Division of Medical Services
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: September 23, 2022

SUBJ: Proposed Rule Amendment: Living Choices Waiver Rate Adjustment

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 Medical Services (DMS) of the Department of Human Services (DHS) 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:

DMS amends the Living Choices Assisted Living (LCAL) waiver following completion of a cyclic rate review. DHS seeks approval form the Centers for Medicare and Medicaid Services to increase reimbursement rates to Assisted Living Facilities to $96.76 per person per day. The proposed rule estimates a financial impact of $ 1,956,994 ($1,401,599 of which is federal funds) for state fiscal year (SYF) 2023 and $3,913,987 ($2,803,198 of which is federal funds) for SYF 2024.

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 on the Medicaid website 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.

A public hearing by remote access only through a Zoom webinar will be held on October 10, 2022, at 2:00 p.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/85421721879
. The webinar ID is 854 2172 1879. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

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

Elizabeth Pitman, Director
Division of Medical Services

Request Information

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*): **Living Choices Assisted Living Waiver**

C. **Type of Request:** *(the system will automatically populate new, amendment, or 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**

☐	**New to replace waiver** Replacing Waiver Number:		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

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

○	**Model Waiver**
●	**Regular Waiver**

E. **Proposed Effective Date:** 07/01/2021

Approved Effective Date *(CMS Use):*

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 Living Choices Assisted Living waiver program allows individuals to live in apartment-style living units in licensed level II assisted living facilities and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity, and independence. The

assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes participants' personal decision-making while protecting their health and safety. The major goal of this program is to delay or prevent institutionalization of these individuals. However, assisted living services are not intended as a substitute for nursing facility or hospital care for individuals needing skilled care, as defined by State administrative rule which is set forth in B-6-d. Room and board services are not covered per federal law.

Living Choices includes 24-hour on-site response staff to assist with participants' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living facility staff will perform their duties and conduct themselves in a manner that fosters and promotes participants' dignity and independence. Supervision, safety and security are required components of the assisted living environment. Living Choices includes therapeutic, social and recreational activities suitable to the participants' abilities, interests, and needs. Assisted living participants' living units are separate and distinct from all others. Laundry and meal preparation and service are in a congregate setting for participants who choose not to perform those activities themselves. The principles of negotiated service plans and managed risk are applied.

Extended Prescription Drug Coverage is available for Living Choices participants who are eligible for regular Medicaid drug benefits, plus three additional prescriptions. Participants dually eligible for Medicare and Medicaid must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

The Living Choices waiver is administered by three (3) state operating agencies, the Division of Aging, Adult, and Behavioral Health Services (DAABHS), the Division of Provider Services and Quality Assurance (DPSQA), and the Division of County Operations (DCO). DAABHS, DCO, and DPSQA operate under the authority of the Division of Medical Services (DMS), the Medicaid Agency. DAABHS DCO, DPSQA, and DMS are all under the umbrella of the Arkansas Department of Human Services (DHS). DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS, DCO, and DPSQA. DAABHS is responsible for the day-to-day administration of the waiver, establishing waiver program policies and procedures, and overseeing the development and management of person-centered service plans, among other functions. DCO, is responsible for determination of level of care. DPSQA is responsible for provider certification, compliance, and provider quality assurance. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the utilization of the approved assessment instrument.

An Independent Assessment Contractor will perform independent assessments that gather functional eligibility information about each Living Choices waiver applicant using the approved instrument. The information gathered is used by the DHS Eligibility Nurse to determine the individual’s level of care. An evaluation is initiated by the DHS PCSP/CC Nurse responsible for care coordination, at least every twelve (12) months and provided to the DHS Eligibility Nurse 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. The assessment is sent to DHS Eligibility Nurse to determine if the applicant’s functional need is at the nursing home level of care. If an applicant is determined both financially and medically eligible, the Division of County Operations approves the application.

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

I. Public Input. Describe how the state secures public input into the development of the waiver:

Policy and form revisions, procedural changes and clarifications have been made through the years based on input from participants, family, and providers. Comments have been reviewed and appropriate action taken to incorporate changes to benefit the participant, service delivery, and quality of care. Comments and public input have been gathered through routine monitoring of program requirements, provider workshops/trainings, program integrity audits, monitoring of participants, and contact with stakeholders. All of these experiences and lessons learned from the public and the resulting improvements are applied to the operations of Living Choices.

Notices of amendments and renewals of the waiver are posted on both the DHS and Medicaid websites for at least thirty (30) days to allow for the general public to submit comments on changes. Notices of amendments and renewals are also published in a statewide newspaper with instruction for submitting comments to DMS. Regulations, policies, rules, and procedures are promulgated in accordance with the Arkansas Administrative Procedure Act. Promulgation includes review by three Arkansas legislative committees, which are open to the public and may include testimony by the public. After review by the committees, the regulations, policies, rules, and procedures are adopted and incorporated into the appropriate document. All provider manuals containing program rules are available to all providers and the general public via the Medicaid website.

The public notice for this waiver renewal was published in the Arkansas Democrat-Gazette on April 14-16, 2021. There was a public hearing on April 16, 2021.The comment period ended May 13,2021. There were no public comments. Physical copies of the proposed waiver amendment were mailed to constituents upon request. Copies were also published on the state's DHS websites at the following link
https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

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:	Deputy Director				
Agency:	Arkansas Department of Human Services				
Address :	P.O. Box 1437, Slot S-295				
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:	Finkbeiner				
First Name:	John				
Title:	~~Deputy~~ Assistant 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- ~~686-9431~~ 320-6310	**Ext:**		☐	**TTY**
Fax:	501-682-8155				
E-mail:	~~Patricia.Gann@dhs.arkansas.gov~~ john.finkbeiner@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:

_____

State Medicaid Director or Designee

Submission Date:	

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:	DAABHS 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:	AR				
Zip:	72203-1437				
Phone:	501-686-9981	**Ext:**		☐	**TTY**
Fax:					
E-mail:	Jay.Hill@dhs.arkanas.gov				

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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

All types of services covered in the approved waiver continue to be covered in the renewed waiver.

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

No service covered by the approved waiver and received by any participant is discontinued under the renewed waiver.

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

Individuals served in the existing waiver may continue to participate in this HCBS program under the renewed waiver, provided they (1) continue to meet financial eligibility and (2) meet the functional eligibility criteria for the program as defined in the state rule and determined following their evaluation completed by a DHS PCSP/CC nurse.

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

The approved waiver provides for assessments using the approved assessment instrument. The approved assessment instrument involves a complex array of questions asked by registered nurses during the face-to-face meetings with applicants and participants.

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

There are no new limitations on the amount of waiver services in the renewed waiver.

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

Evaluations will be performed at least every twelve (12) months by the DHS PCSP/CC Nurse. Re-assessments of existing participants will be performed using the approved assessment instrument when referred by the DHS Eligibility nurse.

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

The renewed waiver makes no changes to waiver eligibility policy.

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

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

Participants who receive negative determinations regarding eligibility determinations or Individual Service Budgets, including the person-centered service plans, will be able to appeal denials and reductions during which time their benefits will be automatically continued; however, the beneficiary will have the ability to opt out of this automatic continuation of benefits.

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), Division of County Operations (DCO)and Division of Provider Services and Quality Assurance (DPSQA).	
	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)*.	

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.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the

operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Arkansas Department of Human Services (DHS) uses an Interagency Agreement to define the responsibilities of the four DHS divisions – Division of Medical Services (DMS, the Medicaid agency) Division of Aging, Adult and Behavioral Health Services (DAABHS), the Division of County Operations (DCO), and the Division of Provider Services and Quality Assurance (DPSQA) – charged with responsibility for administering both the AR Choices in Homecare (AR Choices) and Living Choices Assisted Living (Living Choices) HCBS waiver programs. This agreement is reviewed annually and updated as needed. DMS, as the Medicaid agency, monitors this agreement on a continuous basis to assure that the provisions specified are executed.

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

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

DPSQA is responsible for provider certification, compliance, and provider quality assurance. Through its medical staff (DHS RNs), DCO is responsible for level of care determinations.

DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the utilization of the approved assessment instrument.

To oversee and monitor the functions performed by DAABHS, DCO, and DPSQA in the administration and operation of the waiver, DMS will conduct team meetings as needed 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.

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.*
	An Independent Assessment Contractor will perform independent assessments that gather functional eligibility information about each Living Choices waiver applicant using the approved instrument. The information gathered is used by the DHS Eligibility Nurse to determine the individual's level of care. An evaluation is initiated by the DHS PCSP/CC Nurse responsible for care coordination, at least every twelve (12) months. Based on the evaluation, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment. The assessment is sent to DHS Eligibility Nurse to determine if the

	applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and medically eligible, the DCO approves the application.
○	**No**. **Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

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, the Division of Medical Services (DMS) the State Medicaid Agency, along with the Division of Aging, Adult, and Behavioral Health Services (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.

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

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

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

The monthly reports include the following:

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

The annual report includes the following:

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

5. Recommendations for improving the efficiency and quality of the services performed.

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

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	Local Non-State 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	☐	☐	☐	☐
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	■	■	☐	☐

	Number and percent of participants with delivery of at least one waiver service per month as specified in the service plan in accordance with the agreement with the Medicaid Agency. Numerator: Number of participants with at least one service per month; Denominator: Number of participants served
Data Source *(Select one) (Several options are listed in the on-line application):* **Other**	
If 'Other' is selected, specify: **No Waiver Service Report**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ *State Medicaid Agency*	☐ *Weekly*	■ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	■ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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 policies and/or procedures developed by DAABHS that are reviewed and approved by the Medicaid Agency prior to implementation. Numerator: Number of policies and procedures by DAABHS** reviewed by the **Medicaid Agency before implementation; Denominator: Number of policies and procedures developed.**
Data Source *(Select one) (Several options are listed in the on-line application):* ***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*	
		■ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	

				☐ *Other Specify:*

Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***

If 'Other' is selected, specify:

D Report of Active Cases (Point in Time)

Sampling Approach *(check each that applies)*
■ *100% Review*
☐ *Less than 100% Review*
☐ *Representative Sample; Confidence Interval =*
☐ *Stratified: Describe Group:*
☐ *Other Specify:*

b. Methods for Remediation/Fixing Individual Problems

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

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

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

were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

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

Remediation to address participants not receiving at least one waiver service a month in accordance with the service plan and the agreement with DMS includes closing a case, conducting monitoring visits, revising a service plan to add a service, checking on provider billing and providing training. DAABHS conducts remediation efforts in these areas. The tool used for record review documents the remediation that is needed and tracks the corrective action taken.

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

b. Additional Criteria. The state further specifies its target group(s) as follows:

N/A

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 sixty-five (65) automatically remains in the waiver under the Aged target subgroup.

Appendix B-3: Number of Individuals Served

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	**1725**
Year 2	**1725**
Year 3	**1725**
Year 4 (only appears if applicable based on Item 1-C)	**1725**
Year 5 (only appears if applicable based on Item 1-C)	**1725**

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The Living Choices waiver provides for the entrance of all eligible persons on a first-come, first-served basis once individuals meet all functional and financial eligibility requirements.

However, once all waiver slots are filled, a waiting list will be implemented for this program and the following process will apply. Each Living Choices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services; that all waiver slots are filled; and that the applicant is number _ in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the Living Choices program.

Entry to the waiver will then be prioritized based on the following criteria:
a) Waiver application determination date for persons inadvertently omitted from the waiver waiting list (administrative error);
b) Waiver application determination date for persons residing in a nursing facility and being discharged after a 90 day stay; or 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-6: Evaluation / Reevaluation of Level of Care

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

LEVEL OF CARE DEFINITIONS:

FUNCTIONAL/MEDICAL ELIGIBILITY means the level of care needed by the waiver applicant/client to receive services through the waiver rather than in an institutional setting. To be determined to meet medical and functional eligibility, an applicant/client must not require a skilled level of care, as defined in state rule, and must meet at least one of the following three criteria, as determined by a DHS Eligibility Nurse:

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

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

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

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

3. 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.

APPROVED ASSESSMENT INSTRUMENT means DHS approved the instrument used by registered nurses employed by the Independent Assessment Contractor to assess functional need.

INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the approved assessment instrument to assess functional need.

INITIAL INDEPENDENT ASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need. This assessment is used by DHS as part of the initial 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 by the DHS PCSP/CC Nurse in conjunction with the client, at a minimum of every twelve (12) months, to determine continued evidence of established medical and functional eligibility or a change in medical condition that may impact continued medical and functional eligibility. The evaluation may result in a reassessment being requested by DHS if the DHS Eligibility Nurse determines that there is evidence of a material change in the functional or medical need of the client.

REASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need when requested by a DHS Eligibility Nurse, based on evidence of a material change in medical and functional eligibility documented at the evaluation performed by a DHS PCSP/CC Nurse. 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, to be used in the development of the PCSP.

DHS ELIGIBILITY NURSE means a registered nurse authorized by DHS to perform reviews of all functional and medical information available and, based on available information, to make an eligibility determination and, if determined eligible, a level of care determination. DHS eligibility nurses are also responsible for reviewing evaluation documentation for material changes to medical or function need and requesting a reassessment if warranted.

DHS PCSP/CC NURSE means a registered nurse authorized by DHS to perform evaluations, develop person-centered service plans, and serve as the primary care coordinator and DHS contact for assigned clients.

Level of Care Criteria: The functional eligibility criteria for Living Choices Assisted Living waiver eligibility are established in administrative rules and the Living Choices Assisted Living manual, as promulgated by the Arkansas Department of Human Services (DHS). Please see DHS rule 016.06 CARR 057 (2017) (Procedures for Determination of Medical Need for Nursing Home Services).

Beneficiaries who are determined to require a skilled level of care are not eligible for this waiver program. 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;

No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than 21 days.

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

Instrument/Tool Used:

The approved assessment instrument is used by the registered nurses employed by the Independent Assessment Contractor to assess functional need. This assessment is used by DHS as part of the initial process to make a final determination of eligibility. When requested by the DHS Eligibility Nurse, based on evidence of a material change in medical and functional eligibility documented at the evaluation performed by the DHS PCSP/CC Nurse, the approved instrument will be completed by registered employed by the Independent Assessment Contractor to assess continued need.

All State laws, regulations, and policies concerning functional/medical eligibility criteria and the assessment instrument (including the approved assessment instrument, the Living Choices waiver program manual, and the assessment instrument manual) are available to CMS upon request through DAABHS.

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.

Level of Care Instrument for Institutional Care:

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

Level of Care Instrument for Waiver Program:

For the Living Choices waiver program the approved assessment instrument will be used to support the functional/medical eligibility determination process. The evaluation initiated by the DHS PCSP/CC Nurse at a minimum of every twelve (12) months, uses the DHS-703 form to make a determination of continued evidence of established medical and functional eligibility or a change in medical condition that may impact continued medical and functional eligibility. The evaluation may result in a reassessment being requested by DHS if the DHS Eligibility Nurse determines that there is evidence of a material change in the functional or medical need of the client.

	Data needed for determining whether the State's level of care criteria are met are gathered by both instruments. The State's level of care criteria is the same for the waiver and institutional care, with the exception that individuals needing skilled nursing care are excluded from the waiver. Both the approved assessment 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. The state ensures that approved assessment instrument is valid and reliable through multiple stages of testing. The Independent Assessment Contractor conducts its own system testing via automated test scripts as well as business testing to validate outcomes. In addition, the state provides mock assessments for a blinded validation analysis. The mock assessments are designed to test the validity of the approved assessment instrument's assigned tiers (0, 1, 2, 3) compared to the nursing home level of care criteria for waiver functional eligibility. The mock assessments are uploaded to the approved assessment instrument and tracked, and the approved assessment instrument's results are compared to the expected tier levels identified by the state. This testing is single-side

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:

Each waiver applicant to the Living Choices program will be assessed by the Independent Assessment Contractor. Each assessment is performed by a licensed registered nurse using the approved assessment instrument. The DHS Eligibility Nurse will review the approved assessment instrument results and the recommended tier level, and make the final level of care determination. Functional/medical eligibility is valid for twelve (12) months unless a shorter period is specified by DCO.

Evaluations will continue to be performed every twelve (12) months, with the functional eligibility re-affirmed or revised and a written determination issued by DCO. 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 by the DHS PCSP/CC Nurse, and based on the review of the evaluation, the DHS Eligibility Nurse may request a reassessment be completed by the Independent Assessment Contractor, as appropriate. In the manner specified in the DHS Independent Assessment Manual, a participant (or their legal representative) or the participant's physician may request that the DAABHS deputy director (or his/her designee) request a reassessment.

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

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

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

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

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

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

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)*:

DHS has established and maintains procedures for tracking review dates and initiating timely - evaluations to determine continued functional/medical eligibility and financial eligibility prior to each participant's expiration of the level of care.

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

On at least a monthly basis, the DHS PCSP/CC Nurse will identify participants who are due for evaluation. The DHS PCSP/CC Nurse will complete the evaluation for continued

functional/medical eligibility. Should the participant show evidence of a change in medical condition, a referral is made for a reassessment by the Independent Assessment Contractor.

The DHS RN Reviewer, through the record review process and through routine monitoring and auditing procedures, notifies the appropriate DHS PCSP/CC Nurse, DHS RN Supervisor and DMS if an assessment has not been completed within the specified DAABHS policy timeframes.

The reports produced by DCO are used by the DHS PCSP/CC Nurse and DHS RN Supervisor 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 and evaluations of functional/medical eligibility are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of County Operations (DCO). Records are maintained 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.

Quality Improvement: Level of Care

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

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

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

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

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

If necessary, the DHS 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.

Appendix B-8: Access to Services by Limited English Proficient Persons

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

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

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

Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

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).

Extended Medicaid State Plan Prescription Drugs Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Services	17990 Other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	

Living Choices waiver participants are eligible for the same prescription drug benefits of regular Medicaid, plus three additional prescriptions beyond the Arkansas Medicaid State Plan Pharmacy Programs benefit limit. An extension of the monthly benefit limit is provided to waiver clients unless a client is eligible for both Medicaid and Medicare (dually eligible). No prior authorization is required for the three additional prescriptions for Living Choices clients.

A waiver client who is dually eligible must obtain prescribed medications through the Medicare Part D Prescription Drug Plan or, for certain prescribed medications excluded from the Medicare Part D plan, through the Arkansas Medicaid State Plan Pharmacy Plan. Medicare has no restrictions on the number of prescription drugs that can be received during a month.

Duplication of services or potential overlap of the scope of services is managed and monitored through the MMIS.

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

N/A

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(s) *(check one or both)***:**	■	Individual. List types:	◘	Agency. List the types of agencies:
				Licensed Pharmacist

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Pharmacist	Licensed as a pharmacist in the state of Arkansas, a pharmacist holding a current Pharmacy Permit issued by the Arkansas State Board of Pharmacy and issued a DEA number by the Drug Enforcement Agency. The Division of Provider Services and Quality Assurance rules and regulations include	Providers must also be enrolled with the Arkansas Division of Medical Services as a Medicaid State Plan Prescription Drug Program provider.	

	specific experience, education and qualifications for Level II Assisted Living Facilities and their staff. Facilities must fulfill these regulations prior to licensure.		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Licensed Pharmacist	The Medicaid program's fiscal agent	Annual	

Living Choices Assisted Living Services Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Basic Living Choices Assisted Living direct care services are: 1. Attendant care services 2. Therapeutic social and recreational activities 3. Periodic nursing evaluations 4. Limited nursing services 5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing 6. Medication oversight to the extent permitted under Arkansas law 7. Assistance obtaining non-medical transportation specified in the plan of care	

Assisted Living services are provided in a home-like environment in a licensed Level II Assisted Living Facility and include activities such as physical exercise, reminiscence therapy and sensorineural activities, such as cooking and gardening. These services are provided on a regular basis according to the clients plan of care and are not diversionary in nature.

Personalized care is furnished to persons who reside in their own living units/apartments at the facility that may include dually occupied units/apartments when both occupants consent to the arrangement that may or may not include kitchenette and/or living rooms and that contain bedrooms and toilet facilities. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence and provides supervision, safety and security. Other persons or agencies may also furnish care directly or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it.

Care must be furnished in a way that fosters the independence of each client to facilitate aging in place. Routines of care provision and service delivery must be consumer driven to the maximum extent possible and treat each person with dignity and respect.

Assisted living services may also include medication administration consistent with the Arkansas Nurse Practice Act and interpretation thereto by the Arkansas Board of Nursing; limited nursing services; periodic nursing evaluations and non-medical transportation specified in the plan of care. Nursing and skilled therapy services (except periodic nursing evaluation) are incidental rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision.

Living Choices waiver clients may receive services through the Medicaid State Plan that are not duplicative of assisted living waiver services. State plan services must be provided by qualified providers enrolled with the Medicaid agency as a provider of the specific service, (i.e. home health services, DME equipment, therapy services, prescription drugs), and who would have to meet the provider standards for the Medicaid State Plan service that is provided. The Medicaid State Plan services are not paid for through the waiver.

Attendant care services through Living Choices is the provision of assistance to a person who is medically stable and/or has a physical disability to accomplish tasks of daily living that the person is unable to complete independently, such as eating, dressing, bathing and personal hygiene, mobility and ambulation, and bowel and bladder requirements. Waiver attendant care services assist persons to remain independent as much as possible and to that extent are most often not provided as direct care to the total degree of doing the task or activity for the person. However, the required assistance may vary from actually doing a task for the person, assisting the person in performing the task himself or herself or providing safety support while the person performs the task. Attendant care services include oversight, supervision and cueing persons while performing a task. Incidental housekeeping and shopping for personal care items or food may be included in attendant care. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Preparation and serving of meals and laundry are in a congregate setting.

Pursuant to Act 1230 of 2001, the Arkansas Legislature defines limited nursing services as acts that may be performed by licensed personnel while carrying out their professional duties, but limited to those acts that the department (DHS) specifies by rule. Acts which may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department (DHS) for facilities offering assisted living services, shall not be complex enough to require twenty-four (24) hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces and splints (Ark. Code Ann. §20-10-1703).

Limited nursing services provided through the Living Choices waiver are not services requiring substantial and specialized nursing skills that are provided by home health agencies or other licensed health care agencies. Living Choices limited nursing services will be provided by registered nurses (RN), licensed practical nurses (LPN) and certified nursing assistants (CNA) who are employed or contracted with the assisted living facility. Limited nursing services include the assessment and monitoring of the waiver client's health care needs, including the preparation, coordination and implementation of services, in conjunction with the physician/primary care physician or community agencies as appropriate. LPN limited nursing services are provided under the supervision of the RN and include monitoring of the waiver client's health condition and notification of the RN if there are significant changes in the waiver client's health condition. Both the RN and LPN may administer medication and deliver medical services as provided by Arkansas law or applicable regulation. CNAs, under the supervision of an RN and LPN, may perform basic medical duties as set forth in Part II, Unit VII of the Rules and Regulations governing Long Term Care Facility Nursing Assistant Curriculum. These basic medical duties include taking vital signs (temperature, pulse, respiration, blood pressure, height/weight), and recognizing and reporting abnormal changes.

Therapeutic, social and recreational activities are activities that can improve a resident's eating or sleeping patterns; lessen wandering, restlessness, or anxiety; improve socialization or cooperation; delay deterioration of skills; and improve behavior management. Therapeutic activities include gross motor activities (e.g., exercise, dancing, gardening, cooking, etc.); self-care activities (e.g., dressing, personal hygiene, or grooming); social activities (e.g., games, music, socialization); and, sensory enhancement activities (e.g., reminiscing, scent and tactile stimulation). A periodic nursing evaluation by the ALF RN is required quarterly, and revisions made as needed. If required by licensing regulations, and an occupancy admission agreement is in place, the health care services plan portion of the occupancy admission agreement shall be revised within fourteen (14) days upon any significant enduring change to the resident and monitoring of the conditions of the residents on a periodic basis.

The daily rate pays for all direct care services in the participants plan of care. These rates are exclusive of room and board.

Potential overlap of the scope of services is managed and monitored through MMIS.

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

N/A

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(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Licensed Level II Assisted Living Facility; Licensed Class A Home Health Agency

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Level II Assisted Living Facility;	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Level II Assisted Living Facility.		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Licensed Level II Assisted Living Facility;	Division of Medical Services	Annual	

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Class A Home Health Agency	Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Class A Home Health Agency.		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Licensed Class A Home Health Agency	Division of Medical Services	Annual	

Appendix C-2: General Service Specifications

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)*:

●	**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):
	A criminal history record check is required for employees of long-term care (LTC) facilities, according to Ark. Code Ann. §20-33-213. The Division of Provider Services and Quality Assurance (DPSQA) requires state and national criminal history record checks on employees of long-term care facilities, including assisted living facilities. 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 assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility to provide care to participants. Before making an offer of employment, the assisted living facility shall inform an applicant that employment is contingent on the satisfactory results of criminal history record checks. When a facility operator applies for certification to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from DPSQA. The forms and appropriate fees shall be submitted to the DPSQA attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the DQSQA shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to DQSQA for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure. Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks so that no applicable employee exceeds five years without a new criminal record check. Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule. In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor. Home Health Agencies that contract with the assisted living facilities (ALF's) must meet the same requirements for initial criminal history record checks. Criminal history/background investigations in long term care/nursing facilities are monitored through the DPSQA Licensing and Surveying Unit.
○	**No**. Criminal history and/or background investigations are not required.

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)*:

●	**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 assisted living facilities conduct adult abuse registry checks on employees prior to licensure. The facility must provide documentation that employees have not been convicted or do not have a substantiated report of abusing or neglecting residents or misappropriating resident property. The facility shall, at a minimum, prior to employing any individual or for any individuals working in the facility through contract with a third party, make inquiry to the Employment Clearance Registry of the 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 (5) years. DHS requires that each facility 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 assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility 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.
○	**No**. The state does not conduct abuse registry screening.

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:

Living Choices provider enrollment is open and continuous. Prospective Living Choices Assisted Living Providers may contact the Medicaid program's Provider Enrollment Unit for information about becoming a provider. There are no restrictions applicable to requesting this information. This process is open and available to any interested party.

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	***Number and percentage of providers, by provider type, which maintained its license to participate in the waiver program in accordance with State law and waiver provider qualifications. Numerator: Number of providers with maintained license; Denominator: Total number of providers.***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
MMIS Provider Report	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ *State Medicaid Agency*	☐ *Weekly*	■ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		■ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Performance Measure:	***Number and percentage of providers, by provider type, which obtained the appropriate license in accordance with State law and waiver provider qualifications prior to delivering services. Numerator: Number of new providers with appropriate license prior to delivery of services; Denominator: Number of new providers.***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
MMIS Provider Report	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■☐ *State Medicaid Agency*	☐ *Weekly*	■ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		■ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*

		☐ *Other Specify:*		
				☐ *Other Specify:*

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

i. 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 qualified providers will be enrolled by the Division of Medical Services (DMS). Numerator: Number of providers with maintained enrollment credentials; Denominator: Total number of providers participating in the waiver program.***
Data Source *(Select one) (Several options are listed in the on-line application):* ***Program Logs***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ *State Medicaid Agency*	☐ *Weekly*	■ *100% Review*
	☐ *Operating Agency*	■ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *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.

i. 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 providers meeting waiver provider training requirement as evidenced by the in-service attendance documentation. Numerator: Number of providers indicating training by in-service attendance documentation; Denominator: Total number of providers.***
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
Provider 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*	
		■ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

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

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

The state verifies that providers meet required licensing or certification standards and adhere to other state standards. License expiration dates are maintained in the MMIS and tracked for all participating and active providers. Non-certified providers are not allowed to provide services under this waiver.

Each month the DHS PCSP/CC Nurse 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.

Training requirements are explained in the provider manual. These contacts provide information regarding proper referrals, eligibility criteria, forms, reporting, 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 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.

In accordance with the Medicaid provider manual, the provider must require staff to attend orientation training prior to allowing the employee to deliver any waiver services. This orientation shall include, but not be limited to, descriptions of the purpose and philosophy of the Living Choices program; discussion and distribution of the provider agency's written code of ethics; activities which shall and shall not be performed by the employee; instructions regarding Living Choices record keeping requirements; the importance of the service plan; procedures for reporting changes in the participant's condition; discussion, including potential legal ramifications, of the participant's right to confidentiality.

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

Non-licensed/non-certified providers are not allowed to provide services under this waiver.

b. Methods for Remediation/Fixing Individual Problems

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

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

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:*

Appendix 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.

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future

ARChoices was implemented starting January 1, 2016. It combined the previous Elder Choices (EC) and Alternatives for Adults with Physical Disabilities (AAPD) waivers.

Most waiver beneficiaries in EC and AAPD, and subsequently ARChoices, reside in private homes in the community and receive HCBS services in their homes. The home may be the person's home or the home of a family member. It is expected that waiver beneficiaries who live in their own home or the home of a family member meets the setting requirements found at 42 CFR 441.301(c)(4). For any home in which HCBS waiver beneficiaries are living with paid staff, who own the home and are not related to the individual, the state considers these to have elements of provider-owned or controlled settings, and as such will plan to assess, validate, and remediate these as needed to assure full compliance with the HCBS Settings rule.

Current DAABHS Registered Nurses, who develop the Person-Centered Service Plan (PCSP), and Case Managers, who monitor services in the home, have been trained on the HCBS Settings rule. New DAABHS Registered Nurses and Case Managers will be trained on the HCBS Settings rule. DAABHS Registered Nurses and Case Managers have always monitored--and will continue to monitor--the participant's home environment and services provided in the home to ensure the participant's human rights are not violated. DAABHS Registered Nurses and Case Managers will continue to monitor services through annual home visits with 100% of waiver clients. In addition, as part of the certification process, the Division of Provider Services and Quality Assurance Provider Certification Unit staff monitor services in the person's home. DAABHS Registered Nurses, Case Managers, and Provider Certification staff has been trained on the HCBS Settings rule. Information on the HCBS Settings rule will be included in annual training opportunities for DAABHS Registered Nurses, Case Managers, and Provider Certification staff.

If it is discovered that a participant's rights are compromised, the DAABHS Registered Nurses and/or Case Managers will work with the client and, when appropriate, include the family or friend to resolve the issue, involving Adult Protective Services personnel, when necessary.

Review of State Policies and Procedures:

In the first half of 2015, DAABHS identified policies, provider manuals and certification requirement changes needed to comply with settings regulations. HCBS settings policy was integrated into the ARChoices provider manual to be effective January 1, 2016. This manual went through public comment from August 3, 2015 through September 1, 2015, as part of promulgation. The ARChoices provider manual governs Adult Day Care and Adult Day Health Care facilities. Also, the Living Choices Assisted Living (LCAL) provider manual received Arkansas Legislative Council approval Sept. 26, 2016. HCBS settings policy has been incorporated into this manual. The public comment period for this change was October 23, 2015 through November 21, 2015. CMS approved the renewal on July 25, 2016. Once these rules are established in the provider manuals, certification procedures will be adjusted to comply with the new rules by July 1, 2017.

During the first half of 2016, DAABHS performed a more formal and extensive crosswalk of statutes, licensing regulations, policies and procedures governing Level II Assisted Living Facilities and Adult Day Care and Adult Day Health Care facilities. A different crosswalk was completed for each facility type and reflects the level of compliance for each regulatory standard, and what must be changed to meet compliance. Statutes and licensing regulations for these facilities govern all Level II Assisted Living Facilities and Adult Day Care and Adult Day Health Care facilities, regardless of whether the facility is a Medicaid waiver provider, or not. Licenses are granted by the Office of Long-Term Care in the Division of Provider Services and Quality Assurance. Since non-Medicaid providers are not required to meet the HCBS settings rules, the HCBS settings requirements will not be implemented in

the statutes or licensing regulations governing these facilities. If a provider of one of these licensed non-Medicaid facilities wants to become a Medicaid waiver provider, they must then enroll as a Medicaid provider and be certified as a Medicaid waiver provider by the Division of Provider Services and Quality Assurance. All new providers must meet the HCBS settings requirements before they can be certified as a waiver provider.

As a result of the DAABHS policy crosswalks, the state will issue a series of Provider Information Memos (PIM) to HCBS residential and non-residential providers. The state will issue a PIM to both HCBS residential and non-residential providers specifying that they must bring themselves into compliance with the HCBS Settings rule even though the state has not codified the HCBS Settings rule into state statue or licensing regulations. In addition, the state will issue a PIM to our HCBS non-residential providers explaining the requirement that the experiences of individuals receiving HCBS in non-residential settings must be consistent with those individuals not receiving HCBS, for example the same access to food and visitors. All PIMs were issued by December 31, 2016.

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:

An inter-divisional HCBS Settings working group has met regularly since 2014 and will continue to meet during the implementation of the STP. The working group consists of representatives from DAABHS, DDS, and DMS within the Arkansas Department of Human Services. The working group initially met to review the new regulations and develop the initial STP and corresponding timeline. The group has met with external stakeholders to discuss the new regulations. These stakeholders include: assisted living providers, aging providers, intellectual and developmental disability providers, advocates, consumers, and associations representing the aforementioned groups.

The group continues to meet to discuss assessment activities, including provider self-assessment surveys, site visits, and ongoing compliance with the HCBS Settings rule. A small team from this inter-divisional HCBS Settings working group reviewed the provider self-assessment surveys, modified existing HCBS Settings on-site assessment tools to validate provider self-assessments, and analyzed. DAABHS has required Adult Day Cares (ADC), Adult Day Health Cares (ADHC) and Level II Assisted Living Facilities (ALF) to conduct a provider self-assessment and provide the results to DAABHS. DAABHS has used and will continue to use the information from the provider self-assessments to determine what qualities of home and community-based settings exist in the current setting and to inform the development of standards which will facilitate the transition of settings which may not fully meet HCBS characteristics to those which include all the necessary characteristics and traits of a fully compliant HCBS setting.

DAABHS has identified three types of settings that are at risk for not meeting the full extent of the regulations either because the service is provided outside a private residence or because the participant resides in and receives services in a home owned by the provider. These settings are:
• Adult Day Care
• Adult Day Health Care
• Level II Assisted Living Facility

Residential provider self-assessment

To assess compliance with the new HCBS settings requirements, the inter-divisional HCBS Settings working group developed a residential provider self-assessment survey. The survey was developed using the exploratory questions provided in the CMS HCBS Toolkit. Residential providers include Level II Assisted Living Facilities (ALF). The survey questions fall under five general categories: 1)

neighborhood characteristics; 2) home environment; 3) community access and supports; 4) services and supports planning process; and 5) setting characteristics and personal experience.

Neighborhood characteristics encompass traits of the surrounding physical environment including location of the facility within the broader community and access to public transportation. The purpose of the CMS HCBS guidelines is to ensure that individuals are receiving services in a facility that resembles a home-like environment. There are several questions on this survey that address qualities of the home, including questions related to free range inside and outside the facility, lack of restrictive schedules, access to home amenities (television, radio, telephone, etc.), access to home appliances (laundry, kitchen, etc.), meal/snack times, meal/snack choices, physical accessibility of facility and individual's room, and individual preferences for decorating room. Community access and supports describe the integration of residents into the broader community for work-related and leisure activities, as well as visitor access to the facility. The services and supports planning process include habilitation planning, housing protections and due process, and resident rights. Finally, the setting characteristics and personal experience category covers a variety of issues including choice of living arrangement/roommate, privacy and restrictions, interventions, and rights modification.

Residential provider self-assessment surveys (n=45) were distributed via mail in July 2014. Non-responders were contacted via phone and email to encourage completion of the survey which resulted in a response rate of 82% (n=37). Follow-up telephone calls and emails ensued to clarify residential provider responses (as needed). These follow-up calls did not take the place of on-site visits. Residential providers that were licensed and certified after data collection efforts ceased for the provider self-assessment survey or residential providers that began receiving HCBS beneficiaries after data collection ceased were not included in this analysis. However, these providers were subsequently mailed a provider self-assessment so the state could have a baseline "snapshot" of the residential provider's existing self-assessed compliance with the HCBS settings rule. Their responses were then analyzed in order to establish priority for the on-site validation visits. Furthermore, other providers (who responded to the provider self-assessment) have become inactive since the initial self-assessment data collection efforts ceased.

The residential provider-self assessment survey is a necessary part of the HCBS compliance process. This survey allows residential providers to reflect on their current level of compliance as well as take note of areas of potential non-compliance. This survey is intended to raise awareness among ALFs serving HCBS Medicaid beneficiaries about the HCBS settings rules. The survey was distributed prior to ALFs receiving any information on the HCBS Settings rule from DHS. Due to a lack of information or knowledge about the HCBS Settings rule, ALFs may have lacked the level of understanding necessary to accurately complete the provider self-assessment. For this reason, the state decided to use the provider self-assessment as a means to raise awareness among ALFs about the intricacies of the HCBS Settings rule and use it as a way to initiate dialogue between the state and the provider community. The information from the surveys allowed the State to provide targeted technical assistance for ALFs as a whole as well as individually as they move into compliance with the HCBS settings rule. As a follow-up to this survey, the State conducted on-site assessments as a way to validate the self-assessment findings.

While it appears that most ALFs serving HCBS Medicaid beneficiaries are progressing toward HCBS compliance, there are a few areas of concern that need to be addressed. Based on residential provider responses, there may be some ALFs that are in effect isolating residents due to the location of the ALF in relation to the broader community. ALFs self-reporting this characteristic received priority for on-site visits.

There are a small number of ALFs that report having a curfew, restricting access to home-like appliances, restricting mealtime and/or choice, and requiring an assigned seat during meals. Some ALFs also report that they do not have a way to ensure privacy for residents using the common-use telephone or computer.

Cameras are also present in approximately half of all ALFs surveyed. Less than half of ALFs report using barriers to prevent resident access to particular areas within the setting.

A small number of ALFs have restricted visiting hours, and half of the ALFs reported not posting visiting hours. Some ALFs indicate that residents do not know how to schedule a person-centered planning meeting; residents may not be able to explain the process of developing and updating their person-centered plan, residents do not attend the planning meeting, and the meeting may not be at a convenient time/place to ensure resident attendance.

Not all ALFs reported that residents have a lease or written agreement to ensure housing rights. Some ALFs also suggest that residents may not understand the relocation process or how to request new housing.

Non-residential provider self-assessment

To assess compliance with the new HCBS settings requirements, DAABHS developed a non-residential provider self-assessment survey. The survey was developed using the exploratory questions provided in the CMS HCBS Toolkit. Non-Residential providers include Adult Day Centers (ADC) and Adult Day Health Centers (ADHC).The survey questions fall under five general categories: 1) neighborhood characteristics; 2) home environment; 3) community access and supports; 4) services and supports planning process; and 5) setting characteristics and personal experience.

Neighborhood characteristics encompass traits of the surrounding physical environment including location of the facility within the broader community and access to public transportation. The purpose of the CMS HCBS guidelines is to ensure that individuals are receiving services in a location that resembles a home-like environment. There are several questions on this survey that address qualities of the home, including questions related to free range inside and outside the facility, lack of restrictive schedules, meal/snack times, meal/snack choices, physical accessibility of facility, ability to secure personal belongings, and privacy. Community access and supports describe the integration of residents into the broader community for non-work and leisure activities, as well as visitor access to the facility. The services and supports planning process include individual needs and preferences, informed consent, and individuals' rights. Finally, the setting characteristics and personal experience category covers a variety of issues including staff behavior and individual restrictions or interventions.

Non-residential provider self-assessment surveys (n=31) were distributed via mail in July. Non-responders were contacted via phone and email to encourage completion of the survey which resulted in a response rate of 77% (n=24). Follow-up phone calls and emails ensued to clarify residential provider responses (as needed). These follow-up calls did not take the place of on-site visits. Non-residential providers that were licensed and certified after data collection efforts ceased for the provider self-assessment survey or non-residential providers that began receiving HCBS beneficiaries after data collection ceased were not included in this analysis. However, these providers were subsequently mailed a provider self-assessment so the state could have a baseline "snapshot" of the non-residential provider's existing self-assessed compliance with the HCBS settings rule. None of these providers returned a survey. Furthermore, other providers (who responded to the provider self-assessment) have become inactive since the initial self-assessment data collection efforts ceased. For this reason, the response rate documented in the non-residential provider self-assessment report of findings will not be the same as the response rate referred to later in this plan (p. 17, paragraph 2).

The non-residential provider-self assessment survey is a necessary part of the HCBS compliance process. This survey allows non-residential providers to reflect on their current level of compliance as well as take note of areas of potential non-compliance. This survey is intended to raise awareness among ADCs/ADHCs serving HCBS Medicaid beneficiaries about the HCBS settings rules. The survey was distributed prior to ADCs/ADHCs receiving any information on the HCBS Settings rule from DHS. Due to a lack of information or knowledge about the HCBS Settings rule, ADCs/ADHCs may have lacked the level of understanding necessary to accurately complete the provider self-assessment. For this reason, the state decided to use the provider self-assessment as a means to raise awareness among ADCs/ADHCs about the intricacies of the HCBS Settings rule and use it as a way to initiate dialogue between the state and the provider community. The information from the surveys will allow the State to provide targeted technical assistance for the ADCs/ADHCs as a whole as well as individually as they move into compliance with the HCBS settings rule. As a follow-up to this survey, the State conducted on-site assessments as a way to validate the self-assessment findings. In doing so, the State was able to use the findings of this survey to prioritize which ADCs/ADHCs to visit first.

While it appears that most ADCs/ADHCs serving HCBS Medicaid beneficiaries are progressing toward HCBS compliance, there are a few areas of concern that need to be addressed. Based on provider responses, there may be some ADCs/ADHCs that are in effect isolating residents due to the location of the ADC/ADHC in relation to the broader community. ADCs/ADHCs self-reporting this characteristic received priority for on-site visits.

There are a small number of ADCs/ADHCs that report restricting meal/snack time and/or choice, lacking a space to secure personal belongings, and prohibiting engagement in age-appropriate legal activities. One-third of ADCs/ADHCs describe barriers to prevent resident access to particular areas within the setting.

Some ADCs/ADHCs indicate that clients do not engage in regular non-work activities in the community. Additionally, some ADCs/ADHCs do not require informed consent prior to using restraints or restrictive interventions. A small number of ADCs/ADHCs reportedly do not provide clients the opportunity to update or change their preferences, provide information on individual rights, nor do they provide information to clients on the process for requesting additional (or making changes to their current) home and community-based services.

Validation of self-assessment (site visits)

An inter-divisional site review subcommittee of the HCBS Settings working group reviewed several HCBS site assessment surveys developed by other states and chose to modify an existing site visit survey for use in Arkansas. The Arkansas HCBS site review survey examines HCBS settings characteristics as outlined in the CMS exploratory questions. The content of the site review survey is consistent with the areas that were included in the provider self-assessment survey. Separate assessment tools were designed for residential and non-residential settings.

The Residential Site Review Survey includes the following content areas: integrated setting and community access (heightened scrutiny), community integration, housing protections and due process, living arrangements, beneficiary rights, and accessible environment. The Non-Residential Site Review Survey includes the following content areas: integrated setting and community access (heightened scrutiny), community integration, non-residential services, and beneficiary rights. For each question included in the site review survey, the reviewer is asked to mark a yes or no response (the “compliant” or normative response is highlighted for reviewer convenience), mark the information sources accessed to gather information, include notes/evidence of compliance or notes/evidence of non-compliance, and

to mark whether remediation will be required. Responses will be qualitatively analyzed for emerging themes that highlight areas of non-compliance.

The on-site visit included: 1) documented observation of the setting, 2) interviews with beneficiaries of the setting, 3) input from staff, family members (of beneficiaries), and others and 4) a review of supporting documents provided by the provider including, but not limited to, occupancy/admission agreements, resident bill of rights, grievance policies, and individual person-centered service plans. This survey has been reviewed by external stakeholders, and revisions have occurred based on stakeholder feedback.

The same inter-divisional site review subcommittee of the HCBS Settings working group reviewed several HCBS beneficiary/member surveys developed by other states and chose to modify an existing survey tool for use in Arkansas. The Arkansas HCBS beneficiary survey is intended to assess the HCBS characteristics of the setting based on the beneficiary's experience within the setting. The content of the beneficiary survey is consistent with HCBS settings characteristics outlined in the CMS "exploratory questions" as well as the Arkansas provider self-assessment surveys and the Arkansas site review survey tools. Separate beneficiary surveys were designed for both residential settings.

The residential beneficiary survey includes the following content areas: community integration, housing protection and due process, living arrangements, and accessible environment. The non-residential beneficiary survey includes the following content areas: community integration and non-residential services. Each section may include several questions to elicit information from the beneficiaries regarding their experience in the setting. For each question included on the beneficiary survey, the reviewer is asked to mark a yes or no response (the "compliant" or normative response is highlighted for reviewer convenience), mark the information sources accessed to gather information, include notes/evidence of compliance or notes/evidence of non-compliance, and to mark whether remediation will be required. Some questions may have an additional no response option which is "no but supported by the person-centered plan". In addition, probing questions are provided for each survey question to allow the reviewer the opportunity to elicit a more robust response from beneficiaries to provide evidence of compliance or non-compliance. Documentation may be requested to validate the congruence between the person-centered plan and the beneficiary's responses, especially for those questions that appear to reflect a non-compliant setting. Responses will be qualitatively analyzed for emerging themes that highlight areas of non-compliance.

The DAABHS beneficiary sample for the residential beneficiary survey was randomly drawn from an unduplicated count of current Medicaid beneficiaries (n=952) residing in a Level II Assisted Living Facility. To determine the number of beneficiaries to randomly sample, we divided the number of unduplicated Medicaid residential beneficiaries at a given ALF by the total unduplicated residential beneficiary count. This process was repeated for all Level II ALFs serving Medicaid beneficiaries. This gave us the percentage of Medicaid beneficiaries at a given ALF in relation to the total number of unduplicated Medicaid beneficiaries. The percentage of Medicaid beneficiaries at a given ALF was multiplied by the target sample size to determine how many beneficiaries to interview at each ALF. The target sample size for the beneficiary survey was derived from a commonly used statistics website (www.stattrek.org) using a sample size calculator. For an unduplicated beneficiary count of 952 with a 95% confidence interval and a 4% margin of error, our residential beneficiary sample size was 369. We were able to interview approximately 79% (n=291) of our target sample of 369. We interviewed beneficiaries at nearly 100% of the Level II ALFs licensed as Medicaid providers. The only reason we were unable to interview beneficiaries at a particular setting was due to the setting being so new that there were no Medicaid beneficiaries residing there yet. There were multiple reasons that contributed to a

lower survey completion rate than we originally expected, including beneficiaries being hospitalized, deceased, non-interviewable (based on diagnosis), as well as beneficiaries refusing to participate and being away from the facility during the site visit. The state has been brainstorming ways to improve outreach efforts to meet the target sample. These efforts may include making announced/planned visits to ensure that the persons we need to interview are willing and able to meet with us at a scheduled day/time. We will also conduct proxy interviews with guardians/family members/advocates on behalf of beneficiaries, as appropriate and necessary. In addition, we will conduct data clean-up activities to generate a more reliable list from which we generate our target sample.

Staff employed by DAABHS, DDS, and DMS were assigned to regional site visit teams. Employees with a background in survey/data collection, auditing, and fieldwork were chosen to serve as reviewers and assigned to a regional site visit team. These employees, along with members of the site review subcommittee, completed a day-long training in appropriate qualitative methods including direct observation, qualitative interviewing, note-taking, and record review prior to conducting site visits as well as during the site visit process (as needed). The site visit team training also included a module on the HCBS Final Rule, criteria for heightened scrutiny, and a module on sensitivity training. The training session also included a thorough review of both the residential and non-residential survey instruments. The survey was reviewed question-by-question to clarify the intent of the question and appropriate probing questions. Current members of the site review subcommittee were trained in qualitative research methods and a "train the trainer" model was utilized. Quality control checks were implemented throughout the site visit process. Quality control checks consisted of a member of the site review subcommittee pairing up with a member of the site review team to review the site visit documentation. Quality control checks occurred throughout the site assessment process to ensure that surveys were completed in a consistent manner across all regional site visit teams and within each site visit team.

The residential site review survey and the residential beneficiary survey were pilot-tested in a small number of DAABHS settings prior to statewide implementation and were revised further based on feedback during the pilot tests. An additional training session was scheduled with all members of the site visit team to re-emphasize the importance of thorough documentation, the use of probing questions during the beneficiary survey, and to finalize the site visit process. The site visit team along with select members of the inter-divisional HCBS Settings working group met bi-monthly to discuss issues in the field, undergo re-training (if necessary), and/or provide status updates on site visits.

DAABHS conducted site visits on 100% of residential ALF providers (n=51) and non-residential providers (n=26). Very few residential and non-residential providers were identified as HCBS compliant based on the provider self-assessment survey responses. Residential providers include Level II Assisted Living Facilities (ALF) while non-residential providers include Adult Day Care (ADC) facilities and Adult Day Health Care (ADHC) facilities. All settings were represented in the provider self-assessment and were represented in the on-site visits. DAABHS completed the residential ALF site visits in July 2016 (timeline row A-22) and the non-residential site visits in August 2016 (timeline row A-23) (see Appendix A).

Prior to the site visit, residential and non-residential providers received a letter from DHS announcing the process and a 2-3 month timeframe when they could expect a site visit. DHS intentionally chose to make unannounced visits without pinpointing specific dates/times to providers in order to get a better sense of the typical day in the lives of waiver beneficiaries. The state will consider announcing to providers the dates/times of site visits in the future.

In addition, the state's regional site visit teams contacted the guardians or power of attorney on record for beneficiaries listed in the target sample for a given facility. The state conducted this outreach to ensure that these guardians/family members/advocates had sufficient notice to make themselves available on the day of the site visit, should they choose to participate and contribute to the beneficiary survey on behalf of the beneficiary. During these outreach efforts, the regional site teams disclosed the day/time of the site visit so that guardians/family members/advocates could arrange their schedules accordingly.

The site visits followed a standard process including a brief introduction with setting administrators/staff, initial rounds with administrators/staff using the Residential Site Review Survey, request for supporting documentation, interviews with beneficiaries using the Beneficiary Survey, and an exit summary with administrators/staff.

Upon completion of the initial site visits and review of supporting documents provided by the provider, notes from the site review team member were summarized in a standardized report. A cover letter and the corresponding report were mailed to each provider following the on-site visit. The letter summarized the visit, noted areas needing clarification that were observed and documented, requested clarification of provider policies and procedures and/or a corrective action plan, and provided a deadline with which to comply with the requested action(s). This letter also highlighted discrepancies between the information provided by facility staff on the site visit survey and the information provided by beneficiaries and/or their family members/advocates on the beneficiary survey. Providers were asked to address these discrepancies in their corrective action plans. DHS has provided technical assistance to providers throughout this time period. This technical assistance is frequently initiated by provider phone calls. However, the state has also engaged in several face-to-face training opportunities through provider workshops hosted by the Provider Certification Unit, annual meetings of advocacy organizations, provider membership organizations, and monthly meetings with the small stakeholder group.

As corrective action plans and/or updated provider policies and procedures are submitted, DHS will review these materials and respond via letter to the provider. Follow-up site visits may occur as a result of this back-and-forth process with providers to ensure that corrective actions are implemented in the setting. If additional site visits are required, the provider will receive additional standardized reports and letters summarizing the visits. These will include directions for any further action(s) on behalf of the provider. The successful completion of any corrective action plans will be closely monitored by the Director of DAABHS along with designated staff who will monitor the remediation activities outlined in the corrective action plans to ensure that the state is progressing in a timely manner to meet compliance. The state's inter-divisional HCBS Settings working group currently meets monthly to discuss the state's progress and upcoming activities. The state will include monthly updates on provider implementation of corrective action plans and determine if additional provider technical assistance is warranted. During the first half of 2017, the HCBS site review subcommittee along with the HCBS Settings working group will monitor provider compliance efforts through corrective action plans and follow-up site visits. Some corrective action plans may only require a desk audit, meaning the site visit and beneficiary surveys did not highlight any non-compliance issues. However, the provider policies may not reflect the true intent of the HCBS Settings rule and as such will need to undergo revisions to become compliant with the HCBS Settings rule. Follow-up site visits will be conducted with all providers submitting substantive corrective action plans that require a change in procedure or reflect a culture change within that setting to ensure that providers are implementing the corrective actions outlined in the plan. These follow-up site visits will be conducted by a different set of reviewers than those that conducted the initial site visits, allowing for an additional layer of scrutiny. The State expects corrective action plans to be fully implemented by December 2017.

Remediation

The inter-divisional HCBS Settings working group will develop and conduct provider trainings as well as provide tailored technical assistance to partially compliant and non-compliant providers. In order to achieve initial compliance, the HCBS Settings working group is planning multiple regional training opportunities for providers, beneficiaries, and advocates to discuss reoccurring themes from provider-initiated technical assistance phone calls, appropriate remediation strategies, heightened scrutiny, and ongoing compliance. These regional training sessions will be advertised in a manner to effectively reach all stakeholders, including providers, beneficiaries and their families, advocates, etc. The HCBS small stakeholder group will be asked to assist the inter-divisional HCBS Settings working group with disseminating information about the regional trainings to the aforementioned stakeholder groups. DHS expects these regional training sessions to occur during the Fall and Winter of 2016-17. In addition, the HCBS Settings working group will host focus groups during Spring 2017to include all providers in an effort to provide a forum for providers to talk openly about provider specific issues and brainstorm potential strategies to achieve compliance. These focus groups will provide the HCBS Settings working group with specific examples of the promising strategies employed by various settings to comply with the HCBS Settings rule. Technical assistance will also be provided on an as needed basis and will be tailored to the specific needs of the provider based on the analysis of the provider self-assessment and the on-site visits. This technical assistance is already occurring via provider-initiated phone calls to an HCBS Settings working group team member. Efforts to engage providers, advocates, beneficiaries, and others will continue to occur through our monthly small stakeholder meetings (with provider representatives and advocates), quarterly large stakeholder meetings, HCBS website, provider workshops, as well as through individual training calls with the aforementioned groups.

Upon receipt of the provider site visit report (see Appendix J and Appendix K), providers are being asked to submit a corrective action plan to respond to the site visit report (timeline row A-28, A-29, A-30, D-19). This corrective action plan should address how the setting meets HCBS compliance in response to a specific discrepancy noted in the site visit report or outline the remediation that will occur to become settings compliant. Provider-initiated remediation may include reviewing their policies and procedures and updating them as necessary to comport with the HCBS Settings requirements. This remediation may also include reviewing their practices and providing in-service training for staff, if applicable. Any changes to policies/procedures/practices should also be communicated to beneficiaries and their families and the provider is also expected to outline how and when this information will be disseminated.

During the first half of 2017, the HCBS site review subcommittee along with the HCBS Settings working group will monitor provider compliance efforts through corrective action plans and follow-up site visits. Some corrective action plans may only require a desk audit, meaning the site visit and beneficiary surveys did not highlight any non-compliance issues. However, the provider policies may not reflect the true intent of the HCBS Settings rule and as such will need to undergo revisions to become compliant with the HCBS Settings rule. However, follow-up site visits will be conducted with all providers submitting substantive corrective action plans that require a change in procedure or reflect a culture change within that setting to ensure that providers are implementing the corrective actions outlined in the plan. The State expects corrective action plans to be fully implemented by December 2017.

DAABHS providers who wish to appeal our findings can follow the appeal rights process described in Section 160.00 Administrative Reconsideration and Appeals of the Arkansas Medicaid Provider Manual (https://www.medicaid.state.ar.us/provider/docs/all.aspx).

If the HCBS Settings working group does not feel that a provider is progressing towards compliance, the State will need to implement the transition plan to move beneficiaries to a compliant setting.

Ongoing Assessment of Settings

The Office of Long-Term Care (OLTC) Licensure unit within the Division of Provider Services and Quality Assurance (DPSQA) is responsible for onsite visits for environmental regulatory requirements. The OLTC Licensure unit licenses the facilities to operate as an Assisted Living Facility or an Adult Day Care or Adult Day Health Care facility and approve the number of slots that individuals may utilize in these settings. The Provider Certification Unit, also within DPSQA, certifies the providers to provide care under the waiver(s) once they are enrolled to be Medicaid providers. On-going compliance with the assessment of settings will be monitored collectively with DMS, DDS and DAABHS staff.

Licensed and certified settings are subject to periodic compliance site-visits by the Provider Certification Unit. HCBS Settings requirements will be enforced during those visits. DAABHS expects every residential and non-residential setting to receive a visit at least once every three years. These visits will include a site survey and beneficiary experience surveys with a select number of Medicaid beneficiaries. DAABHS Registered Nurses, Case Managers, and Provider Certification staff has been trained on the HCBS Settings rule. Information on the HCBS Settings rule will be included in annual training opportunities for DAABHS Registered Nurses, Case Managers, and Provider Certification staff. Ongoing training for providers on the HCBS Settings rule will be provided during biannual provider workshops hosted by the Provider Certification Unit, as well as through annual meetings of provider membership organizations and via updates to the Arkansas HCBS website.

Settings found to have deficiencies will be required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. Providers who wish to appeal our findings can follow the appeal rights process described in Section 160.00 Administrative Reconsideration and Appeals of the Arkansas Medicaid Provider Manual https://www.medicaid.state.ar.us/provider/docs/all.aspx). New waiver providers will also be subject to an assessment of compliance with the HCBS Settings requirements before being approved to provide services for the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person Centered Service Plan

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

During the service plan development, the DHS PCSP/CC Nurse explains to the participant the services available through the Living Choices waiver.

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

d. 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) DHS PCSP/CC Nurses will develop initial person-centered service plans for Living Choices in Homecare participants based on the Independent Assessment Contractor's assessment of the participant's needs and information gathered during the service plan development meeting with

the participant. The DHS PCSP/CC Nurse will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting. The DHS PCSP/CC Nurse will assist in notifying interested parties if requested by the participant or the representative.

The development of the person-centered service plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor within ten (10) days from contact with the beneficiary. Evaluations, which will be conducted by the DHS PCSP/CC Nurse, will be completed at least every twelve (12) months, or more often, if deemed appropriate by the DHS PCSP/CC Nurse. Following the evaluation, the DHS PCSP/CC Nurse will develop a person-centered service plan. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans are developed and sent to all providers before services may begin.

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

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

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

The assessment is a complete functional eligibility determination of level of care and includes a medical history. The Independent Assessment Contractor will evaluate the participant's physical, functional, mental, emotional and social status, and will obtain a medical history to ensure that

the service plan addresses the participant's strengths, capacities, health care, and other needs. The DHS 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.

(c) During the person-centered service plan development process, the DHS PCSP/CC Nurse explains the services available through the Living Choices 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 and evaluation process and the discussion of available services with the participant. The service plan addresses the participant's needs, goals and preferences. The participant may invite anyone they choose to participate in the assessment and service plan development process, including family members and caregivers. Also, the DHS PCSP/CC Nurse may contact anyone who may be able to provide accurate and pertinent information regarding the participant's condition and functional ability.

If there is any indication prior to or during the assessment or person-centered service plan development process that the participant is confused or incapable of answering the questions required for a proper assessment and service plan development, the assessment or service plan development will not be conducted without another person present who is familiar with the participant and his or her condition. This may be a family member, friend, neighbor, caregiver, etc. If unavailable for the interview, this person may be contacted by phone. These individuals' participation in the service plan development process also helps to ensure that the participant's goals, preferences and needs are met.

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

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

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

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DHS PCSP/CC Nurse, who is the only authorized individual who may adjust a participant's service plan. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Facility Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify 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 necessitate a change in the participant's person-centered service plan; to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS PCSP/CC Nurse in writing within one week of services being terminated, documenting the termination effective date and the reason for the termination.

Providers assure DPSQA that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted a Living Choices Assisted Living service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS PCSP/CC Nurse. Providers acknowledge that the DHS PCSP/CC Nurse is the only authorized individual who may adjust a Living Choices Assisted Living waiver participant's service plan. Providers will implement the service plan with the flexibility to schedule hours to best meet the needs of the participant and will be monitored by DAABHS for compliance.

Person-centered Service plans are revised by DHS PCSP/CC Nurses, as needed between evaluations, based on reports secured through providers, waiver participants, and their support systems.

(g) Each evaluation of functional/medical eligibility and development of a person-centered service plan is completed at a minimum of twelve (12) months or more often, if deemed appropriate the service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Changes are reported to the DHS PCSP/CC Nurse by the participant, the participant's family or representatives, and service providers. The DHS nurse has sole authority for all development and revisions to the waiver service plan. Service plan updates must be based on a change in the participant's status or needs.

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 Independent Assessment Contractor assesses a participant's needs, functional abilities, and performance of activities of daily living during the assessment. The DHS PCSP/CC Nurse assesses a participant’s preferences, risks, dangers, and supports during the meeting with the participant to develop a person-centered service plan. In addition, the service plan development process includes assessment of risk factors and strategies to mitigate risk conducted in a manner that is sensitive to the waiver participant's preferences and the responsibilities required to reduce

risk. The risk mitigation includes factors regarding the participant's functioning ability, ADL performance, support systems in place, risk of falls, environmental factors, and other dangers. This information is included on the person-centered service plan and in the participant's record. Services are started as soon as possible in order to mitigate risk.

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

Routine monitoring of Living Choices in Homecare participants also helps to assess and mitigate risk. DHS PCSP/CC Nurses make at least annual contact with participants and take action to mitigate risks if an issue arises.

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 Nurse also -evaluates potential participant risks during monitoring visits. DHS PCSP/CC Nurses 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.

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

Also, participants, family members or the participant's representative may also contact the DHS PCSP/CC Nurse any time a change is needed or a safety issue arises. Additional monitoring is performed by DMS as part of the validation review, by Office of Medicaid Inspector General audits, and in response to any complaints received.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The participant must choose a provider for each waiver service selected. When a person-centered service plan is developed, the DHS PCSP/CC Nurse must inform the individual, their representative, or family member of all qualified Living Choices in Homecare qualified providers in the individual's service delivery area. The participant, representative, or guardian/family member may choose the providers from which to receive services. The name of the providers chosen by the participant, representative, or family member/representative must be included on the person-centered service plan prior to securing the individual's signature. Along

with signing the service plan, and the Freedom of Choice form, an up-to-date provider listing from DPSQA must be signed and initialed. If a family member/representative chooses a provider for the participant, the DHS PCSP/CC Nurse must identify the individual who chose the providers on the service plan and on the Freedom of Choice form. Documentation is also included in the participant's record and reviewed during the DHS RN Reviewer review process.

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

DHS PCSP/CC Nurses leave contact information with participants at each visit. The participant may contact the DHS PCSP/CC Nurse at any time to find out more information about providers.

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 waiver service plans 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).

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 twenty percent (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 a ninety-five percent (95%) confidence level and a margin of error of +/- five percent (5%). Every nth name is selected for review until the sample size is reached. The sample is then divided into twelve (12) 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.

DHS RN Reviewer staff also conduct record reviews drawing from a statistically valid random sample. Using the Raosoft software calculations program, a statistically valid sample with at ninety-five percent (95%) confident level and a margin of error of +/- five percent (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.

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.

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

☐	**Medicaid agency**
■	**Operating agency**
☐	**Case manager**
■	**Other** *Specify:*
	The service plan is maintained by the DHS PCSP/CC Nurse in the participant's record and by the Living Choices Assisted Living waiver service providers.

Appendix 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.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) employs Registered Nurses who are responsible for monitoring the implementation of the person-centered service plans (PCSP). When the DHS PCSP/CC Nurse sends the person-centered service plan to the provider for implementation, he/she also sends a start of care form along with the PCSP. The provider is required to document the date the service began and return the form to the DHS PCSP/CC Nurse. If the start of care form is not returned to the DHS PCSP/CC Nurse within 10 business days, the DHS PCSP/CC Nurse contacts the provider about the status of implementation. If the provider is unable to provide the service, the DHS PCSP/CC Nurse contacts the participant and offers other qualified providers for the service. The DHS PCSP/CC Nurse is only required to have one start of care form per service in the participant record if services remain at the same level by the same provider when reassessed. If the amount of service changes or the provider of the service changes a new start of care form is required.

DHS PCSP/CC Nurses monitor each waiver participant's status on an as-needed basis for changes in service need, evaluate continued functional/medical eligibility , 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 may invite anyone they choose to participate in the visit. Most often this is the participant's legal representative, guardian or family member.

At each person-centered service plan meeting, the DHS PCSP/CC Nurse provides the participant with their business card with 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.

LIVING CHOICES 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. Providers are required to report any changes in the participant's condition to the participant's DHS PCSP/CC Nurse.

INFORMATION EXCHANGE:

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

The DHS 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 Nurse's contact information. DHS RN Supervisor assist in the resolution of problems, monitor the work performed by the DHS PCSP/CC Nurses by making periodic visits with each DHS PCSP/CC Nurse, and assist in overall program monitoring and quality assurance. Additionally, a record review process is conducted on a monthly basis by DHS RN Reviewers. Records are pulled at random and reviewed for accuracy and appropriateness in the areas of medical assessments, service plans, level of care determinations and documentation. Selection begins by reviewing the latest monthly report from the 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. DHS RN Reviewers uses the Raosoft Calculation System to determine the appropriate sample size for record review with a 95% confidence level and a margin of error of +/-5%, and selects every name on the list to be included in the sample.

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

1. Monthly Reports - compiled by each DHS PCSP/CC Nurse and reported monthly to DHS RN Supervisor. All monitoring visits are reported.

2. DHS RN Reviewer Report - compiled by each DHS RN Reviewer and reported monthly to the Nurse Manager. All monitoring visits are reported.

3. Monthly Record Reviews - performed monthly by DHS RN Reviewers and reported monthly to Nurse Manager.

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

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

Quality Improvement: Service Plan

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

i. 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 service plans that were reviewed and updated by the DHS PCSP/CC Nurse according to changes in participants' needs before the waiver participants' annual review date. Numerator: Number of participants service plans that were reviewed and revised by the DHS PCSP/CC Nurse before annual review date; Denominator: Number of records reviewed.***
Data Source *(Select one) (Several options are listed in the on-line application): 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*
[redacted]	■ *Operating Agency*	☐ *Monthly*	■ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	■ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	*DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.*
		■ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *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*

State:	
Effective Date	

	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. 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 waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed***
Data Source *(Select one) (Several options are listed in the on-line application): 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*
[redacted]	■ *Operating Agency*	☐ *Monthly*	■ *Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*	[redacted] ■ *Representative Sample; Confidence Interval =*
[redacted]	☐ *Other Specify:*	☐ *Annually*	[redacted] *DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level*

				and a +/-5% margin of error.
		■ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Data Aggregation and Analysis

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

Performance Measure:	***Number and percent of waiver participant records reviewed with an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with a choice between institutional care and waiver services and among waiver services; Denominator: Number of records reviewed.***
Data Source *(Select one) (Several options are listed in the on-line application): 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:*	☐ *Annually*		*DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/-5% margin of error.*
		■ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Data Aggregation and Analysis

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

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

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

Individual records are reviewed monthly by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report.

Start of Care forms are reviewed to confirm the appropriateness of service delivery.

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 service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Monthly chart reviews check for the presence of justification for requested changes and proper documentation and data is summarized for the Chart Review Summary.

Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers.

Remediation is performed on service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the DHS RN Reviewer and is a part of the record review process.

DHS RN Reviewers uses the Raosoft calculation system to determine appropriate sample size for Living Choices Record Review and selects every ninth name on the list to be included in the sample.

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

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

The State Medicaid Agency assures compliance with the service plan subassurances through the review of 20% of the records reviewed by DAABHS. DAABHS provides DMS with copies of any data analysis of the findings and plans for remediation of data analysis, including trend identification. DMS and DAABHS participate in team meetings to review findings and discuss resolution.

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations), and 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 service plans, 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.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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 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 Living Choices. 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.

Living Choices 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-3: State Grievance/Complaint System

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 DHSPCSP/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, DCO, 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 (5) working days from when the DAABHS staff received the complaint. Complaints must be resolved within thirty (30) days from the date the complaint was received. If a complaint cannot be resolved by an DHS RN Supervisor, the information is forwarded to the DAABHS central office 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 and DHS RN Supervisors work to resolve any complaints. This involves contacting all parties involved to obtain all sides of the issue, a participant home visit and a review of the participant's service plan, if necessary. The Nurse Manager at the DAABHS central office

may also be asked to assist. Based on the nature of the complaint, the Nurse Manager will use their professional judgment on issues that must be resolved more quickly, such as instances where the participant's health and safety are at risk. Compliance with this policy is tracked and reported through the database. This issue continues to be tracked and reviewed by the DHS RN Reviewers and the Medicaid Quality Assurance staff during the chart review process.

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

If a participant is dissatisfied with the resolution of a complaint, a fair hearing request may be made at the local Division of County Operations 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.

A complaint received on a DHS PCSP/CC Nurse is reported to his or her supervisor, who investigates the complaint.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

Ark. Code Ann. § 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. Living Choices in Homecare waiver staff, providers, and DAABHS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

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

Reporting requirements for DHS employees and contractors:

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

reports within the specified time is subject to disciplinary action unless the employee can show that it was not physically possible to make the report within the required time.

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

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

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

The DHS 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.

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 Living Choices 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. Living Choices 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 will investigate 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 will forward 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.

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

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

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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

●	**The state does not permit or prohibits the use of restraints** Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
	The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restraints. This oversight is conducted through incident reports received; monitoring of the participant by the DHS PCSP/CC Nurse, if needed. DHS PCSP/CC Nurses reassess participants annually.
○	**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:

b. Use of Restrictive Interventions

●	**The state does not permit or prohibits the use of restrictive interventions** Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
	The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted through incident reports received and monitoring of the participant by the DHS PCSP/CC Nurse, if needed.
○	**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.

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

●	**The state does not permit or prohibits the use of seclusion** Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
	The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. This oversight is conducted through incident reports received and monitoring of the participant by the DHS PCSP/CC Nurse, if needed.
○	**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.

Quality Improvement: Health and Welfare

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.***

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.

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

Arkansas addresses this assurance with a three-step process that involves record review, ongoing communication with Adult Protective Services (APS) and Division of Medical Services (DMS) audits of waiver participants' records. Monthly record reviews are performed by DHS RN Reviewer to assure that DHS PCSP/CC Nurses report incidences of abuse or neglect, and that safety and protection are addressed during the development of each person-centered service plan and reported in the Record Review Summary Report. APS reports specific cases of abuse and neglect affecting waiver participants to DAABHS waiver staff. Findings are reported to the DPSQA QA Unit.

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

Policy requires compliance and mandates the DHS PCSP/CC Nurse to report alleged abuse to APS and/or the Division of Provider Services and Quality Assurance (DPSQA). All reports of alleged abuse, follow-ups and actions taken to investigate the alleged abuse, along with all reports to APS or DPSQA must be documented in the nurse narrative. Record reviews include verification of this requirement and are included on the annual report.

The process for reporting abuse as established in Ark. Code Ann. § 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult

Maltreatment Hotline refers the matter to the appropriate investigating agency. Under this statute, a resident of an assisted living facility is identified as a long-term care facility resident, and for the purposes of the statute is presumed to be an impaired person. A report for a long-term care facility resident is to be made to the local law enforcement agency for the jurisdiction in which the long-term care facility is located, and to DPSQA under the regulations of that office. DHS has jurisdiction to investigate all cases of suspected maltreatment of an endangered person or an impaired person. The APS unit of DHS shall investigate all cases of suspected adult maltreatment if the act or omission occurs in a place other than a long-term care facility; and all cases of suspected adult maltreatment if a family member of the adult person is named as the suspected offender, regardless of whether or not the adult is a long-term care facility resident. The Division of Provider Services and Quality Assurance within DHS shall investigate all cases of suspected maltreatment of a long-term care facility resident.

b. Methods for Remediation/Fixing Individual Problems

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

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

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

Appendix H: Quality Improvement Strategy

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.

DAABHS analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DAABHS will meet with DMS 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 the Division of Medical Services (Medicaid agency) and the Division of Aging, Adult, and Behavioral Health Services (operating agency).

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

Medicaid related issues are documented by DAABHS waiver staff and reviewed by DMS staff, 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 the DMS staff. DMS staff review reports for proper resolution. These activities occur on a daily basis, and reviews occur monthly by DMS.

i. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
■ **State Medicaid Agency**	☐ **Weekly**
■ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	■ **Annually**
☐ **Other** Specify:	■ **Other** Specify:
	Ongoing, as needed

b. **System Design Changes**

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

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

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

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

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
- o Yes *(Complete item H.2b)*

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

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

Appendix I: Financial Accountability

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

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

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

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APPENDIX I-2: Rates, Billing and Claims

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).

Assisted Living Facility Rate Determination Methods: This amended waiver reforms the payment rate determination method for assisted living facilities (ALFs) serving waiver participants. For purposes of this waiver, “assisted living facility” means a Medicaid-certified and enrolled assisted living facility with a Level II license. As described below, a rate change took effect 01/01/2019, with the implementation of the rate phased-in over two years.

Methods Employed to Determine Rates: To establish the new assisted living facility payment methodology, the State employed two methods:

1. An actuarial analysis by the Arkansas Medicaid program’s contracted actuaries. This included a cost survey of assisted living facilities and consideration of other states’

federally-approved rate methods and rate levels; direct care cost factors (e.g., direct care work wages and benefits, direct care-related supervision and overhead); Arkansas labor market wage levels; rate scenarios; and Arkansas' minimum and prevailing assisted living facility staffing levels. The actuary's report is available to CMS upon request through the Division of Aging, Adult, and Behavioral Health Services (DAABHS).

2. Negotiations with representatives of the State's participating assisted living facilities.

The rate methodology excludes reimbursement of room and board costs.

The new methodology and resulting new per diem rates provide for payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough assisted living facility providers, as required under 42 U.S.C. 1396a(a)30(A) and 42 CFR §447.200-205.

Uniform, Statewide Rate Methodology: The rate methodology is uniform and applies statewide to all Level II licensed assisted living facilities serving waiver participants.

Opportunities for Public Comment: Before submitting this waiver renewal to CMS for federal review and approval, DHS engaged in various opportunities for public comment and consultations with assisted living facility providers and other interested stakeholders. This includes webinars and regional public meetings. These are in addition to the public comment process for this amended waiver and the revised provider manual. Further, both the amended waiver and the revised provider manual undergo prior review by Arkansas legislative committees.

Entities Responsible for Rate Determination and Oversight of Rate Determination Process: The assisted living facility rate methodology is determined by the Division of Aging, Adult, and Behavioral Health Services (DAABHS), in consultation with the contracted actuaries, and with oversight by the Division of Medical Services (DMS). As the Medicaid agency, DMS is responsible for oversight of all Medicaid rate determinations and for ensuring that provider payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers. DAABHS (as the operating agency responsible for day-to-day waiver administration, service planning, and access and care delivery in the waiver). and DPSQA (as the operating agency responsible Living Choices provider accountability, quality of care, inspections, and auditing) jointly monitors to ensure that assisted living facility payments are consistent with the requirements of 42 U.S.C. § 1396a(a)30(A) and 42 CFR § 447.200-205.

Implementation of New Assisted Living Facility Rates:

Effective after January 1, 2019, assisted living facilities are reimbursed on a fee-for-service basis according to a single statewide per diem rate, determined by DAABHS according to the rate determination methods (actuarial analysis and negotiations) described in this Appendix.
Rates are posted in the fee schedule in the associated Medicaid provider manual and reviewed on a regular basis.

DAABHS will review the rate methodology no later than the end CY 2021. During the last two years of the current 5-year waiver term (CY 2019-2020), as data from the approved assessment instrument and use of the Task and Hour Standards for personal care-type services are accumulated and assessed, DAABHS will consider whether an acuity-adjusted methodology is appropriate. If a methodology change is determined appropriate, it will be addressed in a subsequent waiver amendment or the waiver renewal application.

FOR THE WAIVER AMENDMENT IN EFFECT BEGINNING JANUARY 1, 2023, RATE STUDY AND METHODOLOGY IS AS BELOW:

The general premise of the rate study was to use the hourly wage data and daily staffing ratios to calculate a base cost for direct care. Adjustments could then be applied to this calculation to account for employee benefits costs and inflation. This analysis would thus produce a total cost of the direct care labor. contracted labor was also included in the calculation. Data for contracted positions was also gathered through the cost survey. This cost represents a smaller share of the total Direct Care staffing costs.

The Direct Care staffing costs are the primary driver of the waiver costs and therefore the primary component of the rate calculation.

The review and analysis of 2021 data included efforts to identify and correct reporting errors. Despite our efforts to contact facilities and investigate data anomalies, the 2021 datasets still included some data pieces that we classified as outliers because they exceeded the mean for that data group by a much greater margin than other data elements. To avoid the impact of these outliers it was decided that the median would be the best measure of facility staffing and pay rate norms. Both the staffing ratio and the hourly pay rate for each of the four direct care facility staff positions and their contracted staffing equivalent were determined from the median for the 2021 data. Analysis of minimum staffing requirements applied to different facility sizes allowed the conclusion that these staffing ratios would exceed the minimum staffing requirements for any facility circumstance.

In addition to the staffing ratios and hourly wage rates, other statistics were necessary to complete the direct care staffing calculation. The median staff benefits percentage from the 2021 cost survey data, 18.99%, was used as the benefits percentage. Applying this factor to the direct care wages subtotal (not including contracted staff wages) accounts for the expected cost of providing employee benefits. An inflation factor, calculated from the IHS Global Insight, CMS Nursing Home without Capital Market Basket Index was used to trend the direct care wages per diem. This index is a standard source used to calculate inflation factors for long term care services. The indices for the mid-point of our data period, June 2021, and for the mid-point of the rate period, June 2024 (based on the premise that the end date of the rate period would be December 2025), were utilized to calculate an inflation factor of 12.94%. Applying this factor to the direct care wages and benefits subtotal accounts for expected increase in these costs.

To ensure access to Medicaid waiver individuals and encourage continued and new participation in the waiver program a five percent (5%) access add-on has been provided to each of the individual rate components to calculate the final rate.

2021 Cost Date was utilized and reviewed. Determination of what costs should be considered allowable waiver expenses was made. Calculation of per diem costs for each of the three remaining rate components; Indirect Care, Administrative and General (A&G), and Rent and Utilities was then made. In reviewing the data it was determined that to address the existence of outliers the median for each of these areas was a valid measure of facility norms and that statistic was used for each of the rate components. The median per diem cost for each rate component was increased by five percent to apply the access add-on the applied inflation to these calculations using the same factor that was applied to the 2021 data for direct care staffing These calculations resulted in the following per diem allowances for the three non-direct cost components; Indirect Care $16.75, Administrative and General $24.15, and Rent and Utilities $2.45.

Some additional detail should be noted about what costs are included in Indirect Care and Rent and Utilities. For indirect care 100% of all costs that were classified into this cost center on the cost survey were included. This includes a per diem total of $9.68 for food preparation salaries and related benefits, which is 56.78% of the indirect care total. For rent and utilities, an allocation of total facility costs was calculated using building area square footage data to allow for the portion of building costs associated with administrative functions and resident activities. This resulted in an allocation of 6.12% of eligible building costs which came to a weighted average of $2.58.

Appendix 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:			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 (Column 7 less Column 4)**
1	$17,243.46	$4,727.00	**$21,970.46**	$61,295.00	$5,818.00	**$67,113.00**	**$(45,142.54)**
2	$17,243.46	$5,185.00	**$22,428.46**	$67,792.00	$6,412.00	**$74,204.00**	**$(51,775.54)**
3	$17243.46	$5678.00	**$22,921.46**	$74,707.00	$7,033.00	**$81,740.00**	**$(58,818.54)**
4	$17,243.46	$6,217.00	**$23,460.46**	$81,953.00	$7,702.00	**$89,655.00**	**$(66,194.54)**
5	$17,243.46	$6,783.00	**$24,026.46**	$89,739.00	$8,433.00	**$98,172.00**	**$(74,145.54)**

67. **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	1725	1725
Year 2	1725	1725
Year 3	1725	1725
Year 4 (only appears if applicable based on Item 1-C)	1725	1725
Year 5 (only appears if applicable based on Item 1-C)	1725	1725

67. **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.

The average length of stay on the waiver is estimated to be 291 days. This average was calculated as days of eligibility from the MMIS segments, using the Medicaid DSS. These numbers were determined by reporting the total days of waiver service (based on service eligibility days within the waiver year) for all participants and dividing by the unduplicated count of participants.

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:

Factor D is derived from current reporting of expenditures from the Medicaid DSS and consideration of previous waiver estimates of utilization and growth rates.

The unduplicated cap of 1725 was used as the number of users for WY1-WY5to allow for full-year participation of each available slot. Given the average length of stay of 291 days, the state calculates 1,505 as the maximum number of unduplicated participants who can be served under a point-in-time (PIT) maximum of 1,200. The calculation is:

1,200 (max PIT cap) x 365 days ÷ 291 days (avg. length of stay) = 1,505

This exact amount was used for the estimated number of users in Appendix J-2-d.

Extended Medicaid State Plan Prescription Drug costs were estimated based on actual costs from the previous 5 years of the waiver. The most recent data from Medicaid DSS shows that this service cost has remained constant, therefore, we do not anticipate an increase in utilization of this service. The number of users for this service has increased over the last 5 years and have been updated to reflect more users of this service.

The state's actuary calculated a composite average of the four (4) tier rate used during the previous renewal cycles, adjusted to reflect the distribution of participants between the four tiers, of $80.33. The payment rate recommended by the actuary is $62.89, which is a 20.7% decrease from the $80.33 composite average Because this is such a significant decrease, the state phased-in the new rate. The phase-in schedule that the state is currently proposing is to move to a single payment tier effective January 1, 2019, at the composite average rate of $80.33, and then reduce the rate by $4.36 every six months: On July 1, 2019, the rate decreased to $75.97; on January 1, 2020, the rate decreased to $71.61; on July 1, 2020, the rate decreased to $67.25; and on January 1, 2021, for the final month of the waiver, the rate should have decreased to the actuary's recommended rate of $62.89, but did not due to restrictions under the CARES act. Currently the state is operating under regulations of the CARES Act, which precludes the state from further reductions, so the rate remains at $67.25 until these regulations are lifted.

~~The state is currently conducting a rate study and will submit an amendment request should the rate study yield a new rate for this service.~~

FOR THE WAIVER AMENDMENT IN EFFECT BEGINNING JANUARY 1, 2023, RATE STUDY AND METHODOLOGY IS AS BELOW:

The general premise of the rate study was to use the hourly wage data and daily staffing ratios to calculate a base cost for direct care. Adjustments could then be applied to this calculation to account for employee benefits costs and inflation. This analysis would thus produce a total cost of the direct care labor. contracted labor was also included in the calculation. Data for contracted positions was also gathered through the cost survey. This cost represents a smaller share of the total Direct Care staffing costs.

The Direct Care staffing costs are the primary driver of the waiver costs and therefore the primary component of the rate calculation.

The review and analysis of 2021 data included efforts to identify and correct reporting errors. Despite our efforts to contact facilities and investigate data anomalies, the 2021 datasets still included some data pieces that we classified as outliers because they exceeded the mean for that data group by a much greater margin than other data elements. To avoid the impact of these outliers it was decided that the median would be the best measure of facility staffing and pay rate norms. Both the staffing ratio and the hourly pay rate for each of the four direct care facility staff positions and their contracted staffing equivalent were determined from the median for the 2021 data. Analysis of minimum staffing requirements applied to different facility sizes allowed the conclusion that these staffing ratios would exceed the minimum staffing requirements for any facility circumstance.

In addition to the staffing ratios and hourly wage rates, other statistics were necessary to complete the direct care staffing calculation. The median staff benefits percentage from the 2021 cost survey data, 18.99%, was used as the benefits percentage. Applying this factor to the direct care wages subtotal (not including contracted staff wages) accounts for the expected cost of providing employee benefits. An inflation factor, calculated from the IHS Global Insight, CMS Nursing Home without Capital Market Basket Index was used to trend the direct care wages per diem. This index is a standard source used to calculate inflation factors for long term care services. The indices for the mid-point of our data period, June 2021, and for the mid-point of the rate period, June 2024 (based on the premise that the end date of the rate period would be December 2025), were utilized to calculate an inflation factor of 12.94%. Applying this factor to the direct care wages and benefits subtotal accounts for expected increase in these costs.

To ensure access to Medicaid waiver individuals and encourage continued and new participation in the waiver program a five percent (5%) access add-on has been provided to each of the individual rate components to calculate the final rate.

2021 Cost Date was utilized and reviewed. Determination of what costs should be considered allowable waiver expenses was made. Calculation of per diem costs for each of the three remaining rate components; Indirect Care, Administrative and General (A&G), and Rent and Utilities was then made. In reviewing the data it was determined that to address the existence of outliers the median for each of these areas was a valid measure of facility norms and that statistic was used for each of the rate components. The median per diem cost for each rate component was increased by five percent to apply the access add-on the applied inflation to these calculations using the same factor that was applied to the 2021 data for direct care staffing These calculations resulted in the following per diem allowances for the three non-direct cost components; Indirect Care $16.75, Administrative and General $24.15, and Rent and Utilities $2.45.

Some additional detail should be noted about what costs are included in Indirect Care and Rent and Utilities. For indirect care 100% of all costs that were classified into this cost center on the cost survey were included. This includes a per diem total of $9.68 for food preparation salaries and related benefits, which is 56.78% of the indirect care total. For rent and utilities, an allocation of total facility costs was calculated using building area square footage data to allow for the portion of building costs associated with administrative functions and resident activities. This resulted in an allocation of 6.12% of eligible building costs which came to a weighted average of $2.58.

67. **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' was computed based on Actual Expenditures that were extracted from the decision support system (DSS) component of the MMIS for CY 2019. Using the market basket forecasts inflation rate of 3.26% that is based on an average rate for 3 years and the related expenditure report from the DSS system of all waiver eligible recipients' annual expenditures.

Note: Costs are indicated for State Category of Service AL (Living Choices), and AX (Extension of 3 prescriptions for Living Choices beneficiaries).

67. **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 that were extracted from the decision support system (DSS) component of the MMIS for SFY 2020. Using the average annual expenditures for nursing home recipients and the market basket forecasts inflation rate of 3.26% that is based on the average rate for 3 years. Factor G was computed for each of the 5 years of the waiver.

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 that were extracted from the decision support system (DSS) component of the MMIS. Using the average annual expenditures for nursing home recipients. Note: Costs indicated for State Category of Service 58 (Private SNF), 59 (Private SNG Crossover), 62 (Public ICF Mentally Retarded), and 63 (Public SNF) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the Living Choices waiver.

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	
Extended Medicaid State Plan Prescription Drugs	manage components
Living Choices Assisted Living Services	manage components

d. Estimate of Factor D.

i. Estimate of Factor D – Non-Concurrent Waiver. 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. 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	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Extended Medicaid State Plan Prescription Drugs Total:					**$292,500.00**

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Extended Medicaid State Plan Prescription Drugs	1 Month	250	15	78.00	$292,500.00
Living Choices Assisted Living Services Total:					~~$42,376,525.80~~ $32,951,734.20
Living Choices Assisted Living Service	1 Day	1505	291	~~96.76~~ 75.24	~~$42,376,525.80~~ $32,951,734.20
GRAND TOTAL:					~~$42,376,525.80~~ **$33,244,234.20**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725
FACTOR D (Divide grand total by number of participants)					~~$24,701.75~~ $19,272.02
AVERAGE LENGTH OF STAY ON THE WAIVER					291

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:					**$292,500.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	250	15	78.00	$292,500.00
Living Choices Assisted Living Services Total:					~~$42,376,525.80~~ $39,415,950.00
Living Choices Assisted Living Service	1 Day	1505	291	~~$96.76~~ $90.00	~~$42,376,525.80~~ $39,415,950.00
GRAND TOTAL:					~~**$42,610,525.80**~~ **$39,708,450.00**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725
FACTOR D (Divide grand total by number of participants)					~~$24,701.75~~ $23,019.39
AVERAGE LENGTH OF STAY ON THE WAIVER					291

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Extended Medicaid State Plan Prescription Drugs Total:					**$292,500.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	250	15	78.00	$292,500.00
Living Choices Assisted Living Services Total:					~~**$29,452,473.75**~~ $42,376,525.80
Living Choices Assisted Living Services	1 Day	1505	291	~~67.25~~ 96.76	~~$29,452,473.75~~ $42,376,525.80
GRAND TOTAL:					~~**$29,744,973.75**~~ **$42,669,025.80**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725
FACTOR D (Divide grand total by number of participants)					~~$17,243.46~~ $24,735.67
AVERAGE LENGTH OF STAY ON THE WAIVER					291

Waiver Year: Year 4					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Extended Medicaid State Plan Prescription Drugs Total:					**$292,500.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	250	15	78.00	$292,500.00
Living Choices Assisted Living Services Total:					~~**$29,452,473.75**~~ $42,376,525.80
Living Choices Assisted Living Services	1 Day	1505	291	~~67.25~~ 96.76	~~$29,452,473.75~~ $42,376,525.80
GRAND TOTAL:					~~**$29,744,973.75**~~ **$42,669,025.80**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725
FACTOR D (Divide grand total by number of participants)					~~$17,243.46~~ $24,735.67
AVERAGE LENGTH OF STAY ON THE WAIVER					291

Waiver Year: Year 5					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:					**$292,500.00**
Extended Medicaid State Plan Prescription Drugs	1 Month	250	15	78.00	$292,500.00
Living Choices Assisted Living Services Total:					~~**$29,452,473.75**~~ $42,376,525.80
Living Choices Assisted Living Services	1 Day	1505	291	~~67.25~~ 96.76	~~$29,452,473.75~~$ 42,376,525.80
GRAND TOTAL:					~~**$29,744,973.75**~~ **$42,669,025.80**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1725
FACTOR D (Divide grand total by number of participants)					~~$17,243.46~~ $24,735.67
AVERAGE LENGTH OF STAY ON THE WAIVER					291