Division of Aging, Adult, & Behavioral Health Services
P.O. Box 1437, Slot W241, Little Rock, AR 72203-1437
P: 501.686.9164

MEMORANDUM

TO: Interested Persons and Providers

FROM: Jay Hill, Director, Division of Aging, Adult & Behavioral Health Services

DATE: Friday, September 23, 2022

SUBJ: **Amendment to ARChoices to allow Inpatient Attendant Care**

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than October 24, 2022.

All DHS proposed rules, public notices, and recently finalized rules may also be viewed at: Proposed Rules & Public Notices.

NOTICE OF RULE MAKING

The Director of the Division of Aging and Adult Behavior Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129.

Effective January 1, 2023:

The Director of the Division of Aging and Adult Behavior Services amends the ARChoices Waiver and Sections 211.000 and 213.210 of the ARChoices Provider Manual to allow inpatient attendant care. The amendment to the waiver allows ARChoices services to be provided to inpatients of hospitals in certain circumstances and such services may be covered and reimbursable on days when the participant has been admitted to an inpatient hospital or institution, though the provided attendant care services may not exceed approved prior authorized rate for the service in place prior to hospitalization. The projected annual cost of this change for state fiscal year (SFY) 2023 is $240,276 (federal share of $172,086) and for SFY 2024 is $480,552 (federal share of $344,171).

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than October 24, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502100209

Jay Hill, Director
Division of Aging and Adult Behavior Services

TOC not required

211.000 Scope

~~10-1-22~~1-1-23

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 are as follows:

A. Attendant Care Services

B. Home-Delivered Meals

C. Personal Emergency Response System

D. Adult Day Services

E. Adult Day Health Services

F. Prevocational Services

G. Respite Care

H. Environmental Accessibility Adaptations/Adaptive Equipment

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

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

Participants who are determined to require skilled level of care as defined by State administrative rule are not eligible for this waiver program. Please see DHS Procedures for Determination of Medical Need for Nursing Home Services as established by the DHS Office of Long Term Care.

Notwithstanding the foregoing, pursuant to Section 3715 of the CARES Act, Section 1902(h)(1) of the Social Security Act, attendant care services are not prohibited as specified if the services are (a) identified in an individual's person-centered plan (or comparable plan of care), (b) provided to meet needs of the individual that are not met through the provision of hospital services; (c) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under applicable requirement; and (d) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities. Moreover, such services may be covered and reimbursable on days when the participant has been admitted to an inpatient hospital or institution. Under such circumstances, attendant care services may be covered or reimbursable, availability of Arkansas Medicaid State Plan Services notwithstanding.

213.210 Attendant Care Services

~~10-1-22~~1-1-23

Procedure Code	Modifier	Description
S5125	U2	Attendant Care Services

Procedure Code	Modifier	Description
S5125		Attendant Care Self-Directed Model

Attendant Care services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible participant's functioning in his or her own home or elsewhere in the community where the participant engages in activities, including work-related activities. Attendant Care services may be provided in a participant's home or while accompanying the participant to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in section 213.220.

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

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

A. "Hands-on assistance" means a provider physically performs all or part of an activity because the participant 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 participant can perform an activity.

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

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

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

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

G. "Support", a form of supervision, means to enhance the environment to enable the participant 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 participant 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 participant against injury, hazard or accident. These specific supports are designed to support participants with cognitive impairments.

Activities of daily living include:

A. Eating

B. Bathing

C. Dressing

D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, menstrual hygiene, etc.)

E. Toileting

F. Mobility/ambulating, including functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

A. Meal planning and preparation consumed only by the participant

B. Laundry for the participant or incidental to the participant's care

C. Shopping for food, clothing and other essential items required specifically for the health and maintenance of the participants

D. Housekeeping (cleaning of furniture, floors and areas directly used by the participant)

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

Health-related tasks are limited to the following activities:

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

B. Additional assistance with self-administration of prescribed medications, and/or

C. Emptying and replacing colostomy and ostomy bags.

Health-related tasks must be:

A. Consistent with all applicable State scope of practice laws and regulations;

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

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

D. Necessary to meet specific needs of the participant consistent with a written plan of care by a physician or registered nurse; and

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

The provision of assistance with ADLs, IADLs or health-related tasks does not entail nursing care.

Attendant care services tasks must be:

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

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

C. Expressly authorized in the participant's person-centered service plan;

D. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services;

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

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

Attendant care services exclude all of the following:

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

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

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

D. Companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);

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

F. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

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

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

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

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

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

The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the participant in accordance with the Arkansas Medicaid Task and Hour Standards

("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, month, and year. Any aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the participant in accordance with the THS specifications are not covered.

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

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

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

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

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

E. On dates of service when the participant:

1. Receives Medicare home health aide services, whether through traditional Medicare fee-for-service or a Medicare Advantage plan of any kind for the same tasks;
2. Receives targeted or other supplemental benefits from a Medicare Advantage plan of any kind, where such supplemental services are reasonably comparable to or duplicative of attendant care services, personal care services, or self-directed personal assistance;
3. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the PCSP/CC Nurse;
4. Receives long-term or short-term facility-based respite care; and/or
5. Receives services from an inpatient hospital, nursing facility, assisted living facility, hospice facility, or residential care facility, unless approved in writing by a PCSP/CC Nurse as reasonable and necessary given the time of day of the facility admission or discharge, the need for transition assistance, or an inpatient hospital admission incident to an emergency department visit or direct inpatient admission by the attending physician.

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

G. For a task that was not actually performed.

Participants 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 participant's 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 participant's case record. See Section 214.000 for additional documentation requirements.

Benefit limits will be determined on a participant basis based on application of the Arkansas Medicaid Task and Hour Standards (THS) and the service limitations described in this manual.

DAABHS will update the Person-Centered Service Plan to take into the account any changes in the participant's condition and/or living arrangements that would affect the number of hours of attendant care that could be approved under the Task and Hour Standards.

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

An ARChoices participant 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 PCSP/CC Nurse.

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

Notwithstanding the foregoing, pursuant to Section 3715 of the CARES Act, Section 1902(h)(1) of the Social Security Act, attendant care services are not prohibited as specified if the services are (a) identified in an individual's person-centered plan (or comparable plan of care), (b) provided to meet needs of the individual that are not met through the provision of hospital services; (c) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under applicable requirement; and (d) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities. Moreover, such services may be covered and reimbursable on days when the participant has been admitted to an inpatient hospital or institution. Under such circumstances, attendant care services may be covered or reimbursable, availability of Arkansas Medicaid State Plan Services notwithstanding.

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 waivers 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:

Appendix A - Clarification of the roles of the state Operating Agency and The Division of Medical Services (DMS) the State Medicaid Agency (SMA); The Division of Aging, Adult and Behavioral Health Services (DAABHS) the state operating agency; the Division of County Operations (DCO) and Division of Provider Services and Quality Assurance (DPSQA).
Appendix B - Throughout the waiver document the state updated the language to clarify the roles of the DHS Eligibility Nurse who is responsible for determination of medical waiver eligibility and determination of level of care and the PCSP/CC Nurse who is responsible for continued oversite of care through the development of the PCSP and evaluation at a minimum of every 12 months.
Appendix C - Updated Setting language in the appropriate location. The updates serve to clarify the roles of DHS RNs within the Department of Human Services particularly defining the role of the PCSP/CC nurse as the primary DHS contact for participants. Add budget limits exception criteria (in case participants need services above and beyond limits set forth in the waiver).
Appendix D - Throughout the waiver document the state updated the language to clarify the roles of the DHS Eligibility Nurse and the PC/CC Nurse. Clarification process, methodology, and roles for review and approval of service plans.
Appendix F - Updated Appeals Language to allow for automatic continuation of benefits with an opt out option.
Appendix G - Streamlined and clarified reporting requirements of critical incidents and provider training requirements.
Appendix H - No Major changes in this section.
Appendix I - Updated information on claims reviews and processing. Updated information related to responsibility for billing errors and monitoring of fraud, waste and
abuse.

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.R06.00
Draft ID: AR.005.06.00

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

Regular Waiver

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

07/01/21

Approved Effective Date: 07/01/21

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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:

Individuals requiring a skilled level of care are not eligible for the ARChoices program. The State's definition of "skilled level of care" is explained in b-6-d.

○ **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.

The purpose of the ARChoices in Homecare (ARChoices) waiver is to offer cost-effective, person-centered home and community based services as an alternative to nursing home placement to persons aged 21 to 64 years with a physical disability, or 65 and older who require an intermediate level of care in a nursing facility. and who do not require a skilled level of care, as defined by State administrative rule which is set forth in B-6-d.

Services are provided according to individualized person-centered service plans (PCSPs). ARChoices services include Attendant Care, Adult Day Services, Adult Day Health Services, Home-Delivered Meals, Personal Emergency Response System (PERS), Environmental Accessibility Adaptations/Adaptive Equipment, Prevocational Services, and Respite Care (in-home and facility-based). Individual PCSPs are developed in coordination with the participant based on the Arkansas Independent Assessment (ARIA) assessment or evaluation and a discussion of their preferences, goals, desired outcomes, and risk factors.

The independent assessment is performed by the Independent Assessment Contactor utilizing the Arkansas Independent Assessment (ARIA) instrument to assess functional need. This assessment of functional need is used as part of the process to determine if the person is medically and financially eligible as well in the development of a participant's PCSP. At least every 12 months, an evaluation will be completed in conjunction with the participant to determine continued evidence of established medical and functional need or a change in medical condition that may impact continued eligibility. The evaluation may result in a reassessment being requested if it is determined that there is evidence of a material change in the functional or medical need of the participant. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system.

ARChoices is operated by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) under the administrative authority of the Division of Medical Services (DMS), the State Medicaid agency. DAABHS and DMS are all under the umbrella of the Arkansas Department of Human Services (DHS). DMS is responsible for monitoring the operations of ARChoices, promulgation of the provider manuals and regulations governing the waiver, reimbursement of licensed waiver providers, and oversight of all waiver-related delegated functions. DAABHS is responsible for developing and implementing internal, administrative policies and procedures to operate the waiver, overseeing the development and management of PCSP, and providing care coordination to waiver participants.

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

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 are based on input from participants, caregivers (related and non-related), and providers. Comments are reviewed and appropriate action taken to incorporate changes or modifications to benefit participants, service delivery, and quality of care. Comments and public input are gathered through routine monitoring of program requirements, provider workshops/trainings, program integrity audits, and monitoring of participants and contact with stakeholders. These experiences and lessons learned are applied to the operations of ARChoices.

Notices of amendments and renewals of the waiver are posted on the DHS website for at least 30 days to allow the general public to submit comments on changes. Notices of amendments and renewals are also published in a statewide newspaper with instructions for submitting comments to DMS.

The public notice for this renewal was published in the Arkansas Democrat-Gazette for three consecutive days from July 4 through 6, 2021. The 30-day public comment period ended August 2, 2021. A public hearing was held by remote access at 11:00 a.m. on July 13, 2021. Physical copies of the entire proposed waiver renewal were mailed to constituents upon request and were posted on the DHS website on the proposed rules page at https://humanservices.arkansas.gov/do-business-with-dhs/proposed -rules/. The entire proposed waiver renewal was also emailed to an Interested Parties list. Commenters could submit comments to either an email address or a physical address.

There were 16 individuals, besides the presenters, who attended the Zoom public hearing on July 13, 2021, at 11:00 a.m. A PowerPoint presentation of the changes was conducted. No one provided comments during the public hearing. Attendees were reminded of how to provide public comments in writing.

DHS received public comments from two commenters, both are directors of Area Agencies on Aging in Arkansas.

Most of the comments related to amendments to the ARChoices and Personal Care provider manuals, which are also being updated with the waiver. Most of the comments were requesting more detail regarding certain processes. The provider manuals are being changed to match the requests.

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: Pitman

First Name: Elizabeth

Title: Director

Agency: Arkansas Department of Human Services, Division of Medical Service

Address:

P. O. Box 1437, Slot S-401

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 244-3944 **Ext:** ☐ **TTY**

Fax: (501) 682-8009

E-mail: Elizabeth.Pitman@dhs.arkansas.gov

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

Last Name: Gann

First Name: Patricia

Title: Deputy Director

Agency: Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health

Address: P. O. Box 1437, Slot W-241

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 686-9431 **Ext:** ☐ **TTY**

Fax: (501) 682-8155

E-mail: Patricia.Gann@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: Patricia Gann

State Medicaid Director or Designee

Submission Date: Mar 8, 2022

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Hill

First Name: Jay

Title: Director

Agency: Arkansas Department of Human Services, Division of Aging, Adult and Behavioral Health Services

Address: P.O. Box 1437 Slot W-241

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 686-9981 **Ext:** ☐ **TTY**

Fax: (501) 682-8155

E-mail: Jay.Hill@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.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **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:

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.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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, Adult, and Behavioral Health Services (DAABHS)

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 Division of Medical Services (DMS, the State Medicaid Agency) is responsible for monitoring the operations of ARChoices, promulgation of provider manuals and regulations governing the waiver, reimbursement of licensed waiver providers, and oversight of all delegated waiver-related functions. The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for developing and implementing internal administrative policies and procedures to operate the waiver, overseeing the development and management of PCSPs, and providing care coordination to waiver participants.

DMS delegates the following responsibilities to the following Divisions under the Arkansas Department of Human Services (DHS):

Division of County Operations (DCO) is responsible for processing ARChoices applications, determining medical and financial eligibility, and assigning levels of care for waiver services; and

Division of Provider Services and Quality Assurance (DPSQA) is responsible for provider licensure compliance.

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

DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system

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.:*

The independent assessment is performed by the Independent Assessment Contractor utilizing the Arkansas Independent Assessment (ARIA) instrument to assess functional needs.

○ **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:

As described in the Interagency Agreement, DMS and DAABHS will jointly share responsibility for oversight of the performance of the Independent Assessment Contractor, with DMS being ultimately accountable. The contract provides for performance measures the Independent Assessment Contractor is required to meet.

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:

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

The Independent Assessment Contractor's quality monitoring and assurance process must include (1) the staff necessary to perform quality monitoring and assurance reviews for accuracy, data consistency, integrity, and completeness of assessments and (2) procedures for assessing the performance of the staff conducting the assessments, include a desk review of assessments and tier recommendations.

The Independent Assessment Contractor is required to include the results of the quality monitoring and assurance process in the monthly reports submitted to the Contract Monitor in the format required by DHS. The monthly reports include the following:
1. Demographics about the participants who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all assessments ; and
3. A running total of the activities completed.

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

The Contract Monitor and senior staff from DMS and DAABHS review the monthly and annual reports submitted by the Independent Assessment Contractor within 15 days after they have been submitted and determine whether the Independent Assessment Contractor has submitted the required information, following its quality monitoring and assurance process, and meeting the performance standards in the contract. If not, the state will initiate appropriate corrective and preventive actions, which may include, for example, further analysis and problem solving with the contractor, root cause analysis to identify the cause of a discrepancy or deviation, enhanced reporting and monitoring, improved performance measures, requiring development and execution of corrective action plans, reallocation of staff resources, data and systems improvements, consultation with stakeholders, and/or sanctions under the contract.

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	Contracted Entity
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	☐	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
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 States quality improvement strategy, provide information in the following fields to detail the States 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 PCSP 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*	Frequency of data collection/generation*(check*	Sampling Approach*(check each that applies):*

each that applies):	*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**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Number and percent of active and 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 and 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 analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Rule or Policy Revision Request Form

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 waiver claims on the Overlapping Services Report having the same date of service as a claim for institutional services, which correctly paid only for the date of discharge. Numerator: Number of waiver claims on the Overlapping Services Report which correctly paid only for the date of discharge; Denominator: Number of waiver claims reviewed from the Overlapping Services Report

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*	**Frequency of data collection/generation***(check*	**Sampling Approach***(check each that applies):*

each that applies):	*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**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **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 DAABHS. For the validation review, DMS reviews 20% of the records reviewed by DAABHS. For the provider file sample, the Raosoft online calculator is used to determine a statistically valid sample size with a 95% confidence level and a margin of error of +/- 5%. Every nth name is selected for review until the sample size is reached. The sample is then divided into twelve groups for monthly review by DMS.

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS), and the Division of Medical Services (DMS) (Medicaid agency) participate in monthly team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement for measures related to administrative authority of the waiver. Problems are identified, documented, and tracked for remediation by DMS and DAABHS.

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	11425
Year 3	11500
Year 4	11575
Year 5	11650

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	9434
Year 2	9496
Year 3	9559
Year 4	9621
Year 5	9683

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, 2025, 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 applicants meet all medical and financial eligibility requirements.

Entry to the waiver will then be prioritized based on the following criteria and in the following order:

a) Waiver application determination date for persons inadvertently omitted from the waiver waiting list (administrative error);
b) Waiver application determination date for persons residing in a nursing facility and being discharged 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.

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**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional state supplement recipients**

☒ **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)**

☒ **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)**

☒ **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 spend down 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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), 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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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:

◉ **Other**

Specify:

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

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:
- ◉ **Other**

  Specify:

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

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 a government agency 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:

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

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.

DEFINITIONS:

MEDICAL ELIGIBILITY means the level of care needed to receive services through the waiver rather than in an institutional setting considering the participants functional needs. To be determined to meet medical eligibility, an applicant/participant must not require a skilled level of care.

Level of Care Criteria:

The medical eligibility for ARChoices is established in administrative rules, as promulgated by the Arkansas Department of Human Services (DHS). Please see DHS Procedures for Determination of Medical Need for Nursing Home Services as established by the DHS Office of Long Term Care. Beneficiaries who are determined to require a skilled level of care are not eligible for this waiver program. All state laws, regulations, and policies concerning the 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, including the instrument/tool utilized.

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

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

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

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

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

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

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

2. Not require a skilled level of care, as defined in the State rule. The State rule defines "Skilled Level of Care" to mean 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:

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

b. Intravenous injections and hypodermoclysis or intravenous feedings;

c. Levin tubes and nasogastric tubes;

d. Nasopharyngeal and tracheostomy aspiration;

e. Application of dressings involving prescription medication and aseptic techniques;

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

g. 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;

h. Initial phases of a regimen involving administration of medical gases;

i. 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;

j. Ventilator care and maintenance; and

k. The insertion, removal and maintenance of gastrostomy feeding tubes;

Level of Care Evaluation for Institutional Care:

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

The ARIA instrument will be used to collect information to evaluate functional eligibility. Registered nurses from the Independent Assessment Contractor will use the ARIA instrument to conduct face-to-face, in-home assessments and reassessments.

A participant who is otherwise eligible for waiver services shall not 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.

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.

DEFINITIONS:

ARKANSAS INDEPENDENT ASSESSMENT (ARIA)) INSTRUMENT means DHS approved the instrument used by registered nurses employed by the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan (PCSP).

INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the approved ARIA instrument for the purpose of collecting information used in determining level of care and developing the PCSP.

INDEPENDENT ASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the ARIA instrument to assess functional need. This assessment of functional need is used by DHS as part of the process to make a final determination of eligibility and, if the person is determined to be eligible, to be used in the development of the PCSP.

EVALUATION means the process completed in conjunction with the participant, at a minimum of every twelve (12) months, to determine continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility. The evaluation may result in a reassessment being requested if there is evidence of a material change in the medical need of the participant.

REASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the ARIA instrument to assess functional need when requested, based on evidence of a material change in medical eligibility documented at the evaluation. This information is used by DHS as part of the process to make a final determination of continued eligibility and, if the person is determined to be eligible, is used in the development of the PCSP.

Level of Care Evaluation for Institutional Care:

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

Level of Care Instrument for Waiver Program:

The ARIA instrument will be used to collect information to evaluate functional eligibility. Registered nurses from the Independent Assessment Contractor will use the ARIA instrument to conduct face-to-face, in-home assessments and reassessments. Using the information collected during the assessment, the Division of County Operations will evaluate whether an individual meets the State's level of care criteria.

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

The evaluation initiated at a minimum of every twelve (12) months, uses the DHS-703 form to make a determination of continued evidence of established medical eligibility or a change in medical condition that may

impact continued medical eligibility. The evaluation may result in a reassessment being requested if there is evidence of a material change in the medical need of the participant.

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

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:

DEFINITIONS:

DHS ELIGIBILITY NURSE means a registered nurse authorized by DMS to perform reviews of all medical information available and, based on available information, to make a medical eligibility determination and then, if determined financially eligible, the application will be approved for ARChoices. DHS eligibility nurses are also responsible for reviewing evaluation documentation for material changes to medical need and requesting a reassessment if warranted.

DHS PERSON CENTERED SERVICE PLAN/CARE COORDINATOR (PCSP/CC) NURSE means a registered nurse authorized by DMS to perform evaluations, develop PCSP, and serve as the primary care coordinator and DHS contact for assigned participants.

Each waiver applicant to the ARChoices program will be assessed by the Independent Assessment Contractor. Each assessment is performed by a registered nurse using the ARIA instrument. Medical eligibility is valid for twelve (12) months, unless a shorter period is specified.

Evaluations will continue to be performed by a registered nurse employed by DHS at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), an evaluation will be performed, and based on the review of the evaluation, a reassessment utilizing the ARIA instrument may be requested.

The Arkansas Independent Assessment (ARIA) instrument is used by registered nurses employed by the Independent Assessment Contractor to collect information to evaluate functional eligibility for individuals applying for ARChoices. The information collected along with the tier determination, and any additional information collected are utilized by registered nurses within the Division of County Operations to evaluate whether the individual meets the states level of care criteria and to determine the level of care.

The DHS-703 form (Evaluation of Medical Need Criteria) is used at a minimum of every 12 months, or more frequently based on reported changes in medical condition, by registered nurses employed by the Division of Aging, Adult and Behavioral Health Services to determine continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility.

If there is evidence of a change in medical condition that may impact continued medical eligibility, based on the evaluation completed using the DHS-703 form, a referral may be made for an independent assessment utilizing the ARIA instrument. The information collected through the reassessment process, utilizing the ARIA instrument along with the tier determination, and any additional information are utilized by registered nurses within the Division of County Operations to evaluate whether the individual continues to meet the states level of care criteria and to determine any changes to the level of care. No change in level of care will occur without the use of the ARIA instrument.

The ARIA instrument will recommend tiers designed to help further differentiate participants by need. The tiers do not replace the Level of Care criteria referenced in B-6-d, waiver eligibility determinations, or the PCSP process.

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

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

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

These indications notwithstanding, the final determination of Level of Care and medical eligibility is made by the Division of County Operations (DCO).

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):*

DCO has established and maintains procedures for tracking review dates and initiating timely evaluations prior to each participant's respective level of care review date and prior to the expiration of the participant's current PCSP.

Specifically, DCO uses online tracking tools with an integrated dashboard functionality to monitor level of care expirations. The process of evaluation begins at a minimum of two months prior to the annual anniversary date of the last medical eligibility determination or financial eligibility determination, whichever is earlier.

On at least a monthly basis, participants who are due for an evaluation will be identified. Reports are used to determine if the assessment is current or has expired. Patterns of noncompliance are documented, and disciplinary action is taken if necessary.

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 assessments conducted as part of the initial application process to inform level of care determination, evaluations completed at least every 12 months to determine continued evidence of established medical and functional eligibility or change in condition, and reassessments based on evidence of a material change in medical eligibility documented at the evaluation are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of County Operations (DCO). Records 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: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 all applicants for whom there is a reasonable indication that services may be needed in the future who receive an evaluation for LOC. Numerator: Number of all applicants for whom there is a reasonable indication that services may be needed in the future who receive an evaluation for LOC; D: Number of applicants for whom there may be need in the future that were reviewed.

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 =

		DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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.

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 participant LOC determinations reviewed where the LOC processes and instruments were applied accurately and as required by the approved description. N: Number of participant LOC determinations reviewed where the LOC processes and instruments were applied accurately and as required by the approved description; D: Number of participant LOC determinations reviewed.

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 = DMS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant level of care determinations reviewed that were made by a qualified evaluator. Numerator: Number of participant level of care determinations made by a qualified evaluator; Denominator: Number of participants level of care determinations 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 =

		DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Number and percent of participant annual re-evaluation LOC determinations where the LOC criteria were applied accurately and as required by the approved description. N: Number of participant annual re-evaluation LOC determinations where the LOC criteria were applied accurately and as required by the approved description; D: Number of participant annual re-evaluation LOC determinations 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 = DAABHS 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 implements a system of monthly monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected from individual participant records, aggregated to produce summation reports, and compared with periodic randomly sampled record reviews and sampled Program Integrity reviews.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

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

A functional eligibility determination of level of care is required annually. applying the functional eligibility criteria, with referral for the use of the ARIA instrument in the event of a change of condition that may affect functional eligibility. When referred, the Independent Assessment Contractor conducts a reassessment using ARIA instrument and applies the functional eligibility criteria. The DHS Independent Assessment Contractor will submit data reports to DMS at least monthly listing the number of assessments and reassessments conducted. DMS will require the DHS Independent Assessment Contractor to develop a corrective action plan when remediation in this area is needed, and document completion of the corrective action plan

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 development of the person-centered service plan (PCSP) for the waiver participant, the DHS PCSP/CC Nurse explains the services available through ARChoices waiver, discusses the qualified ARChoices providers in the state, and develops an appropriate PCSP. As part of the PCSP development process, the participant (or representative) documents their choice to have services provided in the community setting through the ARChoices 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 PCSP, which includes the signature of the waiver participant (or representative) and the DHS PCSP/CC Nurse, and is included in the participant's record.

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

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

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice forms and PCSPs are maintained by DHS 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):

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.

Accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. DHS PCSP/CC Nurses provide written materials to participants and will read information to participants if needed. DHS PCSP/CC Nurses may utilize assistance from other divisions within DHS. When this occurs, it is documented in the participant 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	Attendant Care Services		
Other Service	Environmental Accessibility Adaptations/Adaptive Equipment		
Other Service	Home-Delivered Meals		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Prevocational Services		

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:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11010 health monitoring
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy
Category 4:	**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 care 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 PCSP, 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.

Adult day health centers operate on a service day of no more than twelve (12) hours. The adult day health center shall serve one meal of nutritional content equal to one-third of the Recommended Daily Allowance, to participants who are present in the adult day health center for more than five (5) hours in that day.

The goals of adult day health go beyond the custodial and personal care goals of adult day services. The emphasis is on rehabilitative and health services. The goals of adult day health are:

1. To enable the participant to function physically, mentally and socially at the highest possible level.

2. To enable functionally impaired participants to remain in a supportive home environment instead of entering a nursing home.

3. To improve the health, well-being and quality of life for the participants by providing a rehabilitation program among their peers.

4. To provide support for family and other caregivers to enable them to maintain the impaired participant in the community.

The essential elements of an adult day health program are directed toward meeting the health restorative and maintenance needs of participants. The objectives of fostering and sustaining optimal capacity for self-care are achieved by:

1. Maximizing the participant's capacity to function independently;
2. Developing the participant's opportunities for socialization and peer support;
3. Providing treatment options other than institutionalization.

Adult day health providers are required to develop a written individual PCSP to guide the delivery of adult day health services provided to each waiver participant in the adult day health facility. There must be a regular, ongoing schedule of services and activities (individual and group) based upon the participant's PCSP. Adult day health programs provide health services that cannot be provided by adult day services programs. Adult day health is appropriate only for participants whose PCSPs specify one or more of the following health services that are not consistently provided by adult day services programs:

1. Rehabilitative therapies;
2. Pharmaceutical supervision;
3. Diagnostic evaluation;
4. Health monitoring.

Participants may also receive any of the following ancillary services in accordance with their PCSP. These services, although they are non-medical in nature, are an important supplement to the basic health care functions:

1. Assistance with the activities of daily living;
2. Social work;
3. Recreation therapy;
4. Exercise;
5. Counseling.

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 participants' PCSP. 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 Provider Services and Quality Assurance, as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

Certificate *(specify):*

Providers must be enrolled in the Arkansas Medicaid program as an Licensed Adult Day Health Care provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**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 Care is provided to waiver participants unable to care for themselves and is furnished on a limited or short-term basis because of the absence of, or need for relief of, those persons normally providing the care.

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

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

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

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

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

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

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

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

Respite Care is available in the following locations:
1. Participant's home or place of residence;
2. Medicaid certified hospital;
3. Medicaid certified nursing facility;
4. Medicaid certified adult day health facility; and
5. Medicaid certified assisted living facility with a level II state license.

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

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

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

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

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

Reimbursement is only permitted for direct care rendered according to the participant’s PCSP by trained respite care workers employed and supervised by certified in-home respite providers.

Reimbursement is not permitted for Respite Care services provided by a participant’s:
1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the participant’s care.

Respite care may be provided in a participant's home or while accompanying the participant to other locations, including without limitation for medical appointments or community activities. 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.

Respite care may be provided in a participant's home or while accompanying the participant to other locations, including without limitation for medical appointments or community activities. 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.

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

Respite Care is subject to the following limitations:

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

2. Respite Care excludes:

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

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

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

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

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

f. Services provided for any task not included in a participant's PCSP.

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

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

5. Respite care may be provided in a participant's home or while accompanying the participant to other locations, including without limitation for medical appointments or community activities. 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

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 Level II Assisted Living Facility
Agency	Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency
Agency	Licensed Adult Day Care Agency
Agency	Licensed Medicaid Certified Nursing Facility
Agency	Licensed Acute Care Hospital
Agency	Licensed Adult Day Health Care Agency
Agency	Licensed Residential Care Facility

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

Certificate *(specify):*

Providers must be enrolled in the Arkansas Medicaid program as an Licensed Level II Assisted Living Facility provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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):*

Providers must be enrolled in the Arkansas Medicaid program as an Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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 Adult Day Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Providers must be enrolled in the Arkansas Medicaid program as an Licensed Adult Day Care Agency provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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 Medicaid Certified Nursing Facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Providers must be enrolled in the Arkansas Medicaid program as an Licensed Medicaid Certified Nursing Facility provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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 Acute Care Hospital

Provider Qualifications

License *(specify):*

Licensed Acute Care Hospital

Certificate *(specify):*

Providers must be enrolled in the Arkansas Medicaid program as an Licensed Acute Care Hospital provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Health andArkansas Department of Human Services, Division of Medical 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 Adult Day Health Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Providers must be enrolled in the Arkansas Medicaid program as an Licensed Adult Day Health Care Agency provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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 Residential Care Facility

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Providers must be enrolled in the Arkansas Medicaid program as an Licensed Residential Care Facility provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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:

Adult Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**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 centers 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 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 PCSP. 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. 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 Provider Services and Quality Assurance, as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et. seq.

Certificate *(specify)*:

Providers must be enrolled in the Arkansas Medicaid program as an Adult Day Care provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08040 companion
Category 3:	**Sub-Category 3:**
08 Home-Based Services	08050 homemaker
Category 4:	**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 available under the ARChoices program consists of direct human assistance with specific types of tasks, provided such tasks are:

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

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

3. Expressly authorized in the participant's PCSP;

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

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

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

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

1. Activities of Daily Living (ADLs):

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

b. Toileting;

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

d. Dressing;

e. Bathing or showering; and/or

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

2. Instrumental Activities of Daily Living (IADLs):

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

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

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

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

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

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

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

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

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

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

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

b. Any such health-related tasks performed:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attendant care may be provided in a participant's home or while accompanying the participant to other locations, including without limitation for medical appointments or community activities. 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.

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

1. The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the participant in accordance with the Arkansas Medicaid Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, or month. Any aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the participant in accordance with the THS are not covered.

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

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

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

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

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

e. On dates of service when the participant:

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

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

iii. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the DHS PCSP/CC Nurse;

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

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

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

g. For a task that was not actually performed.

Attendant care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. 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.

(1) Notwithstanding the foregoing, pursuant to Section 3715 of the CARES Act, Section 1902(h)(1) of the Social Security Act, services are not prohibited as specified if the services are (a) identified in an individual's person-centered plan (or comparable plan of care), (b) provided to meet needs of the individual that are not met through the provision of hospital services; (c) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under applicable requirement; and (d) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities. Moreover, such services may be covered and reimbursable on days when the participant has been admitted to an inpatient hospital or institution. Under such circumstances, attendant care services may be covered or reimbursable, availability of Arkansas Medicaid State Plan Services notwithstanding. The provided attendant care services may not exceed approved prior authorized rate for the service in place prior to hospitalization.

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

Certificate *(specify)*:

Providers must be enrolled in the Arkansas Medicaid program as an Arkansas Medicaid Personal Care Provider provider before reimbursement may be made for services

Other Standard *(specify)*:

The attendants hired by the agency must meet the following minimum qualifications:
* Be 18 years of age or older;

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

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

* Be free from communicable diseases;

* Be free from diseases readily transmittable through casual contact;

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

* Be in adequate physical health to perform job tasks required;

* Have a current signed formal agreement with an eligible;

*Enrolled in Arkansas Medicaid and obtain a Personal Identification Number (PIN);

*Be an ARChoices participant for the provision of agency attendant care services.

Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant. Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical Services

Frequency of Verification:

Annually

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):*

Providers must also be enrolled in the Arkansas Medicaid program as an Licensed Home Health Agency provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

The attendants hired by the agency must meet the following minimum qualifications:
* Be 18 years of age or older;

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

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

* Be free from communicable diseases;

* Be free from diseases readily transmittable through casual contact;

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

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

*Enrolled in Arkansas Medicaid and obtain a Personal Identification Number (PIN);

*Be an ARChoices participant for the provision of agency attendant care services.

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

Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant. Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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:

Environmental Accessibility Adaptations/Adaptive Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**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 PCSP, 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 participant, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. Any equipment or supply covered by the state plan Durable Medical Equipment (DME) program is excluded. No permanent fixtures are allowed to leased or rented homes. The DHS PCSP/CC Nurse will research the need and will assist participants in choosing appropriate adaptations that are safe and portable if they lease or rent. Adaptations may not be performed on vehicles. All services must be in accordance with applicable state or local building codes.

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment provided by a participant's:
1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the participant's care.

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 participant for the life of the participant. A 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):*

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 Medical 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:

Home-Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**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:

1. To facilitate participant independence by allowing them the choice to remain in their own homes rather than entering a nursing facility.

2. To provide one (1) daily nutritious meal to participants at risk of being institutionalized;

3. To provide a daily social contact to homebound participants to insure the participant's safety and well- being.

In order to receive home-delivered meals under the waiver, a participant must:

1.Be homebound which is defined as:

a) A participant with normal inability to leave home without assistance (physical or mental) from another person;
b) The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
c) Leaving home requires considerable and taxing effort by the participant, and
d) Absences of the participant from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment; and

2. Be unable to prepare some or all of the participant's own meals, or require a special diet and is unable to prepare it; and

3. Have no other person available to prepare the participant's meals, and the provision of a home-delivered meal is the most cost-effective method of ensuring a nutritionally adequate meal; and

4. Have the provision of meals included in the participant's PCSP.

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 is one (1) per calendar day.

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**
- ☒ **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	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 Department of Health

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**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.

The goals of the personal emergency response system are:

1. To provide a high-risk participant with the security and assurance of immediate assistance in an emergency, making it possible for them to remain in their home.

2. To eliminate the need for costly in-home supervision provided by a paid attendant that also affords the participant the emotional satisfaction or independent living.

PERS is not intended to be a universal benefit. It is specifically for those "high-risk" participants whose needs are determined through the PCSPdevelopment process. The criteria for eligibility are based on the participant's level of medical vulnerability, functional impairment and social isolation. Participants receiving PERS services must be physically and mentally capable of utilizing the service or reside in the home with a caregiver who is capable of utilizing the service for the benefit of the waiver participant.

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**

☒ **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	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):*

CCertificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards Providers must provide a copy of their current certificate of compliance for protective signaling services issued by the Underwriters Laboratories Safety Standards.
Providers must also be enrolled in the Arkansas Medicaid program as an ARChoices home personal emergency response services provider before reimbursement may be made for services provided to ARChoices participants.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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:

Prevocational Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**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):*

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

Prevocational services are as follows:

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

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

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

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

All prevocational services must be prior approved in the participant's PCSP, and delivered and documented consistent with requirements of the ARChoices provider manual.

Reimbursement is not permitted for Respite Care services provided by a waiver participant's:
1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the participant's care.

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

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

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

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

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

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

☐ **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	Certified Prevocational Services Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Certified Prevocational Services Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Prevocational Services. Providers must also be enrolled in the Arkansas Medicaid program as Prevocational Services provider before reimbursement may be made for services provided to ARChoices participant

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Medical 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.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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 PCSP will include Medicaid State Plan targeted case management, unless refused by the waiver participant. Qualified targeted case managers who can deliver targeted case management services are the employees of providers enrolled in the Medicaid State Plan Targeted Case Management Program. A qualified targeted case manager must be licensed in the State of Arkansas as a social worker, a registered nurse or a licensed practical nurse or have a bachelor's degree from an accredited institution or have performed satisfactorily as a case manager for a period of two (2) years.

The targeted case manager is responsible for monitoring the waiver participant's status on a regular basis for changes in his or her service need, and reporting any waiver participant's complaints or changes to the DHS PCSP/CC Nurse 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 scope of the criminal background checks is national. This requirement applies to any employee who in the course of employment may have direct contact with an ARChoices participant. At the time of initial licensure, providers must submit a list of all direct care services staff and the dates of their last criminal background check.

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

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

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

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's provider enrollment vendor. All attendant care and respite care direct service providers must enroll with Arkansas Medicaid.

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):

The Division of Provider Services and Quality Assurance (DPSQA), requires that ARChoices providers conduct adult abuse registry checks on employees prior to providing services. The provider must provide documentation that employees have not been convicted or do not have a substantiated report of abuse. The provider shall, at a minimum, prior to employing any individual or for any individuals working through contract with a third party, make inquiry to the Employment Clearance Registry of DPSQA, the Child Maltreatment Central Registry maintained by the Division of Children & Family Services another division within DHS, and the Adult Abuse Register maintained by the Adult Protective Services Unit within the Division of Aging, Adult, and Behavioral Health Services. Employees must be re-checked every five years. DHS requires that each provider have written employment and personnel policies and procedures, which include verification that an adult abuse registry check has been completed.

Employees include any person who has unsupervised access to participants; provides care to participants on behalf of a service provider, under supervision of, or by arrangement with the provider; is employed by the provider to provide care to participants; or is a temporary employee placed by an employment agency with the provider to provide care to participants.

The DPSQA Licensing and Surveying Unit ensures that mandatory screenings have been conducted.

Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule.

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).**

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.*

☐ **Self-directed**

☐ **Agency-operated**

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.*

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

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

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

Controls are maintained through the required documentation for all service providers. This documentation must support each service for which billing is made and include a copy of the participant's person-centered service plan, a brief description of the specific services provided, the signature and title of the individual providing the service, and the date and actual time services were provided. DHS RN supervisory staff conducts chart reviews to ensure that services were provided according to the service plan. DPSQA performs audits and quality reviews of providers.

○ **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 the Division of Medical Services (DMS) Provider Enrollment Unit for information. There are no restrictions applicable to requesting this information.

The Arkansas Medicaid website provides enrollment information for potential ARChoices providers.

Information related to licensure and certification may be found on the Division of Provider Services and Quality Assurance Website.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 percent of licensed/certified providers, by provider type, whose license/certification renewals are in accordance with state law and waiver provider qualifications. N: Number of licensed/certified providers, by provider type, whose license/certification renewals are in accordance with state law and waiver provider qualifications; D: Total number of license/certification renewals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DPSQA 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: DPSQA	☒ **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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of new licensed/certified providers who obtained license/certification in accordance with state law and waiver provider qualifications prior to delivering services N: Number of new licensed/certified providers who obtained license/certification in accordance with state law and waiver provider qualifications prior to delivering services D: Number of licensed/certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment 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.

Performance Measure:
Number and percent of non-licensed/non-certified providers which adhere to waiver requirements. Numerator: Number of non-licensed/non-certified providers which adhere to waiver requirements; Denominator: Total number of non-licensed/non-certified providers.

Data Source (Select one):
Program logs
If 'Other' is selected, specify:
Provider Enrollment 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 providers meeting waiver provider training requirement conducted in accordance with state requirement and approved waiver as evidenced by attendance documents. Numerator: Number of providers meeting waiver provider training requirement conducted in accordance with state requirement and approved waiver as evidenced by attendance documents. Denominator: Number of 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: DPSQA	☒ **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 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 and tracked for all participating and active providers. Non-certified providers are not allowed to provide services under this waiver.

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

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

Provider training consists of program policy, including documentation requirements, reporting, claims processing and billing, the Medicaid Provider Manual and other areas. This training is scheduled, at a minimum, of annually or more frequently based on training needs.

Training requirements are explained in the provider manual. In addition, the Division of Provider Services and Quality Assurance (operating agency) (DPSQA) is responsible for contacting new providers according to program policy. These contacts provide information regarding proper referrals, eligibility criteria, forms, reporting change of status, general information about the program, etc.

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

The Medicaid fiscal agent provides DPSQA access to Provider License/Certification Status. If needed, this provides a second monitoring tool for monitoring licensure and certification compliance. The mandatory Medicaid contract, signed by each waiver provider, states compliance with required enrollment criteria. Failure to maintain required certification and/or licensure results in loss of their Medicaid provider enrollment. Each provider is notified in writing at least two months prior to the certification/licensure expiration date that renewal is due and failure to maintain proper certification will result in loss of Medicaid enrollment.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

DAABHS,DPSQA, and DMS, under the Department of Humans Services (DHS) participate in monthly team meetings to discuss and address individual problems related to qualified providers, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver.

In cases where providers do not maintain requirements for provider participation, remediation by DMS may include termination of the provider's Arkansas Medicaid enrollment, recouping payment for services provided after certification/licensure has expired and allowing the participant to choose another provider. Providers are notified in writing and documentation is maintained by DMS. The PSCP/CC Nurse would assist the participant in choosing a new provider from the Freedom of Choice List and update the PCSP to indicate chosen provider.

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.

DEFINITIONS:

PANEL means a team of three medical professionals, comprising DAABHS nurse supervisory staff and a DHS Eligibility Nurse responsible for the determination of eligibility and LOC. Upon referral, the panel completes a review to determine a change in medical condition that may impact continued medical eligibility. The review may result in a temporary increase in the Service Budget Limit (SBL) for a period of 60 days and a reassessment utilizing the ARIA instrument if the panel determines that there is evidence of a material change in the functional or medical need of the participant which may require an increase in the SBL. Final determination of change in SBL is made by the DCO Eligibility Nurse.

Upon referral, the panel completes a review to determine an exception to the $34,000 maximum SBL due to additional medical or behavioral needs, without which the individual is likely to be institutionalized. The review may result in a temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis for 60 calendar days. During the 60-calendar day temporary increase time period, a reassessment must be completed utilizing the ARIA Instrument and a final determination must be made by the panel, based on all information available, whether to grant the exception.

TEMPORARY LEVEL OF CARE criteria means a temporary increase in SBL approved by the panel. The PCSP, ISB, and SBL shall be adjusted to provide additional services on a temporary basis within and up to the participant's new SBL. The temporary PCSP, ISB, and SBL will remain in effect for up to 60 calendar days. Before the end of this 60 calendar days period, a reassessment must be completed using the ARIA instrument and a new SBL determination must be made."

SERVICE BUDGET LIMIT (SBL) means the limit on the maximum dollar amount of waiver services that may be authorized for and received by each specific participant.

Methodology for Determining the SBL:

A. An Independent Assessment Contractor will perform independent assessments that gather functional information about each applicant using the Arkansas Independent Assessment (ARIA)instrument. This assessment is used as part of the process to make a final determination of eligibility and, if the applicant is determined to be eligible, to be used to determine the SBL.

B. For participants, an evaluation is initiated at least every twelve (12) months. Based on the review of the evaluation, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment utilizing the ARIA instrument. This information is used as part of the process to make a final determination of continued eligibility and, if the participant is determined to be eligible, to be used to determine the SBL.

C. The three SBLs are:

1. Intensive: The participant requires total dependence or extensive assistance from another person in all three (3) areas of mobility, feeding and toileting. The maximum SBL for services is $34,000 annually.
2. Intermediate: The participant requires total dependence or extensive assistance from another person in two (2) of the areas of mobility, feeding and toileting. The maximum SBL for services is $23,000 annually.
3. Preventative: The participant meets the functional need eligibility requirements for ARChoices but does not meet the criteria for the ISB Levels of Intensive or Intermediate. The maximum SBL for services is $6,000 annually.

If the projected cost of services identified in the PCSP is less than the applicable SBL amount, this shall not be construed to permit, suggest, or justify approval, coverage, or reimbursement of different or additional waiver services (including changes in amount, frequency, or duration); coverage and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or other actions to increase spending to use the remaining "unused" portion of the SBL amount.

DHS will monitor and take steps necessary to update these SBL amounts when waiver rates change.

3. Individual Service Budget Limit (ISB):

D. Each PCSP shall include an Individual Service Budget (ISB) based upon the determination of Service Budget Limit (SBL) described above. The projected total cost of all authorized services in any PCSP shall not exceed the participant's SBL applicable to the time period covered by the PCSP.

E. For purposes of determining the projected cost of all waiver services in a PCSP, DAABHS shall assume that:
a. The participant will receive or otherwise use all services identified in the PCSP and in their respective maximum authorized amounts, frequencies, and durations; and
b. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.

F. Each participant's ISB and PCSP shall be discussed with the participant.

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

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

I. Adjustments and Considerations Regarding Individual Services Budgets:

1. Process for a Change of Condition within the SBL Level with an increase in ISB: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, steps shall be taken to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition. A face-to-face visit and the task and hours guide shall be completed. If it is determined that the participant may require additional services within the current SBL, the results shall be reviewed with the program supervisor and the supervisor may approve the adjustment of the participant's PCSP and ISB to provide additional services up to the participant's current SBL. If the supervisor approves the additional services, the PCSP and ISB will remain in effect until the participant's next evaluation and determination of eligibility.

2. Process for a Change of Condition with an Increase of SBL Level: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, steps shall be taken to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition. An evaluation and task and hours guide is completed. If it is determined that the participant may be in need of additional services that may require an increase in the participant's SBL, the participant's case will be submitted to the panel for review and approval of temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis within and up to the participant's new SBL. The temporary PCSP, ISB, and SBL will remain in effect no longer than 60 calendar days. Before the end of this 60 calendar days period, a reassessment must be completed using the ARIA instrument and a new SBL determination must be made.

3. Process for a Change in Condition with a Decrease in SBL, ISB or Change in Eligibility: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, and which may result in a decrease in the participant's SBL, ISB, or change in eligibility. An evaluation is initiated and provided for review. Based on the review, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment utilizing the ARIA Instrument. This information is used as part of the process to make a final determination of continued eligibility and, if the participant is determined to be eligible, to be used to determine the

4. Process for Granting an Exception to the $34,000 Maximum SBL: If a waiver participant , physician, family member, Targeted Case manager, or PCSP/CC Nurse requests an exception to the $34,000 maximum SBL due to additional medical or behavioral needs, without which the individual is likely to be institutionalized, steps will be taken to determine if the exception is to be granted. A participant will be granted

an exception to the $34,000.00 maximum Service Budget Limit (SBL) if the participant, due to additional medical or behavioral needs, is likely to be institutionalized but for additional waiver services and the cost of the needed additional waiver services exceeds the $34,000 maximum SBL.

a. The DHS PCSP/CC Nurse will exercise professional medical judgment to make an initial determination of whether the participant may qualify for an exception to the maximum SBL based on:

i. The participant's evaluation utilizing the DHS-703 Form;
ii. Other medical records or information pertinent to the participant's needs and documented in the participant's record;
iii. The participant's physical, mental, or environmental needs observed by the DHS PCSP/CC Nurse and documented in the DHS-703 Form; and
iv. The participant's preferences, risks, dangers, and supports as documented in the DHS-703 Form.

b. If the DHS PCSP/CC Nurse makes an initial determination that the beneficiary may qualify for an exception, the DHS PCSP/CC Nurse will calculate the SBL as the sum of the SBL maximum above, plus the cost of the additional waiver services needed to prevent institutionalization. The participant's case will be submitted to the panel for review and approval of temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis for 60 calendar days. During the 60-calendar day temporary increase time period, a reassessment must be completed utilizing the ARIA Instrument and a final determination must be made by the panel based on all information available whether to grant the exception.

c. The panel shall ensure that:
i. Any temporary increase granted under this section meets the above criteria; and
ii. Both temporary increase and exception amounts are determined in an equitable manner across the program, so that participants with comparable needs receive comparable exception amounts

d. In no case may an exception increase the SBL above the cost of institutionalization as set form in Column 5 of Appendix J-1 Factor G.

☐ **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.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide 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):*

☒ **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 (PCSP) development meeting, the DHS PCSP/CC Nurse explains to the participant or authorized representative the process and informs the participant that they may invite anyone they choose to participate in the PCSP development process. Involved in this PCSP development meeting is the participant and anyone they choose to have attend, such as their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the PCSP process. It is the participant or family member’s responsibility to notify interested parties to attend the PCSP development meeting.

During the PCSP development meeting, the DHS PCSP/CC Nurse discusses with the participant the services available through the ARChoices waiver.

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

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) Upon notification of participant eligibility for the ARChoices program, the DHS PCSP/CC Nurse will schedule a meeting with the participant to develop the person-centered service plan (PCSP). The DHS PCSP/CC Nurse will inform participants that they may invite anyone that they choose to participate in the PCSP plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment/evaluation, or PCSP development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting. The DHS PCSP/CC Nurse will assist in notifying interested parties if requested by the participant or the representative. The PCSP will be updated at a minimum of every 12 months in coordination with the annual evaluation/reassessment, as appropriate. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances.

(b) The development of the PCSP plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor or an in-person evaluation conducted by the DHS PCSP/CC Nurse. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor utilizing the Arkansas Independent Assessment (ARIA) instrument. Reassessments, which will be conducted by the Independent Assessment Contractor, if deemed appropriate by the DHS Eligibility Nurse based on a change in condition or circumstance which may result in a change in Level of Care. Evaluations are conducted face-to-face at a minimum of every 12 months or as required based on changes in condition or circumstances using the DHS 703 form.

The results of the Independent Assessment Contractor's functional assessment using the ARIA instrument, or the results of the annual evaluation using the DHS 703 form will be used by the Division of County Operations to evaluate the level of care and by the DHS PCSP/CC Nurse to develop the person-centered service plan.
Information collected will include demographic information and information on the waiver participant's ability to perform the activities of daily living; transferring and ambulation; continence status; nutritional status; hearing, vision, speech and language; skin condition; behavior and attitude; orientation level; other medical conditions; psychosocial and cognitive status; and medications/treatments. The assessment/evaluation is a complete functional assessment and includes a medical history, as well as, the participant's physical, functional, mental, emotional and social status, and will include a medical history to ensure that the service plan addresses the participant's strengths, capacities, health care, and other needs.

The DHS PCSP/CC Nurse will assess the participant's preferences, goals, desired outcomes, and risk factors. Support systems available to the participant are identified and documented, along with services currently in place. Based on this assessment information, the DHS PCSP/CC Nurse will discuss the service delivery plan with the participant.
The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances.

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

(d) The DHS PCSP/CC Nurse develops the person-centered service plan based on the information gathered through the assessment/evaluation process and the discussion of available services with the participant including services related to their health care needs. The service plan addresses the participant's needs, goals and preferences. The participant may invite anyone they choose to participate in the assessment and service plan development process, including family members and caregivers. Also, the DHS PCSP/CC Nurse may contact anyone who may be able to provide accurate and pertinent information regarding the participant's condition and functional ability. These individuals participation in the service plan development process also helps to ensure that the participant's goals, preferences and needs are met.

(e) Service plans are developed and sent to all providers before services may begin. Services are coordinated by the DHS PCSP/CC Nurse as the primary point of contact or through the Target Case Manager.

(f) Implementation, compliance, and monitoring of the person-centered service plan is the responsibility of DAABHS (Operating Agency), DMS (Medicaid Agency), and providers of ARChoices in Homecare waiver services. Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of

monitoring, timeframes, reporting and documentation requirements and are required to report any change in the participant's condition to the DHS/PCSP/CC Nurse.

(g) PCSPs are revised by DHS PCSP/CC Nurses as needed between evaluations, based on reports relative to the participant's condition or circumstances secured through providers, Targeted Case Managers, waiver participants and their support systems. Each evaluation of medical eligibility and development of a PCSP is completed at a minimum of every twelve (12) months or more often, if deemed appropriate.

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.

The DHS PCSP/CC Nurse assesses a participant's preferences, risks, dangers, and supports during the PCSP development meeting. In addition, the PCSP development meeting includes assessment of risk factors and strategies to mitigate risk conducted in a manner that is sensitive to the 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 PCSP and in the participant's record. Services are started as soon as possible in order to mitigate risk.

The PCSP 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 PCSP. Backup caregivers are often family members, neighbors or others familiar with the participant.

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

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

Providers agree to inform the DHS PCSP/CC Nurse 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 PCSP

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 PCSP is developed, the DHS PCSP/CC Nurse must inform the participant, their representative, or family member of all qualified providers in the participant'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 PCSP prior to securing the participant's signature. Along with signing the PCSP, and the Freedom of Choice form, an up-to-date provider listing from DPSQA must be signed and initialed. If a family member/representative chooses a provider for the participant, the DHS PCSP/CC Nurse must identify the individual who chose the providers on the PCSP and on the Freedom of Choice form.

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

The participant may contact the DHS PCSP/CC Nurse at any time to find out more information about providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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

All ARChoices waiver person-centered service plans (PCSP) are subject to the review and approval by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) and the Division of Medical Services (DMS) (Medicaid agency).

The DAABHS Reviewer conducts record reviews drawing from a statistically valid random sample. Using the Raosoft software calculations program, a statistically valid sample with at 95% confident level and a margin of error of +/- 5%. Records are reviewed to assess the appropriateness of the service plan, to validate service provision, to ensure that services are meeting the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS PCSP/CC Nurse addresses any needed corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the Office of Medicaid Inspector General.

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval and are available by the operating agency upon request. DMS reviews a validation sample of participant records which includes the person-centered service plan. For the validation review, DMS reviews 20% of the records reviewed by DAABHS. For the provider file sample, the Raosoft online calculator is used to determine a statistically valid sample with at 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. Reviewed service plans are compared to policy guidelines, the functional assessment, and the narrative detailing the participant's living environment, physical and mental limitations, and overall needs.

Information reviewed by both DAABHS and DMS during the record review process includes without limitation: development of an appropriate individualized service plan, completion of updates and revisions to the service plan and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

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:

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 the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) waiver staff, Targeted Case Managers, and providers includes compliance with the PCSP, the health and welfare of the participant, access to services, effectiveness of backup plans, and complaints or problems. Contact with participants is maintained to ensure that services are furnished according to the PCSP and that the services meet the participant's needs. Monitoring is an essential component of Targeted Case Management. Targeted Case Managers are required to conduct routine monitoring and report to the DHS PCSP/CC Nurse. Targeted Case Managers must follow the monitoring guidelines and timeframes outlined in the Medicaid Provider Manual.

DHS PCSP/CC Nurses:

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

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

ARCHOICES IN HOMECARE PROVIDERS:

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

TARGETED CASE MANAGERS:

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

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

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

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

During each home visit, the Targeted Case Manager must document the participant's condition, the condition of the home, living environment, adequacy of the participant's PCSP, and overall success of PCSP delivery. Any problems, changes, complaints, observations, concerns or other participant issues (e.g., provider changes, information regarding change of condition, hospital admissions, hospital discharges, address changes, telephone number changes, deaths, any change in waiver or non-waiver services) must be documented in the participant's record and reported to the DHS

PCSP/CC Nurse via the Change of Client Status form (AAS-9511) or email. The AAS-9511 may be transmitted via fax or email to the DHS PCSP/CC Nurse. Copies of required forms and/or communication must be maintained in the participant's record.

Targeted Case Managers review the PCSP with the participant during all face-to-face visits to ensure that services are being provided according to the plan. The Targeted Case Manager will also measure the participant's progress toward PCSP goals. The contacts listed above are a minimum requirement. In an effort to assure health and safety, compliance with the waiver PCSP, and the integrity of services billed to the Medicaid Program, it is the Targeted Case Manager's responsibility to visit, call and support the waiver participant as much as is needed based on the participant's circumstances and the stability of their services.

INFORMATION EXCHANGE:

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

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

The following reports are used to compile monitoring information and reported as indicated:

1. Program reports are available to all nurse DAABHS supervisory staff through integrated software with dashboard functionality and on demand reporting.

2. Monthly Record Reviews - performed monthly by DAABHS and reported monthly to Senior DAABHS Staff.

3. DMS Monthly Record Reviews - performed monthly by DMS and reported monthly to DAABHS.

4. DMS Annual QA Report - compiled annually by DMS and reported to DAABHS.

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 DHS PCSP/CC Nurse 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 PCSP.

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

ARChoices in Homecare providers assure that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted an ARChoices in Homecare waiver PCSP. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the PCSP developed by the DHS PCSP/CC Nurse. Providers acknowledge that the DHS PCSP/CC Nurse is the only authorized individual who may adjust an ARChoices in Homecare waiver participant's PCSP. Providers accept full responsibility for the quality and number of service units provided to an ARChoices in Homecare waiver participant by their staff, and assure DAABHS appropriate management and supervision of services takes place at all times.

PCSPs are revised by DHS PCSP/CC Nurse as needed, based on information secured through providers, waiver participants and their support systems.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 participant records reviewed which had PCSPs that address health and safety risk factors. Numerator: Number of participant records reviewed which had PCSPs that address health and safety risk factors; Denominator: Number of PCSPs 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 = DAABHS 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 records reviewed which had PCSPs that were adequate and appropriate to their needs as indicated by the assessment(s).
Numerator: Number of participants records reviewed which had PCSPs that were adequate and appropriate to address their needs as indicated by the assessment(s);
Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(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 = DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants records reviewed which had PCSP that addressed personal goals. Numerator: Number of participant records reviewed which had PCSP 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 =

		DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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 PCSPs that were updated when necessary to address a change in the participant's needs. Numerator: Number of PCSPs that were updated when necessary to address a change in the participant's needs. Denominator: Number of PCSPs 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service plans reviewed that were updated at least every 12 months. Numerator: Number of service plans reviewed that were updated at least every 12 months; Denominator: Number service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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 =

		DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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 records reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan.
Numerator: Number of participants records reviewed who received services in the type, scope, amount, duration and frequency specified in the service plan;
Denominator: Number of participants 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 =

		DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

e. ***Sub-assurance: Participants are afforded choice: 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 PCSP reviewed that indicated choice among waiver services was offered. Numerator: Number of PCSPs reviewed that indicated choice among waiver services was offered; Denominator: Number of PCSPs reviewed in which a change in participants needs was indicated.

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 =

		DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Number and percent of participant records reviewed that indicated choice of provider was offered as evidenced by an appropriately completed and signed freedom of choice form. Numerator: Number of participant records reviewed that indicated choice of provider was offered as evidenced by an appropriately completed and signed freedom of choice form; Denominator: Number of participant 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 = DAABHS 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 person-centered service planning and delivery, participant rights and responsibilities, and participant outcomes and satisfaction.

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

Finally, records are reviewed to assure that a Freedom of Choice form was presented to the participant and that a complete, up-to-date list of providers has been made available to the participant.

The state monitors PCSP 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. Monthly chart reviews check for the present of justifying for requested changes and proper documentation and data is summarized for the Chart Review Summary.

Remediation is performed on PCPSs that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by DAABHS as a part of the record review process.

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

Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including PCSP development and delivery of services. Initial verification of service delivery is verified via the Start of Services Form (9510). This documentation is a part of every record review.

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

The state monitors PCSP 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 PCSP’s that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by DAABHS and is a part of the record review process.

b. Methods for Remediation/Fixing Individual Problems

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

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

If a participant record lacks required documentation regarding this assurance, DAABHS's remediation includes completing the required documentation according to policy and additional staff training in this area. Appropriate disciplinary action is taken when determined necessary per DHS policy.

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

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.

Applicant and participant appeals are the responsibility of the Department of Human Services (DHS), Office of Appeals and Hearings. DHS uses the Notice of Action to provide notice to a participant when an adverse action is taken to deny, suspend or terminate eligibility for ARChoices. The Notice of Action explains the action taken; the effective date of the action; and the reason(s) for the action. It also explains the appeal process, including how to request an appeal; that the participant has the right to request a fair hearing; the time by which an appeal and a request for a hearing must be submitted; and that if the participant files an appeal within the timeframe specified in the notice, his or her case will automatically remain open and any services and benefits he or she had been receiving will continue until the hearing decision is made, unless the participant informs DHS that he or she does not wish to continue receiving the benefits pending the appeal hearing decision. The Notice of Action also informs the participant that if he or she does not elect to discontinue benefits and the appeal hearing decision is not in his or her favor, he or she may be liable for the cost of any benefits received pending the appeal hearing decision. Notices of Action and the opportunity to request a fair hearing are kept in the participant's case record. An applicant's request for an appeal must be received by the DHS Office of Appeals and Hearings no later than 30 days from the date on the Notice of Action.

Participants have the right to appeal if they were not provided a choice in institutional care or waiver services, or a choice of providers. During the person-centered service plan development process, the DHS PCSP/CC Nurse explains to the participant or the participant's family member or representative that the participant has the right to choose institutional care or waiver services and his or her provider. The participant or another person authorized to sign for participant, signs the service plan to verify the exercise of participant choice between waiver services or institutional care. During the process, participants choose a provider from a list provided by the DHS PCSP/CC Nurse. The participant's choice of provider is documented on the Freedom of Choice form and the participant or his or her authorized family member or representative signs the list of providers to verify that the choice was made. NOTE: During the development of the person-centered service plan, if no change in provider is requested, the provider list is not signed by the participant.

Waiver participants have the right to appeal any action that involuntarily reduces or terminates some or all their services or benefits, even if their eligibility remains active. The DHS Office of Appeals and Hearings is responsible for these types of appeals. Information regarding hearings and appeals is included with the participant's service plan. Requests for appeals must be received by the DHS Office of Appeals and Hearings no later than 30 days from the date on the of the Notice of Action.

The Notice of Action is kept in the participant's electronic case record. the Notice of Action will be retained for five years from the date of last approval, closure, or denial.

Fair hearings for applicants and participants are the responsibility of the Department of Human Services Office of Appeals and Hearings. This information and the contact information for the Office of Appeals and Hearings is provided on the form the Notice of Action. The form and the system-generated Notice of Action are available in Spanish and large print formats.

ARChoices participants' Medicaid eligibility and services will automatically continue during the appeal process and until the hearing decision when the administrative appeal is timely filed, unless the participant elects to have the benefits discontinue. The participants are informed of their option when they are notified of the pending adverse action. If the appeal decision is not in the participant's favor, and if the services and benefits were continued pending the appeal decision, DHS may recover the cost of services furnished pending the appeal decision. The Notice of Action informs participants that they may be liable for the costs of continued services if they have not elected to have services discontinued pending the appeal decision and if the appeal decision does not favor them.

The Office of Medicaid Provider Appeals is responsible for hearing service provider appeals. Requests for appeals must be received by the Office of Medicaid Provider Appeals no later than thirty (30) days from the date on the Notice of Action.

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, and Behavioral Health Services (DAABHS) .

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

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAABHS Central Office or their DHS PCSP/CC Nurse. When a DHS PCSP/CC Nurse is contacted regarding a complaint or dissatisfaction, the DHS PCSP/CC Nurse explains the complaint process to the participant and completes the HCBS Complaint Intake Report (AAS-9505). Any DAABHS staff receiving a complaint must complete the HCBS Complaint Intake Report.

The HCBS Complaint Intake Report (AAS-9505), along with the complaint database, is used to track any dissatisfaction or complaint, including complaints against DAABHS staff and providers. The record of complaint includes the date the complaint was filed.

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

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

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

The HCBS Complaint Intake Report (AAS-9505) must be completed within five working days from when the DAABHS staff received the complaint. Complaints must be resolved within 30 days from the date the complaint was received. If a complaint cannot be resolved by a DHS RN Supervisor, the information is forwarded to the DAABHS Nurse Manager to resolve. To ensure that participants are safe during these time frames, the DHS PCSP/CC Nurse may put in place the backup plan on the participant’s service plan or report the situation to Adult Protective Services, if needed.

DHS PCSP/CC Nurses, DHS RN Supervisors, or the DAABHS Nurse Manager work to resolve any complaints. This involves contacting all parties involved to obtain all sides of the issue, a participant home visit and a review of the participant's service plan, if necessary. Based on the nature of the complaint, the Nurse Manager will use their professional judgment on issues that must be resolved more quickly, such as instances where the participant's health and safety are at risk. Compliance with this policy is tracked and reported through the database. This issue continues to be tracked and reviewed by the DHS RN Reviewers and the Medicaid Quality Assurance staff during the chart review process.

Complaints against DAABHS staff including DHSPCSP/CC nurses are referred to the DHS RN supervisor or the DAABHS Nurse Manager for investigation and resolution. If the complaint is not resolved at this level the complaint is referred to the appropriate internal agency depending on the nature of the complaint for investigation and appropriate action. Complaints may result in corrective action plan or appropriate personnel action.

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

If a participant is dissatisfied with the resolution of a complaint, a fair hearing request may be made at the local DHS county office. The DHS PCSP/CC Nurse explains the hearings and appeals process to the participant at this time.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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 waiver staff, providers, and DHS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

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

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

Telephone notifications and informational e-mails to Division Directors or Designees, the DHS Client Advocate and other parties as appropriate for early reporting of unusual or sensitive information are welcomed. All such reports must be followed with completion and submission of Form DHS-1910.

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

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

The Division of Aging, Adult and Behavioral Health Services provides training and information to participants when initial contact is made and at a minimum of every 12 months with the update to the PCSP. DAABHS PCSP/CC Nurse provides waiver applicants and their families with an Adult Protective Services (APS) brochure when initial contact is made. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including to the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DHS PCSP/CC Nurses review this information with participants and family members during the development of the person-centered service plan. In addition, providers are required to post information about how to report a complaint to APS and the Adult Maltreatment Hotline in a visible area on their premises.

Information is provided during the initial development of the PCSP, and at a minimum of every 12 months in conjunction with the update to the PCSP.

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

For incidents involving alleged abuse, neglect, and exploitation regarding adult clients, Adult Protective Services (APS) receives, investigates, evaluates, and resolves reports.

Adult Protective Services (APS) Responsibilities:
APS visits clients within 24 hours for emergency cases or within three working days for non-emergency cases. Emergency cases are instances when immediate medical attention is necessary or when there is imminent danger to health or safety which means a situation in which death or serious bodily harm could reasonably be expected to occur without intervention, according to Ark. Code Ann. 12-12-1703(8). Non-emergency cases refer to situations when allegations do not meet the definition of imminent danger to health or safety. APS fast tracks waiver participants so they can be seen in 24 hours if possible.
As required by law, investigations are completed and an investigative determination entered as required by state law.
APS notifies the client and other relevant parties, including the offender, of the determination.
APS communicates with the waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.
Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.

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

Division of Provider Services and Quality Assurance (DPSQA) Responsibilities
DPSQA investigates those incidents that relate to allegations of failed provider practices.
Reports to DPSQA are entered into a tracking system which DPSQA uses to determine if further investigation is needed in the event of multiple complaints at one provider locations or facility.

DPSQA forwards failed provider practices that are regulated by other entities to the appropriate regulating entity or entities.

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.

DAABHS as the operating agency for the waiver assumes responsibility for submitting critical incidents and events through the IRIS system. DPSQA is responsible for compiling all incidents into a single database for review and action. All incident reports for all sources are entered into the database. This database generates monthly, quarterly and annual reports to the DAABHS Program Administrator. The administrator reviews these reports to identify patterns and make systematic corrections when 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:

Division of Provider Services and Quality Assurance (DPSQA) is responsible for detecting unauthorized use of restraints. This oversight is conducted on an ongoing basis through incident reports received and investigated.

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 contact DAABHS regarding any concerns for the participant's health and welfare.

○ **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:

Division of Provider Services and Quality Assurance (DPSQA) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted on an ongoing basis through incident reports received and investigated.

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 contact DAABHS regarding any concerns for the participant's health and welfare.

○ **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:

Division of Provider Services and Quality Assurance (DPSQA) is responsible for detecting unauthorized use of seclusion. This oversight is conducted on an ongoing basis through incident reports received and investigated.

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 contact DAABHS regarding any concerns for the participant's health and welfare.

○ **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.

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.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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)*

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 States quality improvement strategy, provide information in the following fields to detail the States 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 within required time frame;
Denominator: Number of complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
JIRA 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 incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRIS

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: DPSQA	☐ **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: DPSQA	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of abuse. Numerator: Number of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of abuse. 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 = DAABHS 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 records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of neglect. Numerator: Number of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of neglect. 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 =

		DAABHS 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Specify:

Performance Measure:
Number and percent of records reviewed that indicated the participant, guardian or family received information about how to ID and report critical incidents of exploitation Numerator: Number of records reviewed that indicated the participant, guardian or family received information about how to ID and report critical incidents of exploitation 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 = DAABHS 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 incidents of abuse, neglect, exploitation, and unexplained death that are reviewed/investigated within the required timeframes. N: Number of incidents of abuse, neglect, exploitation, and unexplained death that are reviewed/investigated within the required timeframes. D: Number of Incidents of abuse, neglect, exploitation, and unexplained deaths.

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 =
☒ **Other** Specify: Adult Protective Services (APS)	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Adult Protective Services	
	☒ **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.

Performance Measure:
Number and percent of critical incidents where the root cause was identified.
Numerator: Number of critical incidents where the root cause was identified;
Denominator: Number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRIS

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: DPSQA	☐ **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: DPSQA	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

policy/law; Denominator: Number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRIS

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: DPSQA	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DPSQA	☒ **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 incidents requiring reviews/investigation where the state adhered to the follow-up methods as specified; Denominator: Number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRIS

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:

DPSQA		
	☒ **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: DPSQA	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 incident reports documenting intervention in which providers adhered to DHS policies for the use of restrictive interventions. Numerator: Number of incident reports documenting intervention in which providers adhered to DHS policies for the use of restrictive interventions; Denominator: Number of incident reports documenting intervention.

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRIS

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: DPSQA	☐ **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: DPSQA	☒ **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 waiver providers who meet and adhered to state health care standards established in licensure requirements upon review. Numerator: Number of waiver providers who meet and adhered to state health care standards established in licensure requirements upon review; Denominator: Number of waiver providers.

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: DPSQA	☐ **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: DPSQA	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 States 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.

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

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

In cases where critical incidents were not reported within required time frames, DAABHS provides remediation, including reporting the critical incident upon discovery, and providing additional training and counseling to staff.

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

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

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

All substantiated incidents are investigated by the DAABHS Deputy Director or his/her designee.

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 3)

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; and
- 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 3)

H-1: Systems Improvement

a. System Improvements

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, the Division of Medical Services (DMS) (Medicaid agency) will meet with the operating agencies (DAABHS and the Division of Provider Services and Quality Assurance (DPSQA)) to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue, etc.), complexity of the solution (does it require an amendment to the waiver application), and the financial impact. If it is determined that a system change is needed, a computer service request will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DMS and a priority status is assigned. MMIP prioritizes system changes to MMIS and coordinates implementation with the state fiscal agent. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. The MMIP Unit and DMS monitor the system changes.

As a result of the discovery processes:

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

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

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

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: DCO and Contracted Vendor	☐ **Other** Specify:

b. System Design Changes

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, the Division of Medical Services (DMS) will meet with DAABHS 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, and the financial impact. If it is determined that a system change is needed, a computer service request is submitted to the Arkansas Medicaid Enterprise (AME) unit within DMS and a priority status is assigned. DMS prioritizes system changes to MMIS and coordinates implementation with AME. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. AME and DMS monitor the system changes.

If the system change is to the eligibility system, DAABHS will coordinate with the Division of County Operations (DCO) to implement and monitor the system change.

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

DAABHS and DMS monitor the Quality Improvement Strategy on an ongoing basis and review the Quality Improvement Strategy annually. When change in the strategy is indicated, a collaborative effort between DMS and DAABHS is set in motion to complete a revision to the Quality Improvement Strategy which may include submission of a waiver amendment. DMS and DAABHS utilizes the Quality Improvement Strategy during all levels of QA reviews.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

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).*

Pre-Payment Integrity
ARChoices waiver providers submit ARChoices Waiver Service claims through the Medicaid Management Information System (MMIS). MMIS act as a pre-payment financial integrity check on all claims submitted. MMIS verifies a participant's ARChoices Waiver eligibility and a ARChoices Waiver service provider's active Medicaid enrollment for the date of service prior to paying a ARChoices Waiver claim. MMIS has the applicable per unit rate for the ARChoices Waiver service pre-loaded and has edits in place that will prevent the payment of claims exceeding any applicable daily, weekly, or annual benefit/service limits for the ARChoices Waiver service. MMIS only pays claims that clear all eligibility and financial edits.

The contracted fiscal agent also conducts random quality assurance checks of the above-listed edits to ensure they are functioning appropriately.

Post-Payment Integrity
Every month DAABHS conducts a random sample retrospective desk review of active and closed participant service records from the previous quarter. The participant service records are reviewed to determine if participants received, and ARChoices Waiver service providers were paid for, the ARChoices Waiver services in the type, scope, amount, frequency, and duration specified in the service plan, and if such services were paid at the correct rate. This is done by reviewing the POC in the participant service record in the ARChoices Database maintained by Vendor and comparing it to the ARChoices services billed and paid through MMIS. DAABHS uses the Raosoft Calculation System to determine a sample size that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.

DAABHS, the Operating Agency, communicates the results of the reviews to DMS. DMS as the State Medicaid Agency, communicates the with providers and creates Corrective Action Plans as necessary.

Additionally, DMS conducts its own retrospective desk review of active participant service records in the immediately preceding quarter to determine if participants received, and ARChoices Waiver service providers were paid for, the ARChopices Waiver services in the type, scope, amount, frequency, and duration specified in the service plan, and if such services were paid at the correct rate. DMS also uses the Raosoft Calculation System to determine a sample size that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.

The DMS financial team reports any recouped payments for ARChoices Waiver services as a prior period adjustment on the CMS-64 to remove the payments from claims for federal financial participation.

DMS notifies providers of patterns of non-compliance or irregularities and takes appropriate action including training to assist with appropriate claims submission. Continued patterns of non-compliance or irregularities resulting in over payment will be referred to the appropriate state agency for review and corrective action or penalties.

The Centers for Medicare and Medicaid Services ("CMS") conducts audits of Medicaid claims (including ARChoices Waiver service claims) in accordance with the Payment Error Rate Measurement ("PERM") regulations every three (3) years. CMS reviews the claims to ensure the services were medically appropriate, provided to an eligible participant, and paid at the correct amount. PERM reviews are intended to:
- *identify those Medicaid programs that may be susceptible to significant improper payments;*
- *estimate the amount of improper payments;*
- *submit those estimates to Congress; and*
- *submit a report on actions the agency is taking to reduce improper payments.*

Arkansas Legislative Audit is responsible for conducting the periodic independent audit of the ARChoices waiver program under the provisions of the Single Audit Act.

The Office of Medicaid Inspector General also conducts independent annual random reviews of all Medicaid programs, including the ARChoices Waiver. If a review finds errors in billing and fraud is not suspected, DMS recoups the payment(s) from the ARChoices Waiver provider. If fraud is suspected, then the provider is referred to the Medicaid Fraud Control Unit and Arkansas Attorney General's office for appropriate action including request for and monitoring of corrective action plan.

All ARChoices Waiver providers who are paid a total of $100,000 or more during a year by the State of Arkansas are required to submit an independent audit of its financial statements for that year in accordance with the Government

Auditing Standards. ARChoices Waiver providers who are paid more than $750,000 in federal funds during a year must have an independent single audit conducted for that year in accordance with OMB Circular A-133. All required ARChoices Waiver service provider audits are submitted to and reviewed by the DHS Office of Payment Integrity and Audit (OPIA) for compliance with audit requirements. The purpose of the OPIA reviews of provider financial audits is to notify the Division of any deficiencies identified by that provider's CPA. DAABHS is notified of any deficiencies via e-mailed letter upon completion of the review. No CAPs are required and individual claims are not reviewed in the process. If during review of an audit issues are discovered, then OPIA is responsible for notifying DMS for recoupment or other appropriate action. Reviews are consistent across all providers and provider types.

Inappropriate claims are recouped and removed from the claims for FFP via the CMS-64 reporting system.

The state implemented a statewide EVV system for personal care, attendant care, and respite services in January 2021. The system is currently operating, and we are moving to cutting off direct billing access and requiring use of the EVV system. The state will implement EVV for home health and other home and community-based services in January 2023, as required by the 21st Century Cures Act. The EVV system captures the required data elements and submits those elements over to the MMIS billing system. The EVV system will not submit a claim unless those data elements are present. The state staff can review data on critical exceptions to determine if a provider needs additional training or to be referred for further audit. The post-payment auditors can use EVV data to detect fraud, waste and abuse.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(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 claims reviewed that paid at the correct rate as specified in the waiver application. Numerator: Number of claims reviewed that paid at the correct rate as specified in the waiver application; Denominator: Number of claims 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 =* *DAABHS 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***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***Operating Agency***	☒ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims reviewed with services specified in the participant service plan. Numerator: Number of claims reviewed with services specified in the participant service plan; Denominator: Number of claims 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 =*

		DAABHS 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:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
Number and percent of claims reviewed that are coded and paid in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. Numerator: Number of claims that are coded and paid in accordance with reimbursement methodology specified in the approved waiver and only for services rendered; Denominator: Number of claims 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 =* *DAABHS 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***	☐ ***Other***

	Ongoing	*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 rates reviewed which remain consistent with the approved rate methodology throughout the five-year waiver cycle. Numerator: Number of rates reviewed which remain consistent with the approved rate methodology throughout the five-year waiver cycle. Denominator: Number of rates

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DMS Rate 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:*
	☐ ***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***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***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 States 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.*

DAABHS and DMS participate in monthly team meetings as needed to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to financial accountability for the waiver.

The MMIS system has audits and edits in place to ensure correct payment of claims. In the monthly case record review, all participant claims on selected cases records are reviewed against services authorized in the PCSP and claims are checked to see if payment was correct.

DMS remediation for failed MMIS checks includes making system changes or training staff.

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

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***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***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 Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) is responsible for the rate determination with oversight conducted by the Division of Medical Services (DMS) (Medicaid agency) Financial Section prior to implementation. There is an established procedure followed by both divisions that ensures DMS reviews and approves all reimbursement rates and methodologies. As ARChoices is not a participant-directed program, payment rates are not routinely sent separately to waiver participants. Rates are published for comment and are made available to all providers. Additionally, providers are notified any time a rate changes via a Provider Information Memorandum from DAABHS and/or an Official Notice from DMS. The public is afforded an opportunity to comment on the rate determination process through the DMS website, in the Proposed Rules for Public Comment section. Upon certification, new providers are referred to the Medicaid Provider Manual, which lists rate information.

Please reference Main Section 6-I for detailed information on the public comment process.

The fee schedule for the ARChoices program can be found on the DHS website: https://humanservices.arkansas.gov/wp-content/uploads/ARCHOICES-fees.pdf

DMS will review the rate methodologies per executive order on a three year cycle. If a methodology change is determined appropriate, it will be addressed in a subsequent waiver amendment or the waiver renewal application.

DMS conducted a review of the ARChoices rate in July 2021. The last rebasing of rates was conducted in January of 2019.

The rates for the ARChoices program are statewide and do not vary by geographic region. The actuarial calculation of rates assumed no geographic adjustment would be required in order to ensure access.

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

Attendant Care - Actuaries under contract with DMS developed a rate per 15 minutes for Attendant Care service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; annual number of hours practitioners are at work; and percentage of time an at-work practitioner is able to convert to billable units (productivity). Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Adult Day Health – Actuaries under contract with DMS developed a rate per 15 minutes for Adult Day Health service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; average number of beneficiaries and hours per beneficiary served each day; and annual number of days of operation. Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Respite (In-Home) - Actuaries under contract with DMS developed a rate per 15 minutes for in-home Respite service using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct service-related expense and overhead costs; annual number of hours practitioners are at work; and percentage of time an at-work practitioner is able to convert to billable units (productivity). Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Respite (facility-based): Facility-based respite service is a fee-for-service rate established and approved by the Division of Medical Services(Medicaid agency) and is equivalent to the rate established for state plan agency personal care services that are services similar to respite services. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

Adult Day Services – Actuaries under contract with DMS developed a rate per 15 minutes for Adult Day Services using a cost-based method developed from the following rating variables: direct service provider salaries and benefits; direct

service-related expense and overhead costs; average number of beneficiaries and hours per beneficiary served each day; and annual number of days of operation. Rate assumptions were developed using multiple data sources including the Bureau of Labor Statistics (BLS), provider surveys, and DAABHS' and actuaries' experience. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

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

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

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

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

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. Attendant care and respite service claims must be verified using the Electronic Visit Verification (EVV) system.

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:*

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.
MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim.

DAABHS and DMS verify services were provided according to the PCSP through an internal monthly case record review as described in Section I-1. Adjustments are made when claims are paid incorrectly and, when fraud, waste or abuse is suspected the case is referred to OMIG. As described in Section I-1, to remove the payments from claims for federal financial participation (FFP), DMS' financial team reports on the CMS-64 that a prior period adjustment is required.

MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DAABHS verifies services were provided according to the PCSP through an internal monthly case record review. Adjustments are made or referred to the OMIG when claims are paid incorrectly and fraud, waste or abuse is suspected. 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.

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MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DAABHS and DMS verify services were provided according to the PCSP through an internal monthly case record review as described in Section I-1. Adjustments are made when claims are paid incorrectly and, when fraud, waste or abuse is suspected the case is referred to OMIG. As described in Section I-1, to remove the payments from claims for federal financial participation (FFP), DMS' financial team reports on the CMS-64 that a prior period adjustment is required.

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):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***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.

- (●) ***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.***
- ( ) ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:*

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

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	11017.53	12160.00	23177.53	69191.00	2885.00	72076.00	48898.47
2	11056.16	12470.00	23526.16	70921.00	2959.00	73880.00	50353.84
3	11090.63	12772.00	23862.63	72694.00	3031.00	75725.00	51862.37
4	11126.47	13075.00	24201.47	74511.00	3103.00	77614.00	53412.53
5	11161.84	13386.00	24547.84	76374.00	3177.00	79551.00	55003.16

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	11425		11425
Year 3	11500		11500
Year 4	11575		11575
Year 5	11650		11650

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 annual reports (CMS-372) was tabulated to estimate the average length of stay on the waiver.

The average length of stay was calculated utilizing data from 02/01/2016 through 01/31/2020.

A total of 9,021 unduplicated participants were served, with a total of 2,656,463 days of waiver coverage. The average length of stay on the waiver(s) is estimated at 295 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 and methodology for these estimates is as follows:*

Historical utilization of waiver services and the number of participants is based on data from CY 2019 historical 372 reports from waiver year 2019 and program managers insights. Data runs were conducted from the DSS for years 2019 and 2020. An emphasis was placed on 2019 data to avoid data skewing based on the public health emergency created by COVID-19. For this reason, 2019 was used as the starting point. Program management constructed the current forecast using the current waiver participation and utilization as a starting point. The waiver management team's experience enabled informed adjustments to be made that account for growth and development in the waiver. Given the uncertainly of the last 18 months, the State would like to monitor waiver utilization and propose changes should any adjustment be necessary. Reports are run using MMIS. MMIS provides more up to date data than 372 reports, can be run for time periods requested here, and uses the same data source relied upon by the 372. Cost per unit of services are current rates with any known changes with the exception of Attendant Care and In Home Respite. The cost per unit of these services is based on actuarially determined rate increase.

The State is aware there will be rate changes in the future but is not aware of what the new rates will be. Rates listed are current and will be amended when required.

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:*

Factor D' is based on SFY 2019 utilization and expenditures for Medicaid services outside the waiver utilized by ARChoices participants. ARChoices annual expenditure data was extracted from the decision support system (DSS) component of the MMIS. Quarter two 2021 to quarter one 2026 were taken into consideration when calculating the growth factor. Growth forecast is based on the CMS market basket index and financial leadership's input as discussed in prior correspondence. – a link to the web site where market basket data was accessed follows.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData
Note: Costs associated with ARChoices waiver services are displayed as "D" and not duplicated here.

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:*

Factor G is computed based on the average annual expenditures for nursing home recipients with similar demographics and conditions of ARChoices participants. All data was extracted from the decision support system (DSS) component of the MMIS for SFY 2019.

Reports are run using DSS. DSS provides more up to date data than 372 reports, can be run for time periods requested here, and DSS uses the same data source relied upon by the 372. An inflationary factor based the State's anticipated cost in direct SNF care of 2.5% annually was applied.

Growth forecast is based on the CMS market Basket index forecasts Q2 2021 to Q12026. Medicaid economic index data pulled at the time of the original waiver submission. An adjustment was made after discussions with financial leadership. We feel growth in the 2.5% range each year is most likely.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

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:*

Factor G' was derived using the same methodology as in prior years. It was computed based on the average annual expenditures for nursing home recipients with similar demographics of ARChoices recipients and reflects Medicaid services not associated with SNF care. Data was extracted from the decision support system (DSS) component of the MMIS. DSS reports were run for 2019 and 2020 (emphasis on 2019 to avoid data impacts due to the COVID19 driven public health emergency) for the population receiving services the waiver participants would be receiving if the waiver did not exist. Factor G services were identified and removed. With only G' services remaining calculations were done to determine the average per person cost. An inflationary factor based on the market basket forecast was applied. Note: Costs associated with SNF care are displayed in "G" and are not duplicated here. 2019 and 2020 data runs were conducted. An emphasis was placed on 2019 data to avoid data skewing based on the public health emergency created by COVID-19.

Growth forecast is based on the CMS market Basket index forecasts Q2 2021 to Q12026. Medicaid economic index data pulled at the time of the original waiver submission. An adjustment was made after discussions with financial leadership. We feel growth in the 2.5% range is most likely.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

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	

Waiver Services	
Respite	
Adult Day Services	
Attendant Care Services	
Environmental Accessibility Adaptations/Adaptive Equipment	
Home-Delivered Meals	
Personal Emergency Response System (PERS)	
Prevocational Services	

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:							**961923.30**
Adult Day Health	☐	15 Minutes	65	4713.00	3.14	**961923.30**	
Respite Total:							**20508139.68**
Respite Long-Term Facility-Based	☐	15 Minutes	5	222.00	0.56	**621.60**	
Respite Short-Term Facility-Based	☐	15 Minutes	20	890.00	1.68	**29904.00**	
Respite In-Home	☐	15 Minutes	2541	1574.00	5.12	**20477614.08**	
Adult Day Services Total:							**1712698.00**
Adult Day Services	☐	15 Minutes	200	3467.00	2.47	**1712698.00**	
Attendant Care Services Total:							**92270100.48**
Attendant Care Services	☐	15 Minutes	6816	2644.00	5.12	**92270100.48**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**750000.00**

GRAND TOTAL:	**125049008.56**
Total: Services included in capitation:	
Total: Services not included in capitation:	125049008.56
Total Estimated Unduplicated Participants:	**11350**
Factor D (Divide total by number of participants):	**11017.53**
Services included in capitation:	
Services not included in capitation:	11017.53
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	100	1.00	7500.00	750000.00	
Home-Delivered Meals Total:							7338694.14
Home Delivered Meals	☐	One Meal	4997	246.00	5.97	7338694.14	
Personal Emergency Response System (PERS) Total:							1492092.96
PERS Unit Monitoring	☐	One Day	5324	257.00	1.07	1464046.76	
PERS Installation	☐	One Installment	938	1.00	29.90	28046.20	
Prevocational Services Total:							15360.00
Prevocational Services - Career Exploration	☐	15 Minutes	10	120.00	6.40	7680.00	
Prevocational Services - Skill Development	☐	15 Minutes	10	120.00	6.40	7680.00	

GRAND TOTAL:	125049008.56
Total: Services included in capitation:	
Total: Services not included in capitation:	125049008.56
Total Estimated Unduplicated Participants:	11350
Factor D (Divide total by number of participants):	11017.53
Services included in capitation:	
Services not included in capitation:	11017.53
Average Length of Stay on the Waiver:	295

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 concurrent managed care authorities utilizing capitated payment arrangements. *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:							991520.94
Adult Day Health	☐					991520.94	

GRAND TOTAL:	126316631.34
Total: Services included in capitation:	
Total: Services not included in capitation:	126316631.34
Total Estimated Unduplicated Participants:	11425
Factor D (Divide total by number of participants):	11056.16
Services included in capitation:	
Services not included in capitation:	11056.16
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 Minutes	67	4713.00	3.14		
Respite Total:							**20608085.28**
Respite Long-Term Facility-Based	☐	15 Minutes	7	222.00	0.56	**870.24**	
Respite Short-Term Facility-Based	☐	15 Minutes	22	890.00	1.68	**32894.40**	
Respite In-Home	☐	15 Minutes	2553	1574.00	5.12	**20574320.64**	
Adult Day Services Total:							**1750835.00**
Adult Day Services	☐	15 Minutes	202	3467.00	2.50	**1750835.00**	
Attendant Care Services Total:							**93285396.48**
Attendant Care Services	☐	15 Minutes	6891	2644.00	5.12	**93285396.48**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**787500.00**
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	105	1.00	7500.00	**787500.00**	
Home-Delivered Meals Total:							**7375409.64**
Home Delivered Meals	☐	One Meal	5022	246.00	5.97	**7375409.64**	
Personal Emergency Response System (PERS) Total:							**1499452.00**
PERS Unit Monitoring	☐	One Day	5350	257.00	1.07	**1471196.50**	
PERS Installation	☐	One Installment	945	1.00	29.90	**28255.50**	
Prevocational Services Total:							**18432.00**
Prevocational Services - Career Exploration	☐	15 Minutes	12	120.00	6.40	**9216.00**	
Prevocational Services - Skill Development	☐	15 Minutes	12	120.00	6.40	**9216.00**	

GRAND TOTAL:	**126316631.34**
Total: Services included in capitation:	
Total: Services not included in capitation:	126316631.34
Total Estimated Unduplicated Participants:	**11425**
Factor D (Divide total by number of participants):	**11056.16**
Services included in capitation:	
Services not included in capitation:	11056.16
Average Length of Stay on the Waiver:	295

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 concurrent managed care authorities utilizing capitated payment arrangements. *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:							1021118.58
Adult Day Health	☐	15 Minutes	69	4713.00	3.14	1021118.58	
Respite Total:							20708030.88
Respite Long-Term Facility-Based	☐	15 Minutes	9	222.00	0.56	1118.88	
Respite Short-Term Facility-Based	☐	15 Minutes	24	890.00	1.68	35884.80	
Respite In-Home	☐	15 Minutes	2565	1574.00	5.12	20671027.20	
Adult Day Services Total:							1746951.96
Adult Day Services	☐	15 Minutes	204	3467.00	2.47	1746951.96	
Attendant Care Services Total:							94300692.48
Attendant Care Services	☐	15 Minutes	6966	2644.00	5.12	94300692.48	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							825000.00
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	110	1.00	7500.00	825000.00	
Home-Delivered Meals Total:							7412125.14
Home Delivered Meals	☐	One Meal	5047	246.00	5.97	7412125.14	
Personal Emergency Response System (PERS) Total:							1506811.04
PERS Unit Monitoring	☐	One Day	5376	257.00	1.07	1478346.24	
PERS Installation	☐	One Installment	952	1.00	29.90	28464.80	

GRAND TOTAL:	127542234.08
Total: Services included in capitation:	
Total: Services not included in capitation:	127542234.08
Total Estimated Unduplicated Participants:	11500
Factor D (Divide total by number of participants):	11090.63
Services included in capitation:	
Services not included in capitation:	11090.63
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							**21504.00**
Prevocational Services - Career Exploration	☐	15 Minutes	14	120.00	6.40	**10752.00**	
Prevocational Services - Skill Development	☐	15 Minutes	14	120.00	6.40	**10752.00**	

GRAND TOTAL:	**127542234.08**
Total: Services included in capitation:	
Total: Services not included in capitation:	127542234.08
Total Estimated Unduplicated Participants:	**11500**
Factor D (Divide total by number of participants):	**11090.63**
Services included in capitation:	
Services not included in capitation:	11090.63
Average Length of Stay on the Waiver:	295

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 concurrent managed care authorities utilizing capitated payment arrangements. *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:							**1050716.22**
Adult Day Health	☐	15 Minutes	71	4713.00	3.14	**1050716.22**	
Respite Total:							**20807976.48**
Respite Long-Term Facility-Based	☐	15 Minutes	11	222.00	0.56	**1367.52**	
Respite Short-Term Facility-Based	☐	15 Minutes	26	890.00	1.68	**38875.20**	
Respite In-Home	☐	15 Minutes	2577	1574.00	5.12	**20767733.76**	
Adult Day Services Total:							**1764078.94**
Adult Day Services	☐	15 Minutes	206	3467.00	2.47	**1764078.94**	
Attendant Care Services							**95315988.48**

GRAND TOTAL:	**128788846.84**
Total: Services included in capitation:	
Total: Services not included in capitation:	128788846.84
Total Estimated Unduplicated Participants:	**11575**
Factor D (Divide total by number of participants):	**11126.47**
Services included in capitation:	
Services not included in capitation:	11126.47
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Attendant Care Services	☐	15 Minutes	7041	2644.00	5.12	95315988.48	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							862500.00
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	115	1.00	7500.00	862500.00	
Home-Delivered Meals Total:							7448840.64
Home Delivered Meals	☐	One Meal	5072	246.00	5.97	7448840.64	
Personal Emergency Response System (PERS) Total:							1514170.08
PERS Unit Monitoring	☐	One Day	5402	257.00	1.07	1485495.98	
PERS Installation	☐	One Installment	959	1.00	29.90	28674.10	
Prevocational Services Total:							24576.00
Prevocational Services - Career Exploration	☐	15 Minutes	16	120.00	6.40	12288.00	
Prevocational Services - Skill Development	☐	15 Minutes	16	120.00	6.40	12288.00	

GRAND TOTAL:	128788846.84
Total: Services included in capitation:	
Total: Services not included in capitation:	128788846.84
Total Estimated Unduplicated Participants:	11575
Factor D (Divide total by number of participants):	11126.47
Services included in capitation:	
Services not included in capitation:	11126.47
Average Length of Stay on the Waiver:	295

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 concurrent managed care authorities utilizing capitated payment arrangements. *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:							**1080313.86**
Adult Day Health	☐	15 Minutes	73	4713.00	3.14	**1080313.86**	
Respite Total:							**20907922.08**
Respite Long-Term Facility-Based	☐	15 Minutes	13	222.00	0.56	**1616.16**	
Respite Short-Term Facility-Based	☐	15 Minutes	28	890.00	1.68	**41865.60**	
Respite In-Home	☐	15 Minutes	2589	1574.00	5.12	**20864440.32**	
Adult Day Services Total:							**1781205.92**
Adult Day Services	☐	15 Minutes	208	3467.00	2.47	**1781205.92**	
Attendant Care Services Total:							**96331284.48**
Attendant Care Services	☐	15 Minutes	7116	2644.00	5.12	**96331284.48**	
Environmental Accessibility Adaptations/Adaptive Equipment Total:							**900000.00**
Environmental Accessibility Adaptations/Adaptive Equipment	☐	Package	120	1.00	7500.00	**900000.00**	
Home-Delivered Meals Total:							**7485556.14**
Home Delivered Meals	☐	One Meal	5097	246.00	5.97	**7485556.14**	
Personal Emergency Response System (PERS) Total:							**1521529.12**
PERS Unit Monitoring	☐	One Day	5428	257.00	1.07	**1492645.72**	
PERS Installation	☐	One Installment	966	1.00	29.90	**28883.40**	
Prevocational Services Total:							**27648.00**
Prevocational Services - Career Exploration	☐	15 Minutes	18	120.00	6.40	**13824.00**	
Prevocational Services - Skill Development	☐	15 Minutes	18	120.00	6.40	**13824.00**	

GRAND TOTAL:	**130035459.60**
Total: Services included in capitation:	
Total: Services not included in capitation:	130035459.60
Total Estimated Unduplicated Participants:	**11650**
Factor D (Divide total by number of participants):	**11161.84**
Services included in capitation:	
Services not included in capitation:	11161.84
Average Length of Stay on the Waiver:	295