created through an electronic data system such as telephony, computer or other electronic devices, a unique identifier such as a PIN number assigned to and entered by the employee at the time of data input may suffice as an electronic signature and title.

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

A provider's failure to maintain sufficient documentation to support his or her billing practices may result in recoupment of Medicaid payment.

No documentation for ARChoices services, as with all Medicaid services, may be made in pencil.

215.000 ARChoices Forms 1-1-16

ARChoices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging and Adult Services. These forms include but are not limited to:

A. Person Centered Service Plan — AAS–9503

B. Start Services — AAS–9510

C. Beneficiary Change of Status — AAS–9511

Providers may request form AAS–9511 by writing to the Division of Aging 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 DAAS RN.

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

216.000 Retention of Records 1-1-16

See Section 142.300 for additional record keeping requirements.

217.000 Electronic Signatures 1-1-16

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

240.000 PRIOR AUTHORIZATION 1-1-16

Services provided under the ARChoices Program do not require prior authorization.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 1-1-16

The reimbursement rates for ARChoices services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

251.010 Fee Schedules 1-1-16

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://www.medicaid.state.ar.us** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

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

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

252.000 Rate Appeal Process 1-1-16

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES 1-1-16

261.000 Introduction to Billing 1-1-16

ARChoices providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 CMS-1500 Billing Procedures

262.100 HCPCS Procedure Codes 1-1-16

The following procedure codes must be billed for ARChoices Services.

Electronic and paper claims now require the same National Place of Service code.

Procedure Code	Modifiers	Description	Unit of Service	National POS for Claims
S5140	Level A – U1 Level B – U2 Level C – U3	Adult Family Homes	1 day	99
S5125		Attendant Care Services	15 minutes	12
S5125	U2	Agency Attendant Care Traditional	15 minutes	99
S5170	U2	Home-Delivered Meals	1 meal	12
S5170		Frozen Home-Delivered Meal	1 meal	12
S5170	U1	Emergency Home Delivered Meals	1 meal	12
S5161	UA	Personal Emergency Response System	1 day	12
S5160		Personal Emergency Response System – Installation	One install	12
S5100	U1	Adult Day Services, 2 to 4 hours per date of service	15 minutes	99
S5100		Adult Day Services, 5 to 10 hours per date of service	15 minutes	99
S5100	TD, U1	Adult Day Health Services, 2 to 4 hours per date of service	15 minutes	99

Procedure Code	Modifiers	Description	Unit of Service	National POS for Claims
S5100	TD	Adult Day Health Services, 5 to 10 hours per date of service	15 minutes	99
S5150		Respite Care – In-Home	15 minutes	12
S5135		Respite Care – Short-Term Facility-Based	15 minutes	99, 21, 32
T1005		Respite Care – Long-Term Facility-Based	15 minutes	21, 32, 99

262.210 Place of Service Codes 1-1-16

Place of Service	Paper Claims	Electronic Claims
Inpatient Hospital	1	21
Patient's Home	4	12
Day Care Facility	5	99
Nursing Facility	7	32
Other Locations	0	99

262.300 Billing Instructions – Paper Only 1-1-16

Hewlett Packard Enterprise offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.

Bill Medicaid for ARChoices services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help Hewlett Packard Enterprise efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Hewlett Packard Enterprise Claims Department. **View or print the Hewlett Packard Enterprise Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.310 Completion of CMS-1500 Claim Form 1-1-16

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.

Field Name and Number			Instructions for Completion
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)		Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)		Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE		Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX		Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)		Required if insurance affects this claim. Insured's last name, first name and middle initial.
5.	PATIENT'S ADDRESS (No., Street)		Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY		Name of the city in which the beneficiary or participant resides.
	STATE		Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE		Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)		The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED		If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)		Required if insured's address is different from the patient's address.
	CITY		
	STATE		
	ZIP CODE		
	TELEPHONE (Include Area Code)		
8.	RESERVED		Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)		If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
	a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b.	RESERVED	Reserved for NUCC use.
		SEX	Not required.
	c.	RESERVED	Reserved for NUCC use.

Field Name and Number			Instructions for Completion
	d.	INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:		
	a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
		PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d.	CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER		Not required when Medicaid is the only payer.
	a.	INSURED'S DATE OF BIRTH	Not required.
		SEX	Not required.
	b.	OTHER CLAIM ID NUMBER	Not required.
	c.	INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
	d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		Enter "Signature on File," "SOF" or legal signature.
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		Enter "Signature on File," "SOF" or legal signature.

Field Name and Number		Instructions for Completion
14.	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15.	OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for ARChoices services. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a.	(blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b.	NPI	Not required.
18.	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19.	ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20.	OUTSIDE LAB?	Not required.
	$ CHARGES	Not required.

Field Name and Number		Instructions for Completion
21.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22.	RESUBMISSION CODE	Reserved for future use.
	ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23.	PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A.	DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B.	PLACE OF SERVICE	Enter the appropriate place of service code. See Section 262.200 for codes.
C.	EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D.	PROCEDURES, SERVICES, OR SUPPLIES	
	CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
	MODIFIER	Modifier(s) if applicable.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Not required for ARChoices.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
	NPI	Not required.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid co-payments.
30.	RESERVED	Reserved for NUCC use.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number		Instructions for Completion
32.	SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state and zip code of the facility where services were performed.
a.	(blank)	Not required.
b.	(blank)	Not required.
33.	BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a.	(blank)	Not required.
b.	(blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

262.400 Special Billing Procedures 1-1-16

Not applicable to this program.

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

This renewal will combine ElderChoices with the Alternatives for Adults with Physical Disabilities (AAPD) 1915(c) waiver (AR.0312). The name of the ElderChoices (EC) waiver will be changed to ARChoices in Homecare (ARChoices) to better reflect the combined populations of age 21 and above. In combining the services provided in both waivers, the services will remain the same, except for the following:

- EC Homemaker, EC Adult Companion Services and AAPD Attendant Care will be provided as Attendant Care. Individuals may self-direct Attendant Care under the 1915(j) authority through Arkansas's IndependentChoices program. Attendant Care will have a rate increase to reflect a new State Plan personal care rate. Once the individual is transitioned to ARChoices in Homecare, the new Attendant Care service will encompass the three existing services. The new Attendant Care will maintain all of the elements of the Elder Choices Homemaker and Adult Companion services. Individuals currently receiving services in AAPD will maintain their current services through the new

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

ARChoices in Homecare

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: AR.0195
Waiver Number:AR.0195.R05.00
Draft ID: AR.005.05.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

01/01/16

Approved Effective Date: 01/01/16

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

Not Applicable

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☑ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

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

ARChoices in Homecare (ARChoices) offers certain home and community-based services as an alternative to nursing home placement to persons aged 21 to 64 years of age with a physical disability, or 65 and older who require an intermediate level of care in a nursing facility. ARChoices services include: Attendant Care, Adult Day Services, Adult Day Health Services, Adult Family Homes, Home-Delivered Meals, Personal Emergency Response System, Environmental Accessibility Adaptations/Adaptive Equipment, and Respite Care (In-home & Facility-Based).

Services are provided on a regular basis according to individualized person-centered service plans that are authorized by a DAAS RN. Services adapt to changing needs and individual preferences; promote dignity, autonomy, privacy and safety; and permit family and community involvement. These services are designed to maintain Medicaid eligible participants at home and to foster community inclusion in order to preclude or postpone institutionalization of the participant.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

⊙ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

⊙ **Not Applicable**

○ **No**

○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

⊙ **No**

○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals

who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be

consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

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

Updates and revisions to the waiver are posted on the DMS website to allow for general public comment. Notices of updates or revisions are also published in a statewide newspaper for 30 days to allow for public review and comment.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:

Blomeley

First Name:

Seth

Title:

DHS/DMS Business Operations Manager

Agency:

Arkansas Dept. of Human Services, Division of Medical Services

Address:

P. O. Box 1437, Slot S-295

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6425 **Ext:** ☐ **TTY**

Fax:

(501) 682-2480

E-mail:

seth.blomeley@dhs.arkansas.gov

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

Last Name:

Blocker

First Name:

Stephenie

Title:

Assistant Director

Agency:

Arkansas Dept. of Human Services, Division of Aging & Adult Services

Address:

P. O. Box 1437, Slot S-530

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6569 **Ext:** ☐ **TTY**

Fax:

(501) 682-8155

E-mail:

stephenie.blocker@dhs.arkansas.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

Blomeley 501-320-6425

State Medicaid Director or Designee

Submission Date:

Nov 13, 2015

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Stehle

First Name:

Dawn

Title:

Director

Agency:

Division of Medical Services

Address:

P. O. Box 1437

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72204

Phone:

(501) 683-4997 **Ext:** ☐ **TTY**

Fax:

(501) 682-1197

E-mail:

dawn.stehle@dhs.arkansas.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☑ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☑ **Eliminating a service.**
- ☑ **Adding or decreasing an individual cost limit pertaining to eligibility.**

- [x] **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- [ ] **Reducing the unduplicated count of participants (Factor C).**
- [x] **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- [ ] **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- [ ] **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Individuals currently in the ElderChoices waiver will remain in the waiver when changes are implemented, but the waiver will have a name change to ARChoices in Homecare (ARChoices). Recipients will be notified of the changes at least 30 days in advance of implementation. The recipient will continue receiving current services at the same level and from the same provider until the next scheduled reassessment with the following exceptions.

- Homemaker and Adult Companion - individuals will continue receiving Homemaker and Adult Companion hours as shown on the plan of care, except the services will be billed by the provider as Attendant Care since Homemaker and Adult Companion will be part of Attendant Care in ARChoices.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Arkansas assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Arkansas will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Most waiver participants in ARChoices will reside in a private home in the community and receive HCBS services in their home. The home may be the participant's home or the participant's family member or friend's home. It is presumed that these waiver participants who live in their own home or the home of a family member or friend receive services in the home that meets the setting requirements found at 42 CFR 441.301(c)(4). DAAS views these regulations as basic human rights for participants. DAAS RNs who complete the assessment and develop the person-centered plan, and Targeted Case Managers, who monitor services in the home, will be trained in the settings rule. DAAS

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

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

Specify the division/unit name:

Department of Human Services/ Division of Aging and Adult Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

The State utilizes the Interagency Agreement to define each agency''s responsibilities in administering the ARChoices in Homecare (ARChoices) waiver program. This agreement is reviewed annually and updated as needed. DMS monitors this agreement to assure that the provisions specified are executed.

As part of the Interagency Agreement:

A. DMS Responsibilities :

Appendix A: Waiver Administration and Operation

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

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

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

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

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

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☐	☐
Utilization management	☑	☑

Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants with delivery of at least one waiver service per month as specified in the service plan in accordance with the agreement with the Medicaid Agency. Numerator: Number of participants with at least one service per month; Denominator: Number of participants served

Data Source (Select one):
Other
If 'Other' is selected, specify:
No Waiver Service Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	

Specify:		☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of LOC assessments completed using the approved instrument according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed using the approved instrument; Denominator: Number of LOC assessments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Quarterly QA Report (Chart Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of LOC assessments completed by DAAS in the time specified in the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by DAAS in time frame; Denominator: Number of LOC assessments reviewed

Data Source (Select one):
Other

If 'Other' is selected, specify:

Average Days Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monthly Activity Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Quarterly QA Report (Chart Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant service plans completed by DAAS in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of service plans completed by DAAS in time frame; Denominator: Number of service plans reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Quarterly QA Report (Chart Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of active participants and number of unduplicated participants served within approved limits specified in the approved waiver. Numerator: Number of active and unduplicated participants served within approved limits; Denominator: Number of active/unduplicated participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
ACES Report of Active Cases (Point in Time)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Division of County Operations	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and	**Frequency of data aggregation and**

analysis *(check each that applies):*	**analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of policies and/or procedures developed by DAAS that are reviewed and approved by the Medicaid Agency prior to implementation. Numerator: Number of policies and procedures developed by DAAS reviewed by Medicaid Agency before implementation; Denominator: Number of policies and procedures developed

Data Source (Select one):
Other
If 'Other' is selected, specify:
PDQA Request Forms

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of provider certifications that are issued as current by DAAS according to the agreement with the Medicaid Agency. Numerator: Number of current provider certifications by DAAS; Denominator: Number of providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider File Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review Process
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Quarterly QA Report (Chart Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver claims paid correctly on the same date of service as institutional services as specified in the waiver application. Numerator: Number of claims paid correctly; Denominator: Number of claims

Data Source (Select one):
Other
If 'Other' is selected, specify:
Overlapping Services Report or similar data preferred by Operating Agency and approved by Medicaid Agency

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of LOC assessments completed by a DAAS qualified evaluator according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by a DAAS qualified evaluator; Denominator: Number of LOC assessments reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Quarterly QA Report (Chart Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	

		☑ **Other** Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	21	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Not Applicable. The State does not further specify its target group.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

The participant who ages out in the Disabled (Physical) target subgroup at age 65 automatically remains in the waiver under the Aged target subgroup.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

The limit specified by the State is *(select one)*

- ○ **A level higher than 100% of the institutional average.**

  Specify the percentage:

- ○ **Other**

  Specify:

- ○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	11350
Year 2	11350
Year 3	11350
Year 4	11350
Year 5	11350

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	8032
Year 2	8176
Year 3	8320
Year 4	8464
Year 5	8608

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ⊙ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Arkansas Money Follows the Person (MFP) Program	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Arkansas Money Follows the Person (MFP) Program

Purpose *(describe):*

Reserved for individuals transitioning from the nursing facilities to the community via the Arkansas Money Follows the Person (MFP) program. At CMS's recommendation, Arkansas MFP will be intensifying efforts through the end of the program, which is currently scheduled to end September 30, 2016, but there is a possibility for an extension so we are reserving capacity for all 5 years. The reserved slots will ensure that transitioned individuals will have access to more cost-effective services

Describe how the amount of reserved capacity was determined:

The number of MFP participants who have historically transitioned into the waivers which ARChoices in Homecare represents has ranged from 25-36 per year. The 100 slots will allow a substantial buffer to account for the intensified activity level.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The ARChoices waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once individuals meet all functional and financial eligibility requirements.

However, once all waiver slots are filled, a waiting list will be implemented for this program and the following process will apply. Each ARChoices application will be accepted and eligibility will be determined. 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 _ in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the ARChoices program.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The State is a *(select one)*:

- (•) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the State is a Miller Trust State *(select one)*:

- ( ) **No**
- (•) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- (•) **% of FPL, which is lower than 100% of FPL.**

Specify percentage: 80

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

SSI recipients with disabilities who work and have continued Medicaid under 1619(b)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

○ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

For waiver participants not receiving the waiver service of Adult Family Home, the allowance will be the special income level for an institutionalized person of 300% of the SSI Federal Benefit Rate.

For waiver participants receiving the waiver service of Adult Family Home, the allowance will be 100% of the SSI Federal Benefit Rate: 9% of the rate rounded to the nearest dollar will be for a personal allowance and 90.8% rounded to the nearest dollar will be for room and board.

Other

Specify:

ii. Allowance for the spouse only (*select one*):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (*select one*):

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
◉ **The State does not establish reasonable limits.**
○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):
○ **SSI standard**
○ **Optional State supplement standard**

- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

  For waiver participants not receiving the waiver service of Adult Family Home, the allowance will be the special income level for an institutionalized person of 300% of the SSI Federal Benefit Rate.

  For waiver participants receiving the waiver service of Adult Family Home, the allowance will be 100% of the SSI Federal Benefit Rate: 9% of the rate rounded to the nearest dollar will be for a personal allowance and 90.8% rounded to the nearest dollar will be for room and board.
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

○ **Other**
Specify:

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

Individuals who perform the initial evaluation of level of care for waiver applicants, and all annual reevaluations, are Registered Nurses licensed in the State of Arkansas.

DAAS RNs receive extensive training on the tool used to perform LOC evaluations before any evaluations are performed. New DAAS RNs are trained by an RN supervisor who is experienced in completing the level of care evaluation using the interRAI Homecare Assessment tool. In addition, new RNs shadow experienced RNs in performing LOC evaluations before ever performing them on their own.

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

INSTRUMENTS/TOOLS USED - The electronic interRAI home care instrument, called ArPath, is the instrument/tool used to collect information to determine the initial and continuing level of care and medical need eligibility for home and community-based services (HCBS) waiver participants. Based on the information that the participant and/or parties on behalf of the participant provide during the assessment, ArPath uses algorithms to evaluate and categorize participant information into scales, Client Assessment Protocols (CAPs), Resource Utilization Groups (RUGs) and levels of care, which correspond to the eligibility criteria listed in this section.

LEVEL OF CARE CRITERIA - To be eligible, the waiver participant must meet at least one of the following three criteria as determined by a licensed medical professional:

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

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

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

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

The instrument used to evaluate institutional level of care is form DHS-703 (Evaluation of Medical Need Criteria). The DHS-703 is completed by a nurse and includes information obtained from the participant, family members, caregivers and others. The DHS-703 was designed based on the MDS and the state's nursing home admission criteria. It is the nurse''s personal assessment of the participant and includes observations and evaluation of the participant''s ability to perform activities of daily living, along with other relevant information regarding the individual's medical history.

ArPath, the electronic interRAI home care instrument is used to evaluate level of care for the ARChoices program. Both the ArPath and the DHS-703 assess needs and are person-centered, focusing on the participant''s functioning and quality of life. However, ArPath applies algorithms in the system that automatically determine functional eligibility and where assistance is needed. Based on the information provided during the assessment, ArPath uses algorithms to evaluate and categorize participant information into scales, Client Assessment Protocols (CAPs), Resource Utilization Groups (RUGs) and levels of care, which

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

The process for the initial evaluation and re-evaluation of level of care for waiver participants is different.

An initial individual assessment of the participant is performed by the waiver DAAS RN utilizing the electronic interRAI home care instrument, called ArPath. Each DAAS RN is a licensed registered nurse, employed by the Department of Human Services, Division of Aging and Adult Services. Once the assessment is completed by the DAAS RN, Arpath will generate a DHS-704, Decision for Nursing Home Placement, which reflects the level of care. Functional need eligibility is valid for one year, unless specified otherwise on the DHS-704. The Office of Long Term Care reviews the assessments to ensure the assessment tool continues to reflect the correct nursing home level of care.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○ **Every three months**

○ **Every six months**

◉ **Every twelve months**

○ **Other schedule**
Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**
Specify the qualifications:

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

The waiver DAAS RN is responsible for tracking the review dates and initiating timely reevaluations prior to the level of care review date and prior to the expiration of the service plan (of care). The DAAS RN establishes a tickler file to track these dates and begins the reassessment process two months prior to the expiration date on the service plan (of care) or two months prior to the date the ArPath assessment was signed in the previous year, whichever is earlier. This process ensures timely reevaluations prior to the level of care review date and the expiration of the service plan (of care) so that no lapse in service occurs.

The DAAS RN supervisory staff, through the record review process and through routine monitoring and auditing procedures, notifies the appropriate DAAS RN and RN supervisor if a re-assessment has not been completed within the specified DAAS policy timeframes. The ACES report produced by the Division of County Operations is used as a tool by the DAAS RN and RN supervisor to determine if the assessment is current or has expired. Patterns of noncompliance are documented and disciplinary action is taken if necessary. The DAAS RN will then complete the reassessment.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of applicants who had a LOC indicating need for nursing facility LOC prior to receipt of services. Numerator: Number of applicants who received level of care prior to service; Denominator: Total number of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who received an annual redetermination of LOC eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC re-evaluation. Numerator: Number of participants receiving annual redetermination in 12 months; Denominator: Number of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants' LOC determinations made where the LOC criteria were accurately applied. Numerator: Number of participants' LOCs with correct criteria; Denominator: Number of participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Level of Care Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants' annual re-evaluation LOC determination forms that were completed as required by the state. Numerator: Number of participants with LOC with forms completed correctly; Denominator: Number of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants' LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings as needed to discuss and address individual problems associated with level of care determination and system improvement, as well as problem correction and remediation. DAAS and DMS have an Interagency Agreement that includes measures related to level of care determinations for the waiver.

The system currently in place for new applicants to enter the waiver program does not allow for services to be delivered prior to an initial level of care assessment. Also, DAAS requires that all initial assessments and reassessments of level of care are completed by a registered nurse. Therefore, performance measures related to these processes will always result in 100% compliance, and not allow for the possibility of remediation.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

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

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

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the ARChoices waiver participant's service plan are maintained with the Division of Aging & Adult Services (operating agency), and with the providers serving the participant and included on the service plan. Freedom of Choice forms and person-centered service plans are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Health**		
Statutory Service	**Respite**		
Other Service	**Adult Day Services**		
Other Service	**Adult Family Home**		
Other Service	**Attendant Care Services**		
Other Service	**Environmental Accessibility Adaptations/Adaptive Equipment**		
Other Service	**Home-Delivered Meals**		
Other Service	**Personal Emergency Response System (PERS)**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services
05 Nursing

Sub-Category 1:

04050 adult day health
04060 adult day services (social model)

Category 2:

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction

Sub-Category 2:

11010 health monitoring
11020 health assessment

Category 3:

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction

Sub-Category 3:

11120 cognitive rehabilitative therapy
11130 other therapies

Category 4:

17 Other Services

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult day health are services furnished two or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

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

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

Adult day health care can be utilized by waiver participants for two (2) or more hours per day, not to exceed ten (10) hours per day, when the service is provided according to the participant's written service plan. Adult day health services of less than two (2) hours per day are not reimbursable. Adult day health services may be utilized up to fifty (50) hours (200 units) per week, not to exceed two hundred and thirty (230) hours (920 units) per month. ARChoices waiver participants can receive both adult day health and adult day services, but the two services are not allowed on the same date of service.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Health Care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Licensed Adult Day Health Care

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Adult Day Health services. To be certified, providers must provide a copy of their current adult day health care agency license through the DHS Division of Medical Services, Office of Long Term Care.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

09 Caregiver Support
10 Other Mental Health and Behavioral Services

Sub-Category 1:

09011 respite, out-of-home
09012 respite, in-home

Category 2:

09 Caregiver Support
10 Other Mental Health and Behavioral Services
11 Other Health and Therapeutic Services

Sub-Category 2:

09011 respite, out-of-home
09012 respite, in-home
09039 caregiver supplies and/or training

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite is a service provided to waiver participants unable to care for themselves that are furnished on a short-term basis (8 hours or less per date of service) or long-term basis (a full 24 hours per date of service) because of the absence or need for relief of those persons who normally provide care for the participant.

Respite care will be provided in the following locations:
- Participant's home or place of residence;
- Medicaid certified hospital;

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

Participants may receive up to 1200 hours (4800 units) per state fiscal year of in-home respite care and facility-based respite care or a combination of the two. Adult Family Home participants are limited to 600 hours (2400 units) of long-term facility-based respite per state fiscal year.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	**Licensed Acute Care Hospital**
Agency	**Licensed Level II Assisted Living Facility**
Agency	**Licensed Medicaid Certified Nursing Facility**
Agency	**Licensed Adult Day Health Care Agency**
Agency	**Licensed Residential Care Facility**
Agency	**Licensed Adult Day Care Agency**

Individual	**Certified Adult Family Home**
Agency	**Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Acute Care Hospital

Provider Qualifications

License *(specify):*

Licensed Acute Care Hospital

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an AChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current acute care hospital license.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Every three years for recertification; however, DAAS must maintain a copy of the agency's current Acute Care Hospital license at all times.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Level II Assisted Living Facility

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a Level II Assisted Living Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their level II assisted living facility license through the DHS Division of Medical Services, Office of Long Term Care.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Medicaid Certified Nursing Facility

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a Medicaid Certified Nursing Facility as required by Ark. Code Ann. 20-10-201, et. seq.

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current Medicaid certified nursing facility license through the DHS Division of Medical Services, Office of Long Term Care.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Adult Day Health Care Agency

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current adult day health care agency license through the DHS Division of Medical Services, Office of Long Term Care.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Residential Care Facility

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a Residential Care Facility as required by Ark. Code Ann. 20-10-201, et. seq.

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current residential care facility license through the DHS Division of Medical Services, Office of Long Term Care.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Every three years for recertification; however, DAAS must maintain a copy of the agency's current Residential Care Facility license at all times.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Adult Day Care Agency

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as an Adult Day Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current adult day care agency license through the DHS Division of Medical Services, Office of Long Term Care.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Every three years for recertification; however, DAAS must maintain a copy of the agency's current Adult Day Care license at all times.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Certified Adult Family Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an Adult Family Home. To be certified, providers must provide a copy of their current completed adult family home certification requirements checklist.

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current adult family home certification certificate.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency as required by Ark. Code Ann. 20-10-807, History: Acts 1987, No. 956, 4; or licensed as a Private Care Agency.

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current Class A and/or Class B home health agency license, or Private Care Agency license through the Arkansas Department of Health

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Every three years for recertification; however, DAAS must maintain a copy of the agency’s current Home Health license at all times.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult day services are services provided in a group program designed to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than twenty-four (24) hours, but more than two (2) hours per day in a place other than the adult's own home.

Adult day care facilities operate on a service day of no more than twelve (12) hours.

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

Adult day services may be utilized by waiver participants for two (2) or more hours per day, not to exceed ten (10) hours per day, when the service is provided according to the participant's written service plan. Adult day services may be utilized up to fifty (50) hours (200 units) per week, not to exceed two hundred and thirty (230) hours (920 units) per month.

ARChoices waiver participants can receive both adult day service and adult day health, but the two services are not allowed on the same date of service.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Licensed Adult Day Care

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et seq

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Adult Day Services. To be certified, providers must provide a copy of their current adlt day care license through the DHS Division of Medical Services, Office of Long Term Care.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Every three years for recertification; however, DAAS must maintain a copy of the agency's current Adult Day Care license at all times.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid

agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Family Home

HCBS Taxonomy:

Category 1:

01 Case Management
02 Round-the-Clock Services

Sub-Category 1:

02013 group living, other
02021 shared living, residential habilitation

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult Family Home services are personal care, attendant care, supportive services such as transportation to allow the waiver participant access to the community, 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. The Adult Family Home provider is responsible for meeting the needs, as described by the waiver service, 24 hours a day, seven days a week. Adult Family Home services shall be included in the service plan only when it is necessary to prevent the permanent institutionalization of a participant as determined by the DAAS RN.

Payment for Adult Family Home services does not include 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 participant's immediate

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

One (1) unit of service equals one (1) day. Adult Family Homes are limited to a maximum of thirty-one (31) units per month.

Adult Family Home participant may receive up to 2,400 units (600 hours) of long-term facility-based respite per state fiscal year. The Adult Family Home service is not allowed on the same date of service as respite service.

Aside from facility-based respite services, a participant receiving Adult Family Home services is not eligible to receive any other ARChoices service

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Adult Family Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Family Home

Provider Category:

Individual

Provider Type:

Certified Adult Family Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Adult Family Home services. To be certified, providers must provide a copy of their current completed adult family home certification requirements checklist.

Other Standard *(specify):*

To be certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Adult Family Home services, providers must provide a copy of their completed Adult Family Homes Certification Requirements Checklist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Attendant Care Services

HCBS Taxonomy:

Category 1:

08 Home-Based Services
09 Caregiver Support

Sub-Category 1:

08030 personal care
08040 companion

Category 2:

08 Home-Based Services
09 Caregiver Support

Sub-Category 2:

08040 companion
08050 homemaker

Category 3:

08 Home-Based Services
09 Caregiver Support

Sub-Category 3:

08050 homemaker
08060 chore

Category 4:

17 Other Services

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Attendant care services is assistance to an individual in accomplishing tasks of daily living that the individual is unable to complete independently. Assistance may vary from actually doing a task for the individual, assisting the individual to perform the task or providing safety support while the individual performs the task. Attendant care services meet the individual's needs that are beyond the limitations of state plan personal care. Attendant care services may also include supervision, companion services, socialization, and transportation assistance, accompanying a participant to assist with shopping, errands, etc.

Attendant care services tasks consist of feeding assistance, encouraging fluids, toileting, grooming/oral care, shampooing, shaving, skin care, bathing, dressing, assisting in mobility/transfer, supervising/assisting with ambulation, aiding in range of motion exercise, meal preparation, laundry, housekeeping, shopping, errands and non-medical transportation.

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

Benefit limits will be determined on a client basis based on the assessed level of need by the DAAS RN. The highest RUG level produced by the interRAI assessment allows a maximum allocation of 359 hours (1436 units) per month.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider
Agency	Licensed Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Attendant Care Services

Provider Category:

Agency

Provider Type:

Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Health as a private care agency enrolled as an Arkansas Medicaid Personal Care Provider, as cited in Act 2273 of 2005.

Certificate *(specify):*

Agencies must be certified by the Division of Aging & Adult Services to provide ARChoices agency attendant care services.

Providers must also complete all applicable forms required by DAAS for certification. Agencies must submit a copy of a current license or certification, as well as proof of current liability and bonding insurance for certification.

Providers must also be enrolled in the Arkansas Medicaid program as an ARChoices agency attendant care provider before reimbursement may be made for any agency attendant care service provided to ARChoices recipients.

Other Standard *(specify):*

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

o Be 18 years of age or older;

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Attendant Care Services

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency, as cited in Arkansas Code Annotated section 20-10-809.

Certificate *(specify):*

Agencies must be certified by the Division of Aging & Adult Services to provide ARChoices agency attendant care services.

Providers must also complete all applicable forms required by DAAS for certification. Agencies must submit a copy of a current license or certification, as well as proof of current liability and bonding insurance for certification.

Providers must also be enrolled in the Arkansas Medicaid program as an ARChoices agency attendant care provider before reimbursement may be made for any agency attendant care service provided to ARChoices recipients.

Other Standard *(specify):*

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

o Be 18 years of age or older;

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Every three years for recertification; however, DAAS must maintain a copy of the provider's current Home Health Agency license in the provider file at all times.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations/Adaptive Equipment

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications
15 Non-Medical Transportation
16 Community Transition Services

Sub-Category 1:

14010 personal emergency response system (PERS)
14020 home and/or vehicle accessibility adaptations
14021 equipment and technologies

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

Medicaid reimbursement for Environmental Accessibility Adaptations/Adaptive Equipment is determined by the job. The Medicaid maximum allowable equals $7,500 per ARChoices participant for the life of the participant. A waiver participant may access through the waiver several occurrences of this service over a span of years or the whole $7,500 at one time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Installer (Builder, Tradesman or Contractor)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations/Adaptive Equipment

Provider Category:

Individual

Provider Type:

Installer (Builder, Tradesman or Contractor)

Provider Qualifications

License *(specify):*

If the particular trade has a license available, the installer must be licensed as appropriate for the environmental accessibility adaptation/adaptive equipment provided. Proof of a plumber or electrician's license must be provided prior to performing this type of work.

Certificate *(specify):*

Environmental Accessibility Adaptations/Adaptive Equipment providers are certified by the Division of Aging & Adult Services as an ARChoices provider of environmental accessibility adaptations/adaptive equipment. Providers must also complete all applicable forms required by DAAS for certification.

Providers must also be enrolled in the Arkansas Medicaid program as an ARChoices environmental accessibility adaptations/adaptive equipment provider before reimbursement may be made for services provided to ARChoices participants.

Other Standard *(specify):*

Environmental Accessibility Adaptations/Adaptive Equipment providers must:

• Certify that his or her work meets state and local building codes

• Be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home-Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals
07 Rent and Food Expenses for Live-In Caregiver

Sub-Category 1:

06010 home delivered meals

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home-delivered meals are services that provide one (1) meal per day of nutritional content equal to one-third of the Recommended Daily Allowance. This service is designed for participants who are unable to prepare meals, and who lack an informal provider to do meal preparation. Provision of home-delivered meals reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner.

The goals of home-delivered meals are:

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

One unit of service equals one meal. The maximum number of home-delivered meals eligible for reimbursement per month is 31 meals.

Four (4) emergency meals may be supplied per SFY.

Home-delivered meals are not allowed on the same date of service when a waiver participant has received more than five (5) hours of adult day health, adult day service, or in-home or facility-based respite. Licensure requirements include provision of a meal while at the day care facility under these circumstances.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider of Food Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Provider of Food Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Food Establishment Permit issued by the Arkansas Board of Health

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Home Delivered Meals. To be certified, providers must provide a copy of their current food establishment permit issued by the Arkansas Board of Health.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Every three years for recertification; however, DAAS must maintain a copy of the agency's current Food Establishment Permit at all times.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications
15 Non-Medical Transportation

Sub-Category 1:

14010 personal emergency response system (PERS)
14020 home and/or vehicle accessibility adaptations

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal emergency response system (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. The system includes an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. PERS enables an elderly, infirm or homebound participant to secure immediate help in the event of physical, emotional or environmental emergency.

PERS services are limited to those participants who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive, routine supervision.

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

One (1) unit of service equals one (1) day. PERS is limited to a maximum of thirty-one (31) units per month.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Alarm or Security Company

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Alarm or Security Company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Personal Emergency Response System services. To be certified, providers must provide a copy of their current certificate of compliance for protective signaling services issued by the Underwriters Laboratories Safety Standards.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Annually

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

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

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

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

Appendix C: Participant Services

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

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

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

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

Each provider receiving payment under the ARChoices program must, as a condition of continued participation in the program, comply with the requirement for criminal history checks for new employees, and periodic criminal history checks for agency operators and all employees at least once every five years. The

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

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

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

The Adult Protective Services unit, housed within the Division of Aging & Adult Services, is responsible for maintaining the abuse registry.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Licensed Nursing Facility	
Residential Care Facility	
Level II Assisted Living Facility	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The waiver service "Respite" is the only waiver service provided in the larger types of facilities (Medicaid certified nursing facilities, Level II assisted living facilities, and residential care facilities) subject to 1616 (e) of the Social Security Act.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Nursing Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Family Home	☐
Respite	☑
Adult Day Services	☐
Environmental Accessibility Adaptations/Adaptive Equipment	☐
Home-Delivered Meals	☐
Personal Emergency Response System (PERS)	☐
Attendant Care Services	☐
Adult Day Health	☐

Facility Capacity Limit:

Capacity limits vary and are determined by the Office of Long Term Care as a part of licensing regulations

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Family Home	☐
Respite	☑
Adult Day Services	☐
Environmental Accessibility Adaptations/Adaptive Equipment	☐
Home-Delivered Meals	☐
Personal Emergency Response System (PERS)	☐
Attendant Care Services	☐
Adult Day Health	☐

Facility Capacity Limit:

Capacity limits are determined by the Office of Long Term Care as a part of the licensing regulations

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Level II Assisted Living Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Adult Family Home	☐
Respite	☑
Adult Day Services	☐
Environmental Accessibility Adaptations/Adaptive Equipment	☐
Home-Delivered Meals	☐
Personal Emergency Response System (PERS)	☐
Attendant Care Services	☐
Adult Day Health	☐

Facility Capacity Limit:

Facility Capacity limit is determined by the Office of Long Term Care as a part of the licensing regulations.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver

participant. *Select one*:

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

No Adult Family Homes (AFH) provider, employee or family member of the provider may be related to the AFH participant. All other ARChoices services, except for Adult Family Homes, may be provided by a relative. This includes Attendant Care, Adult Day Service, Adult Day Health Service, Home-Delivered Meals, PERS, Environmental Accessibility Adaptations/Adaptive Equipment and Respite.

For the purposes of this section, relative shall be defined as all persons related to the participant by virtue of blood, marriage or adoption. Relatives other than a spouse, legal guardian or attorney-in-fact granted authority to direct the participant's care can provide all ARChoices services except Adult Family Homes.

- ○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ○ **Other policy.**

Specify:

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

ARChoices provider enrollment is open and continuous. Those interested in becoming an ARChoices provider can contact DAAS Provider Enrollment for information and to obtain certification materials. There are no restrictions applicable to requesting this information. The provider certification process is open and available to any interested party.

The Division of Aging and Adult Services' website lists information for potential ARChoices providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of providers, by provider type, which obtain re-certification in accordance with state law and waiver provider qualifications. Numerator: Number of providers with re-certification; Denominator: Total number of providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certification Unit (DAAS) Provider Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of providers, by provider type, which obtained the appropriate license/certification in accordance with state law and waiver provider qualifications prior to delivering services. Numerator: number of providers with appropriate license/certification prior to delivery of services; Denominator: Number of new providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certification Unit (DAAS) Provider Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of agency providers meeting waiver provider training requirement as evidenced by in-service attendance documentation. Numerator: Number of agency providers indicating training by in-service documentation; Denominator: Total number of agency providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
In-Service Attendance Documentation

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings as needed to discuss and address individual problems related to qualified providers, as well as problem correction and remediation. The Interagency Agreement between DAAS and DMS includes measures regarding qualified providers enrolled to provide services under the waiver.

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- ◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Attachment 2 for the transition plan to ensure all providers are in compliance.

Arkansas is still assessing settings compliance in accordance with the transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [x] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- [ ] **Social Worker**

  Specify qualifications:

- [ ] **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (•) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

During the assessment and prior to the service plan development, the DAAS RN explains to the participant the services available through the ARChoices waiver.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

The DAAS RN works with the waiver participant to schedule a convenient time and location for the assessment and service plan development meeting. During each assessment and reassessment the DAAS RN develops a person-centered service plan. Each assessment is scheduled and completed within 10 working days of the

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

DAAS RNs:

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans that were reviewed and revised as warranted on or before waiver participants' annual review date. Numerator: Number of participants' service plans that were reviewed/revised before annual review date; Denominator: Number of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan. Numerator: Number of participants' service plans who received services specified in service plan; Denominator: Number of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other**	☐ **Annually**	

Specify:		☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participant records reviewed with an appropriately completed service

plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with choice between institutional care waiver services and among waiver services; Denominator: Number of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Remediation is performed on service plans

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings as needed to discuss and address individual problems related to service plans, as well as problem correction and remediation. DAAS and DMS have an Interagency Agreement that includes measures related to the service plans as part of the waiver.

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

⊙ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Arkansas Department of Human Services, Division of Aging & Adult Services

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

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAAS Central Office or their DAAS RN. When DAAS is contacted regarding a complaint or dissatisfaction, DAAS explains the complaint process to the participant, and completes the HCBS Complaint Intake Report electronically. Any DAAS staff receiving a complaint must complete the HCBS Complaint Intake report.

The HCBS Complaint database, is used to track any dissatisfaction or complaint, including complaints against DAAS staff and DAAS providers. The record of complaint includes the date the complaint was filed.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

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

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

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

An Adult Protective Services (APS) brochure is provided to the waiver applicant and his or her family by the DAAS RN when initial contact is made. Additional copies of the brochure are available to other interested parties upon request. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DAAS RNs review this information with participants and family members at the initial assessment and at each annual reassessment.

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

Adult Protective Services (APS) receives, investigates, evaluates and resolves reports of suspected abuse, neglect or exploitation of impaired or endangered adults who do not live in long-term care facilities, or whose alleged offender is a family member, regardless of where the endangered or impaired adult lives. Arkansas state law grants investigative powers to the Department of Human Services (DHS). As statutorily directed in Arkansas Code Annotated 12-12-1701 et. seq., APS will have the responsibility for review and response to these critical events or incidents for ARChoices in Homecare waiver participants.

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

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

The Division of Aging & Adult Services (DAAS) assumes responsibility for compiling all incident reports for review and action. Incidents are reported to the DAAS staff through the online Incident Reporting Information System (IRIS) by DAAS staff. The reports are retrieved from the IRIS system. Incidents or events involving abuse, neglect or exploitation must also be reported immediately to the Adult Maltreatment Hotline.

The DAAS staff reviews the reports as events and incidents occur, identifies patterns and makes systematic corrections when necessary. Current policy is reviewed at each occurrence and revisions may be made if necessary.

Appendix G: Participant Safeguards

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

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

◉ **The State does not permit or prohibits the use of restraints**

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

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

DAAS RNs reassess participants annually.

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

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

◉ **The State does not permit or prohibits the use of restrictive interventions**

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

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

DAAS RNs reassess participants annually.

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

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

◉ **The State does not permit or prohibits the use of seclusion**

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

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

DAAS RNs reassess participants annually.

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

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

The service criteria for adult family home services include medication oversight. The provider is not administering medication - the provider is providing medication oversight (to the extent permitted under State law).

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

The DAAS RN reviews the medication regimens at the time of assessment and reassessment. All medications are documented. Included in the ArPath assessment tool is information regarding the medications taken by the participant, identifying the type of assistance needed in taking medication, the frequency of the assistance, and who provides the assistance. Any potentially harmful practices the DAAS RN discovers during the assessment or during a monitoring visit are documented in the participant record, addressed, and tracked for resolution.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- (●) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

Do not complete the rest of this section

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

- ( ) **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of complaints addressed within required time frame. Numerator: Number of complaints addressed in required time frame; Denominator: Number of complaints

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of unpreventable and preventable causes. Numerator: Number of deaths with unpreventable causes; Denominator: Number of deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
Unexpected Death Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of substantiated complaints. Numerator: Number of substantiated complaints; Denominator: Number of complaints

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of the use of restrictive interventions requiring investigations. Numerator is the number of investigations for the use of restrictive interventions. Denominator is the reported uses of restrictive interventions.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of the Changes in Health, End-Stage Disease, Signs, and Symptoms Scale (CHESS). Numerator - number of changes in CHESS scores. Denominator - Number of all CHESS scores.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DAAS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement

Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

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

DMS analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DMS will meet with the operating agency (DAAS) to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue, etc.), complexity of the solution (does it require an amendment to the waiver application), and the financial impact. If it is determined that a system change is needed, a Customer Service Request will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DMS and a priority status is assigned. MMIP prioritizes system changes to the MMIS system and coordinates implementation with the state fiscal agent. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. The MMIP Unit and the DMS monitor the system changes. An online CSR Management System is used to monitor and track the status of computer service requests.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: Ongoing, as needed

b. System Design Changes

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

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

MMIS claims data are audited periodically for program policy alignment, and claims processing worksheets are audited, processed and returned on a daily basis. Discovery and monitoring also includes an ongoing review of CMS-372 reports and CMS-64 reports. DMS reviews are validation reviews of 20% of the records reviewed by DAAS and include a review of the services billed and paid when compared with the services listed on a participant's person-centered service plan.

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient Profiles

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other**

		Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of failed MMIS edit checks which are corrected to assure appropriate payment. Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks

Data Source (Select one):
Other
If 'Other' is selected, specify:
Weekly Worksheets

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Daily LTC Update Error Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Daily Waiver Update Error Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient Claims History Profile (Chart Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

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

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

The operating agency (DAAS) is responsible for the rate determination with oversight conducted by the DMS (Medicaid agency) Financial Section prior to implementation. There is an established procedure followed by both divisions that ensures DMS reviews and approves all reimbursement rates and methodologies. As ARChoices is not a participant-directed program, payment rates are not routinely sent separately to waiver participants. Rates are published for comment and are made available to all providers. Additionally, providers are notified any time a rate changes via a Provider Information Memorandum from DAAS and/or an Official Notice from DMS. The public is afforded an opportunity to comment on the rate determination process through the DMS website, in the Proposed Rules for Public Comment section. Upon certification, new providers are referred to the Medicaid Provider Manual, which lists rate information.

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

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver providers bill for the services and are reimbursed directly through the MMIS.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- [ ] **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

- [ ] **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

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

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DAAS staff verifies services were provided according to the person-centered service plan through an internal monthly monitoring system. Adjustments are made or referred to the Office of Medicaid Inspector General when claims are paid incorrectly.

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

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (•) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (•) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- ☑ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement,

and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

  Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

  Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

For Adult Family Homes, 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.

For any given year of the ARChoices waiver, Adult Family Homes shall charge waiver participant residents no more than 90.8% of the current individual SSI Federal Benefit Rate amount rounded to the nearest dollar for room and board.

The waiver eligible participant 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 participant.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

(●) No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

( ) Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8504.21		18170.21			50100.00	31929.79

		9666.00		47580.00	2520.00		
2	7726.73	9934.00	17660.73	48898.00	2590.00	51488.00	33827.27
3	8248.90	10209.00	18457.90	50252.00	2662.00	52914.00	34456.10
4	8934.28	10492.00	19426.28	51644.00	2735.00	54379.00	34952.72
5	9684.43	10782.00	20466.43	53075.00	2811.00	55886.00	35419.57

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

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

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Data from the annnual reports (CMS-372) for the 2013 reporting year for each of the two existing DAAS 1915(c) waivers which are being replaced with the new ARChoices in Homecare waiver were tabulated to estimate the average length of stay on the waiver.

A total of 9,374 unduplicated participants were served by the two waivers, with a total of 2,591,698 days of waiver coverage. The average length of stay on the waiver(s) is estimated at 276 days.

Appendix J: Cost Neutrality Demonstration

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

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

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

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

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Weighted average of factor D from historic waivers, less current D, plus historic D prime.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Weighted average of historic waivers forward to forecast the combined waivers.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Weighted average of historic waivers forward to forecast the combined waivers.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Health	
Respite	
Adult Day Services	
Adult Family Home	
Attendant Care Services	
Environmental Accessibility Adaptations/Adaptive Equipment	
Home-Delivered Meals	
Personal Emergency Response System (PERS)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**799606.08**
Adult Day Health	☐	15 Minutes	63	4068.00	3.12	**799606.08**	
Respite Total:							**6441773.60**
Respite In-Home	☐	15 Minutes	1147	1228.00	4.50	**6338322.00**	
Respite Short-Term Facility-Based	☐	15 Minutes	75	779.00	1.68	**98154.00**	
Respite Long-Term Facility-Based	☐	15 Minutes	10	946.00	0.56	**5297.60**	
Adult Day Services Total:							**2176785.00**
Adult Day Services	☐	15 Minutes	234	3721.00	2.50	**2176785.00**	

Adult Family Home Total:							**12000.40**
Adult Family Home - Level A	☐	Day	1	76.00	56.25	**4275.00**	
Adult Family Home - Level C	☐	Day	1	76.00	48.22	**3664.72**	
Adult Family Home - Level B	☐	Day	1	76.00	53.43	**4060.68**	
Attendant Care Services Total:							**77957590.50**
Attendant Care Services	☐	15 Minutes	6577	2291.00	4.50	**67805581.50**	
Self-directed Attendant Care Transitioning-1st Year	☐	15 Minutes	1050	3806.00	2.43	**9711009.00**	
CSM Transition Costs-1st Year	☐	1 Month	1050	6.00	70.00	**441000.00**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**715864.00**
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	172	1.00	4162.00	**715864.00**	
Home-Delivered Meals Total:							**6927038.76**
Home-Delivered Meals	☐	Meal	5422	214.00	5.97	**6927038.76**	
Personal Emergency Response System (PERS) Total:							**1492092.96**
PERS Installation	☐	One Installment	938	1.00	29.90	**28046.20**	
PERS Unit Monitoring	☐	Day	5324	257.00	1.07	**1464046.76**	

GRAND TOTAL:	**96522751.30**
Total: Services included in capitation:	
Total: Services not included in capitation:	96522751.30
Total Estimated Unduplicated Participants:	**11350**
Factor D (Divide total by number of participants):	**8504.21**
Services included in capitation:	
Services not included in capitation:	8504.21
Average Length of Stay on the Waiver:	276

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**799606.08**
Adult Day Health	☐	15 Minutes	63	4068.00	3.12	**799606.08**	
Respite Total:							**6574397.60**

Respite In-Home	☐	15 Minutes	1171	1228.00	4.50	**6470946.00**	
Respite Short-Term Facility-Based	☐	15 Minutes	75	779.00	1.68	**98154.00**	
Respite Long-Term Facility-Based	☐	15 Minutes	10	946.00	0.56	**5297.60**	
Adult Day Services Total:							**2176785.00**
Adult Day Services	☐	15 Minutes	234	3721.00	2.50	**2176785.00**	
Adult Family Home Total:							**12000.40**
Adult Family Home - Level A	☐	Day	1	76.00	56.25	**4275.00**	
Adult Family Home - Level C	☐	Day	1	76.00	48.22	**3664.72**	
Adult Family Home - Level B	☐	Day	1	76.00	53.43	**4060.68**	
Attendant Care Services Total:							**68857150.50**
Attendant Care Services	☐	15 Minutes	6679	2291.00	4.50	**68857150.50**	
Self-directed Attendant Care Transitioning-1st Year	☐	15 Minutes	0	0.00	0.01	**0.00**	
CSM Transition Costs-1st Year	☐	1 Month	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**753322.00**
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	181	1.00	4162.00	**753322.00**	
Home-Delivered Meals Total:							**7033077.90**
Home-Delivered Meals	☐	Meal	5505	214.00	5.97	**7033077.90**	
Personal Emergency Response System (PERS) Total:							**1492092.96**
PERS Installation	☐	One Installment	938	1.00	29.90	**28046.20**	
PERS Unit Monitoring	☐	Day	5324	257.00	1.07	**1464046.76**	

GRAND TOTAL:	**87698432.44**
Total: Services included in capitation:	
Total: Services not included in capitation:	87698432.44
Total Estimated Unduplicated Participants:	**11350**
Factor D (Divide total by number of participants):	**7726.73**
Services included in capitation:	
Services not included in capitation:	7726.73
Average Length of Stay on the Waiver:	276

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D

fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**863066.88**
Adult Day Health	☐	15 Minutes	68	4068.00	3.12	**863066.88**	
Respite Total:							**6707021.60**
Respite In-Home	☐	15 Minutes	1195	1228.00	4.50	**6603570.00**	
Respite Short-Term Facility-Based	☐	15 Minutes	75	779.00	1.68	**98154.00**	
Respite Long-Term Facility-Based	☐	15 Minutes	10	946.00	0.56	**5297.60**	
Adult Day Services Total:							**2223297.50**
Adult Day Services	☐	15 Minutes	239	3721.00	2.50	**2223297.50**	
Adult Family Home Total:							**24000.80**
Adult Family Home - Level A	☐	Day	2	76.00	56.25	**8550.00**	
Adult Family Home - Level C	☐	Day	2	76.00	48.22	**7329.44**	
Adult Family Home - Level B	☐	Day	2	76.00	53.43	**8121.36**	
Attendant Care Services Total:							**74331495.00**
Attendant Care Services	☐	15 Minutes	7210	2291.00	4.50	**74331495.00**	
Self-directed Attendant Care Transitioning-1st Year	☐	15 Minutes	0	0.00	0.01	**0.00**	
CSM Transition Costs-1st Year	☐	1 Month	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**844886.00**
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	203	1.00	4162.00	**844886.00**	
Home-Delivered Meals Total:							**7139117.04**
Home-Delivered Meals	☐	Meal	5588	214.00	5.97	**7139117.04**	
Personal Emergency Response System (PERS) Total:							**1492092.96**
PERS Installation	☐	One Installment	938	1.00	29.90	**28046.20**	
PERS Unit Monitoring	☐	Day	5324	257.00	1.07	**1464046.76**	

GRAND TOTAL:	**93624977.78**
Total: Services included in capitation:	
Total: Services not included in capitation:	93624977.78
Total Estimated Unduplicated Participants:	**11350**
Factor D (Divide total by number of participants):	**8248.90**
Services included in capitation:	
Services not included in capitation:	8248.90
Average Length of Stay on the Waiver:	276

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**926527.68**
Adult Day Health	☐	15 Minutes	73	4068.00	3.12	**926527.68**	
Respite Total:							**6839645.60**
Respite In-Home	☐	15 Minutes	1219	1228.00	4.50	**6736194.00**	
Respite Short-Term Facility-Based	☐	15 Minutes	75	779.00	1.68	**98154.00**	
Respite Long-Term Facility-Based	☐	15 Minutes	10	946.00	0.56	**5297.60**	
Adult Day Services Total:							**2279112.50**
Adult Day Services	☐	15 Minutes	245	3721.00	2.50	**2279112.50**	
Adult Family Home Total:							**36001.20**
Adult Family Home - Level A	☐	Day	3	76.00	56.25	**12825.00**	
Adult Family Home - Level C	☐	Day	3	76.00	48.22	**10994.16**	
Adult Family Home - Level B	☐	Day	3	76.00	53.43	**12182.04**	
Attendant Care Services Total:							**81661549.50**
Attendant Care Services	☐	15 Minutes	7921	2291.00	4.50	**81661549.50**	
Self-directed Attendant Care Transitioning-1st Year	☐	15 Minutes	0	0.00	0.01	**0.00**	
CSM Transition Costs-1st Year	☐	1 Month	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**923964.00**
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	222	1.00	4162.00	**923964.00**	
Home-Delivered Meals Total:							**7245156.18**
Home-Delivered Meals	☐	Meal	5671	214.00	5.97	**7245156.18**	
Personal Emergency Response System (PERS) Total:							**1492092.96**
PERS Installation	☐	One Installment	938	1.00	29.90	**28046.20**	

PERS Unit Monitoring	☐	Day	5324	257.00	1.07	**1464046.76**	

GRAND TOTAL:	**101404049.62**
Total: Services included in capitation:	
Total: Services not included in capitation:	101404049.62
Total Estimated Unduplicated Participants:	**11350**
Factor D (Divide total by number of participants):	**8934.28**
Services included in capitation:	
Services not included in capitation:	8934.28
Average Length of Stay on the Waiver:	276

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**989988.48**
Adult Day Health	☐	15 Minutes	78	4068.00	3.12	**989988.48**	
Respite Total:							**6972269.60**
Respite In-Home	☐	15 Minutes	1243	1228.00	4.50	**6868818.00**	
Respite Short-Term Facility-Based	☐	15 Minutes	75	779.00	1.68	**98154.00**	
Respite Long-Term Facility-Based	☐	Hour	10	946.00	0.56	**5297.60**	
Adult Day Services Total:							**2325625.00**
Adult Day Services	☐	15 Minutes	250	3721.00	2.50	**2325625.00**	
Adult Family Home Total:							**48001.60**
Adult Family Home - Level A	☐	Day	4	76.00	56.25	**17100.00**	
Adult Family Home - Level C	☐	Day	4	76.00	48.22	**14658.88**	
Adult Family Home - Level B	☐	Day	4	76.00	53.43	**16242.72**	
Attendant Care Services Total:							**89723578.50**
Attendant Care Services	☐	15 Minutes	8703	2291.00	4.50	**89723578.50**	
Self-directed Attendant Care Transitioning-1st Year	☐	15 Minutes	0	0.00	0.01	**0.00**	
CSM Transition Costs-1st Year	☐	1 Month	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**1015528.00**
Environmental							

Accessibility Adaptations/Adaptive Equipment	☐	Package	244	1.00	4162.00	**1015528.00**	
Home-Delivered Meals Total:							**7351195.32**
Home-Delivered Meals	☐	Meal	5754	214.00	5.97	**7351195.32**	
Personal Emergency Response System (PERS) Total:							**1492092.96**
PERS Installation	☐	One Installment	938	1.00	29.90	**28046.20**	
PERS Unit Monitoring	☐	Day	5324	257.00	1.07	**1464046.76**	

GRAND TOTAL:	**109918279.46**
Total: Services included in capitation:	
Total: Services not included in capitation:	109918279.46
Total Estimated Unduplicated Participants:	**11350**
Factor D (Divide total by number of participants):	**9684.43**
Services included in capitation:	
Services not included in capitation:	9684.43
Average Length of Stay on the Waiver:	276