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

I. Request Information

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

B. Waiver Title (optional): ARChoices in Homecare

C. CMS Waiver Number: AR.0195

D. Amendment Number (Assigned by CMS): 

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

E.2 Approved Effective Date (CMS Use): 

II. Purpose(s) of Amendment

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

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

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

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

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

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

5. The deletion of Adult Family Home Services, an obsolete service not used by enrollees;
6. The addition of a new service, Prevocational Services, for persons with physical disabilities.

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

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

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

III. Nature of the Amendment

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

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
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<td>X Waiver Application</td>
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<tr>
<td>X Appendix A – Waiver Administration and Operation</td>
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<td>Quality Improvement</td>
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<td>X Appendix B – Participant Access and Eligibility</td>
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<td>Quality Improvement</td>
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<td>B-7-a</td>
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<td>X Appendix C – Participant Services</td>
<td>C-1/C-3</td>
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<td>C-1-c</td>
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<td>C-4-a</td>
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B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

- [ ] Modify target group(s)
- [X] Modify Medicaid eligibility
- [X] Add/delete services
- [X] Revise service specifications
- [ ] Revise provider qualifications
- [ ] Increase/decrease number of participants
- [X] Revise cost neutrality demonstration
- [ ] Add participant-direction of services
- [X] Other (specify):
  1. Transition independent assessment process from (a) DHS RNs using the ArPath instrument to (b) RNs of independent assessment contractor using the Arkansas Independent Assessment (ARIA) instrument. DHS RNs will gather additional information from individuals in connection with developing the person-centered service plan (PCSP).
2. Add limit on the maximum dollar amount of waiver services authorized for each specific participant by the prospectively determined Individual Services Budget (ISB).

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

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

IV. Contact Person(s)

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

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Dave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>Mills</td>
</tr>
<tr>
<td>Title:</td>
<td>Business Operations Manager, Office of Policy Coordination &amp; Promulgation</td>
</tr>
<tr>
<td>Agency:</td>
<td>Arkansas Department of Human Services</td>
</tr>
<tr>
<td>Address 1:</td>
<td>P. O. Box 1437, Slot S-295</td>
</tr>
<tr>
<td>City</td>
<td>Little Rock</td>
</tr>
<tr>
<td>State</td>
<td>AR</td>
</tr>
<tr>
<td>Zip Code:</td>
<td>72203-1437</td>
</tr>
<tr>
<td>Telephone:</td>
<td>(501) 320-6306</td>
</tr>
<tr>
<td>E-mail:</td>
<td><a href="mailto:dave.mills@dhs.arkansas.gov">dave.mills@dhs.arkansas.gov</a></td>
</tr>
<tr>
<td>Fax Number:</td>
<td>(501) 404-4619</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Mark</th>
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<tbody>
<tr>
<td>Last Name:</td>
<td>White</td>
</tr>
<tr>
<td>Title:</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>Agency:</td>
<td>Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services</td>
</tr>
<tr>
<td>Address 1:</td>
<td>P. O. Box 1437, Slot S-530</td>
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<tr>
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<td>Zip Code:</td>
<td>72203-1437</td>
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<tr>
<td>Telephone:</td>
<td>(501) 320-6009</td>
</tr>
<tr>
<td>E-mail:</td>
<td><a href="mailto:mark.white@dhs.arkansas.gov">mark.white@dhs.arkansas.gov</a></td>
</tr>
<tr>
<td>Fax Number:</td>
<td>(501) 682-8155</td>
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State: 

Effective Date: 

Request for Amendment: 4
This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: ___________________________  Date: November 16, 2019

State Medicaid Director or Designee

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Jay</th>
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<tbody>
<tr>
<td>Last Name:</td>
<td>Hill</td>
</tr>
<tr>
<td>Title:</td>
<td>Director</td>
</tr>
<tr>
<td>Agency:</td>
<td>Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services</td>
</tr>
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<td>Address 1:</td>
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<td>Address 2:</td>
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<td>Telephone:</td>
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<tr>
<td>E-mail:</td>
<td><a href="mailto:jay.hill@dhs.arkansas.gov">jay.hill@dhs.arkansas.gov</a></td>
</tr>
<tr>
<td>Fax Number:</td>
<td>(501) 682-8155</td>
</tr>
</tbody>
</table>
REQUESTED AMENDMENT TO WAIVER INFORMATION

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

[X] Nursing Facility

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

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

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

2. Brief Waiver Description

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

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

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

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

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Effective Date: 

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

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

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

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

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

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

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

Effective Date: Request for Amendment: 7
Specify the transition plan for the waiver:

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

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

Transition Plan for the Waiver

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

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

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

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

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

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

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

By definition, all IADLs, whether or not assistance is covered, are not necessary for fundamental functioning. Human assistance with medically necessary ADLs (such as toileting and mobility and ambulating) remain covered both in the home setting and outside the home when a waiver participant wishes to participate in community activities or attend religious services and needs such assistance at those venues. Non-emergency medical transportation is already a covered service. Management of a participant’s personal finances should be performed by either the participant themselves if able or by a properly delegated and qualified family member or professional. Management of finances by attendants presents risks for abuse and oversight is extremely difficult. With modern communications technology, communication with others is far more readily available and, where assistance is needed, it is incidental to time covered for other covered services or tasks. Finally, under the current ArPath assessment system...
replaced in this waiver amendment and ArPath use of RUGs-based hours calculations, time for these three IADL tasks was rarely explicitly covered, identified, or quantified or otherwise supported by the RUGs-determined hours per the assessment results, and/or in approved in service plans. Therefore, these reforms to the IADL-related portion of the attendant care service description are not expected to adversely affect participant health and welfare.

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

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

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

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

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

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

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

4. In the event the waiver services authorized for the participant within the limit of the applicable Individual Services Budget amount, Medicaid State Plan services, other waiver services, Medicare-covered services, and other available family and community supports, when taken together, are insufficient to meet the participant’s needs, the DAABHS registered nurse will counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing
facility services and assisted living facility services) and make appropriate referrals. The nurse may also order a re-assessment of the participant.

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

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

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

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

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

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

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

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

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

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

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

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

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

All new policies about person-centered service planning, including authorization of services and the prospective Individual Services Budgets, will be phased in and applied to existing participants as their existing person-centered service plans are renewed, updated, or otherwise revised for a new period (up to
one year). Similarly, re-assessments of existing participants will be performed through the new independent assessment process on a revolving basis as previously approved person-centered service plans near expiration or earlier if appropriate (such as in the event of care transitions).

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

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

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

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

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

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

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

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

As described above, existing participants will be transitioned to the amended waiver on revolving basis according to the expiration date of their current person-centered service plan and timing of their next re-
assessments. Existing participants requiring earlier-than-planned re-assessments as a result of care transitions or other life changes will be phased into the amended waiver during that re-assessment and new service plan.

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

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

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

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

Relevant beneficiary materials will be updated to describe policy changes.

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

**REQUESTED AMENDMENTS TO APPENDIX A**

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

**A-2. Oversight of Performance.**

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

The Arkansas Department of Human Services (DHS) uses an Interagency Agreement to define the responsibilities of the three DHS divisions – Division of Medical Services (DMS, the Medicaid agency) DAABHS, and DPSQA – charged with responsibility for administering both the ARChoices in Homecare
Request for Amendment to a §1915(c) HCBS Waiver
ARChoices in Homecare

State:

Effective Date

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

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

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

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

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

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

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

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

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

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

As described in the Interagency Agreement between the Division of Medical Services (DMS, the Medicaid agency), the Division of Aging, Adult, and Behavioral Health Services (DAABHS), and the
Division of Provider Services and Quality Assurance (DPSQA), DAABHS and DMS will jointly share responsibility for oversight of the performance of the Independent Assessment Contractor, with DMS being ultimately accountable. The contract provides for performance measures the Independent Assessment Contractor is required to meet.

**A-6 Assessment Methods and Frequency.**

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

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

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

The monthly reports include the following:

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

The annual report includes the following:

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

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

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

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

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior authorization of waiver services</td>
<td>☑</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

**Appendix A: Waiver Administration and Operation**

**Quality Improvement: Administration Authority of the Single State Medicaid Agency**

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

**i. Performance Measures**

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

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

Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

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

Performance Measure:
Number and percent of providers licensed by the Division of Provider Services and Quality Assurance (DPSQA). Numerator: Number of current providers licensed by DPSQA; Denominator: Number of providers participating in the waiver program.

Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Performance Measure:
Number and percent of LOC assessments completed by an Independent Assessment Contractor qualified evaluator according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by an Independent Assessment Contractor qualified evaluator; Denominator: Number of LOC assessments reviewed.

Case Record Review
Sampling Approach (check each that applies)
X Other
Specify: DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.

Appendix A: Waiver Administration and Operation
Quality Improvement: Administration Authority of the Single State Medicaid Agency
a. Methods for Discovery: Administrative Authority
   ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

State:  
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Request for Amendment: 17
b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

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

The tool used for record review documents and tracks remediation.

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

b. Limitation on the Number of Participants Served At Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way (select one):
The State does not limit the number of participants that it serves at any point in time during a waiver year.

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

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During The Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>8032</td>
</tr>
<tr>
<td>Year 2</td>
<td>8176</td>
</tr>
<tr>
<td>Year 3</td>
<td>8320</td>
</tr>
<tr>
<td>Year 4</td>
<td>9071</td>
</tr>
<tr>
<td>Year 5</td>
<td>9434</td>
</tr>
</tbody>
</table>

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

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

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

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

   X Other

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

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

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

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

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

   X Other

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

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

State: 
Effective Date: 

Request for Amendment: 19
c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

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

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

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

Level of Care Criteria:

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

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

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

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

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

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

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

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

2. Not require a skilled level of care, as defined in the State rule.
For administration of this waiver, the term “life-threatening” means the probability of death from the diagnosed medical condition is likely unless the course of the condition is interrupted by medical treatment.

**Instrument/Tool Used:**

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

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

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

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

**Appendix B: Participant Access and Eligibility**

**B-6. Evaluation/Reevaluation of Level of Care**

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

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
- X A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

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

**Level of Care Instrument for Institutional Care:**

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

**Level of Care Instrument for Waiver Program:**

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

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

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

**Appendix B: Participant Access and Eligibility**

**B-6. Evaluation/Reevaluation of Level of Care**

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

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

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

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

Re-evaluations will continue to be performed on at least an annual basis, with the level of care re-affirmed or revised and a written determination issued by the Office of Long Term Care. A re-evaluation may also be ordered anytime (or scheduled on a more frequent than annual basis) by the DHS registered nurse responsible for the participant’s person-centered service plan, said nurse’s supervisor, the DPSQA Office of Long Term Care director (or his/her designee), or the DAABHS deputy director (or his/her designee). In cases where a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), a re-assessment will be performed as appropriate. In the manner specified in the DHS Independent Assessment Manual, a participant (or their legal representative) or the participant’s physician may request that the DAABHS deputy director (or his/her designee) order a re-assessment.
The ARIA instrument is a comprehensive tool to collect detailed information to determine an individual’s functional eligibility; identify needs, current supports, some of the individual’s preferences, and some of the risks associated with home and community-based care for the individual; and inform the development of the person-centered service plan. The ARIA instrument is used to gather information on the applicant’s (or participant’s in the case of a re-evaluation) demographics; health care providers; current services and supports received (including skilled nursing, therapies, medications, durable medical equipment, and human assistance services), housing and living environment; decision-making and designated representatives; emergency contacts; Activities of Daily Living (ADLs) needs; Instrumental Activities of Daily Living (IADLs) needs; health status (including symptoms, conditions, and diagnoses); psychosocial status (including assessment of behavioral health impairments and risk factors); memory and cognition; mental status; sensory and functional communication skills; self-preservation capabilities and supports; family and other caregiver supports; participation in work, volunteering, or educational activities; and quality of life (including routines, preferences, strengths and accomplishments, and goals for future).

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

In summary:

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6. Evaluation/Reevaluation of Level of Care

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (specify):
DAABHS has established and maintains procedures for tracking review dates and initiating timely re-evaluations prior to each participant’s respective level of care review date and prior to the expiration of the participant’s current person-centered service plan (Arkansas’ term for a person-centered care plan). This process ensures timely reevaluations prior to the level of care review date and the expiration of the person-centered service plan so that no lapse in service occurs.

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

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

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care
Quality Improvement: Level of Care

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

i. Sub-Assurances:

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

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

c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.
   Performance Measures:
   Number and percentage of participants annual re-evaluation LOC determinations that were completed as required by the state. Numerator: Number of participants with LOC determinations completed correctly; Denominator: Number of records reviewed.
   Number and percentage of participants LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed.
   Case Record Review
   Sampling Approach (check each that applies)
   X Representative Sample
   Confidence Interval =
   DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
b. Methods for Remediation/Fixing Individual Problems
   
i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

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

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

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

Appendix B: Participant Access and Eligibility
B-7: Freedom of Choice

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

At the time of assessment and re-assessment of the waiver participant, the DHS RN explains the services available through the ARChoices waiver, discusses the qualified ARChoices providers in the state, and develops an appropriate person-centered service plan. As part of the service plan development process, the participant (or representative) documents their choice to have services provided in the community setting through the HCBS waiver as opposed to receiving services in an institutional setting. In addition, freedom of choice is explained through a Freedom of Choice form and the applicable qualified provider listing; both are signed by the waiver participant or their representative. This is documented on the service plan, which includes the signature of the waiver participant (or representative) and the DHS RN, and included in the participant's electronic record.
NOTE: For reassessments, the Freedom of Choice form is utilized showing if changes are requested by the participant. If no changes are requested, no signatures are required on the provider listing; however, the Freedom of Choice form is signed and dated by the participant or representative. The participant's signature on the service plan, as entered by the participant or representative, documents that the participant (or representative) has made an informed decision to receive HCBS rather than services in an institutional setting and that HCBS are based on the participant's assessment of needs. Freedom of Choice documentation is tracked through the record review process, all staff performance evaluations and monthly reporting.

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

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

Copies of the waiver participant's service plan are maintained with the DAABHS (operating agency) and with the providers chosen by the participant and included on the service plan. Freedom of Choice forms and person-centered service plans are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

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

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

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

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Service</td>
<td>Adult Day Health</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Respite</td>
</tr>
<tr>
<td>Other Service</td>
<td>Adult Day Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Adult Family Home [delete from table]</td>
</tr>
<tr>
<td>Other Service</td>
<td>Prevocational Services [add to table]</td>
</tr>
<tr>
<td>Other Service</td>
<td>Attendant Care Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Environmental Accessibility Adaptations/Adaptive Equipment</td>
</tr>
<tr>
<td>Other Service</td>
<td>Home-Delivered Meals</td>
</tr>
<tr>
<td>Other Service</td>
<td>Personal Emergency Response System (PERS)</td>
</tr>
</tbody>
</table>
Appendix C: Participant Services

C-1/C-3: Service Specification

Service Type: Other Service
Service Title: Attendant Care Services
HCBS Taxonomy: (no change)

Service Definition (Scope):

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

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

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

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

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

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

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

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

1. Activities of Daily Living (ADLs):
   a. Eating (i.e., feeding assistance during meal times and encouraging fluids, excluding tube feeding and total parenteral nutrition and meal preparation);
   b. Toileting;
   c. Personal hygiene and grooming (i.e., face shaving; nail trimming; shampooing, brushing, or combing of hair; and menstrual hygiene);
   d. Dressing;
e. Bathing or showering; and/or

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

2. Instrumental Activities of Daily Living (IADLs):

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

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

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

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

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

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

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

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

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

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

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

b. Any such health-related tasks performed:

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

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

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

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

   v. Are tasks that the participant is unable to perform for themselves without hands-on assistance, direct supervision, and/or active cueing of the attendant.
In the ARChoices program, attendant care services exclude all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   e. On dates of service when the participant:

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

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

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

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

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

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

   g. For a task that was not actually performed.
Appendix C: Participant Services

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

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

Service Definition (Scope):

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

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

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

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

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

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

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

1. The participant lives at home and is cared for, without compensation, by their families or other informal support systems;
2. As determined by the independent assessment, the participant has a severe physical, mental, or cognitive impairment(s) that prevents him or her from being left alone safely in the absence or availability of the primary caregiver;
3. The primary caregiver to be relieved is identified and with sufficient documentation that he or she furnishes substantial care of the client comparable to or in excess of services described under the Attendant Care service;
4. No other alternative caregiver (e.g., other member of household, other family member) or source of assistance is available to provide a respite for the primary caregiver(s);
5. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b) supervision necessary to maintain the health and safety of the participant, as supported by the independent assessment and determined medically necessary by the DAABHS registered nurse; and
6. Respite Care solely serves to supplement (not replace) and otherwise facilitate the continued availability of care provided to waiver participants by families and other informal support systems.

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

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

To allow the person who normally provides care for the waiver participant some time away from his or her caregiving of the participant, Respite Care may be provided in or outside the participant's home as follows:
1. In-home respite may be provided for up to 24 hours per date of service.

2. Facility-based respite care may be provided outside the participant's home on:
   a. A short-term basis (eight (8) hours or less per date of service), or
   b. A long-term (maximum of 24 hours per date of service and used most often when respite needed exceeds the short-term respite amount).

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

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

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

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

Respite Care is subject to the following limitations:

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

2. Respite Care excludes:
   a. Skilled health professional services, including physician, nursing, therapist, and pharmacist services.
   b. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
   c. Services provided for any other person other than the participant;
   d. Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship;
   e. Habilitation services, including but not limited to, assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and
   f. Services provided for any tasks not included in a beneficiary’s service plans.
3. Participants are limited to no more than 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof. Respite care is not subject to a monthly or weekly limit, but is limited to the annual amount of time identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards.

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

C-1/C-3: Service Specification
Service Type: Other Service
Service Title: Prevocational Services
HCBS Taxonomy: Category 04 Day Services; Subcategory 04010 Prevocational services

Service Definition (Scope):

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

Prevocational services are as follows:

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

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

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the participant interacts with individuals without disabilities, other than those providing services to the participant or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
Prevocational services may be provided one-to-one or in a small group format and may be provided as a site-based service or in a community setting, consistent with requirements of the ARChoices provider manual.

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

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

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

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

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

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

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

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

Service Delivery Method (check each that applies):

- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

C-1/C-3 Provider Specifications

Service: Adult Day Health
Provider Type – Licensed Adult Day Health Care
Provider Qualifications - License (specify)
Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

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

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

Service: Respite
Provider Type - Licensed Acute Care Hospital
Provider Qualifications – Certificate (specify)
Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current acute care hospital license.

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

Service: Respite
Provider Type – Licensed Level II Assisted Living Facility
Provider Qualifications - License (specify)

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

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

Service: Respite
Provider Type - Licensed Medicaid Certified Nursing Facility Agency
Provider Qualifications – License (specify)
Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Medicaid Certified Nursing Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001

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

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

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**Service: Respite**

**Provider Type – Licensed Adult Day Health Care Agency**

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

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

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

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**Service: Respite**

**Provider Type – Licensed Residential Care Facility**

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

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

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
**Frequency of Verification:**
Annually for recertification; however, DPSQA must maintain a copy of the agency's current Residential Care Facility license at all times.
**Service: Respite**
Provider Type – **Certified Adult Family Home**
[Delete provider type]
Provider Qualifications – Certificate (specify)
[Delete current language]
Verification of Provider Qualifications
Entity Responsible for Verification:
[Delete current language]
Frequency of Verification:
[Delete current language]

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

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

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

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

Provider Qualifications - Certificate (specify)
Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Services. To be certified, providers must provide a copy of their current adult day care license through the DHS Division of Provider Services and Quality Assurance.

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
Frequency of Verification:
Annually for recertification; however, DPSQA must maintain a copy of the agency’s current Adult Day Care license at all times.

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

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

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

Service: Attendant Care Services
Provider Type – Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider

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

Provider Qualifications - Other Standard (specify)
In order to be certified by DPSQA as an agency attendant care provider and enrolled as a Medicaid provider, the attendants hired by the agency must meet the following minimum qualifications:

- Be 18 years of age or older;
- Be a United States citizen or legal alien authorized to work in the U.S.;
- Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime;
- Be free from communicable diseases;
- Be free from diseases readily transmittable through casual contact;

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

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

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

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

**Service: Attendant Care Services**

**Provider Type** – Licensed Home Health Agency

**Provider Qualifications - Certificate (specify)**
Agencies must be certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, to provide ARChoices agency attendant care services.

**Provider Qualifications - Other Standard (specify)**
In order to be certified by DPSQA as an agency attendant care provider and enrolled as a Medicaid provider, the attendants hired by the agency must meet the following minimum qualifications:

o Be 18 years of age or older;

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

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

o Be free from communicable diseases;

o Be free from diseases readily transmittable through casual contact;

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

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

o Have a current signed formal agreement with an eligible ARChoices participant for the provision of agency attendant care services.
Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant.

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

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

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

**Verification of Provider Qualifications**
**Entity Responsible for Verification:** Arkansas Department of Human Services, Division of Provider Services and Quality Assurance
**Frequency of Verification:** Annually.

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

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

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

**Service: Personal Emergency Response System (PERS)**
**Provider Type –** Alarm or Security Company
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Provider Qualifications - Certificate (specify)
Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

Frequency of Verification:
Annually

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

Long-term Case Management. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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

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

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

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):
   Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
All ARChoices waiver providers employing persons providing direct services (personal assistants, attendants) shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere to any disqualifying criminal offense.

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

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

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

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

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

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

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

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):
X Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

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

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

C-2: General Services Specifications (3 of 3)
e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:

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

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

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

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

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

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

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

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

The DPSQA website lists information for potential ARChoices providers.

**C-4: Additional Limits on Amount of Waiver Services**

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

- [ ] Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3
- [x] Applicable - The State imposes additional limits on the amount of waiver services

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

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

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

- [ ] Other Type of Limit. The State employs another type of limit. Describe the limit and furnish the information specified above.

**Prospective Individual Budget Amount:**

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

1. **Individual Services Budget (ISB):**

   a. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant.
This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.

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

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

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

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

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

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

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

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

c. In the event that a participant’s ISB requires changes or limitations to ARChoices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type,
or amount of ARChoices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.) Any such participant-requested changes and substitutions are subject to the following:

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

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

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

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

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

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

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

iii. Such unique circumstances may include (1) recent major life events not known at the time the current person-centered service plan was approved, including without limitation death of a spouse or caregiver, and loss of a home or residential placement;
and (2) a temporary increase in care needs, for a period not to exceed ninety (90) days after a discharge from inpatient acute treatment or post-acute care.

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

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

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

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

3. Transition Process:

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

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

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

(a) Waiver eligibility is re-evaluated;
(b) The Level of Care is reaffirmed or revised;
(c) A new independent assessment or re-assessment is performed;
(d) Expiration, renewal, extension, or revision of the participant’s person-centered service plan occurs; or

(e) Admission to or discharge from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or transfer from a hospice facility occurs.
b. For all other ARChoices participants not otherwise identified above, the Individual
Services Budget limit shall apply no later than 60 days after the effective date of this
waiver amendment.

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

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

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

4. Methodology for Determining Individual Services Budgets:

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

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

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

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

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

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

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

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

c. For a participant with total waiver expenditures of more than $30,000 for calendar year
2018:
i. The participant will be granted a Transitional Allowance for one year, increasing the participant’s maximum Individual Services Budget to the amount of the participant’s total waiver expenditures for calendar year 2018.

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

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

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

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

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

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

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

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

f. Determination of ISB Amounts

   i. The maximum ISB amount, $30,000, which is also the threshold for the Transitional Allowance, is based on the average annual state and federal cost of nursing home care, excluding the average resident share, the average revenue from the state-imposed Quality Assurance Fee (QAF), and the average FMAP revenue associated with the QAF. For FY2018, the average amount of state general revenue paid for a nursing home stay was $24.04 per day; the average amount of the FMAP on that state general revenue was $57.67, for an average daily total of $81.71, multiplied by 365 days to produce an annual total average cost of $29,824.15. This amount is then rounded up to the nearest thousand to produce the $30,000 ISB amount.
ii. The ISB amounts for the Preventative and Intermediate levels are based on a DHS review of actual waiver service expenditures during FY2018 by a set of 6,810 ARChoices participants who received an assessment or reassessment during FY2018. The expenditures for each participant were adjusted to produce a projected annual total expenditure amount, and participants were divided into the Preventative, Intermediate, and Intensive ISB levels based on the results of the ArPath assessment or reassessment recorded in FY2018. DHS then reviewed the distribution of projected annual total expenditure amounts by ISB level to determine an appropriate ISB amount.

Appendix C: Quality Improvement

Quality Improvement: Qualified Providers

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

i. Sub-Assurances:
   a. Sub-assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
   Performance Measure: Number and percentage of providers, by provider type, which obtain re-certification in accordance with state law and waiver provider qualifications. Numerator: Number of providers with re-certification; Denominator: Total number of providers
   Data source (Select one):
   Other: Provider Certification Unit (DPSQA) Provider Database
   Performance Measure: Number and percentage of providers, by provider type, which obtained the appropriate license/certification in accordance with state law and waiver provider qualifications prior to delivering services. Numerator: number of providers with appropriate license/certification prior to delivery of services; Denominator: Number of new providers
   Data source (Select one):
   Other: Provider Certification Unit (DPSQA) Provider Database

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

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

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

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

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

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

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

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

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

All waiver providers are responsible for all provider requirements, penalties and sanctions as detailed in the Medicaid provider manual.
b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

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

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

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

D-1: Service Plan Development (4 of 8) – Service Plan Development Process
(a) DHS RNs will develop initial person-centered service plans for ARChoices in Homecare participants based on the Independent Assessment Contractor’s assessment of the participant's needs and information gathered during the service plan development meeting with the participant. The DHS RN will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member’s responsibility to notify interested parties to attend the service plan development meeting. The DHS RN will assist in notifying interested parties if requested by the participant or the representative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Each reassessment and person-centered service plan development is completed annually or more often, if deemed appropriate by the DHS RN. The service plan may be revised at any time, based on
information relevant to the participant's condition or circumstances. Changes are reported to the DHS RN by the participant, the participant's family or representatives, service providers and Targeted Case Managers. The DHS RN has sole authority for all development and revisions to the waiver service plan. Service plan updates must be based on a change in the participant's status or needs.

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

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

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

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

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

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

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

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

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

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

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

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

Appendix D: Participant -Centered Planning and Service Delivery

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

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

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

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

A statistically valid random sample of service plans is determined, using the Raosoft software calculations program, for review by the DHS RN supervisory staff. Records are reviewed to assess the appropriateness of the service plan, to validate service provision, to ensure that services are
meet the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS RN addresses any needed corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the Office of Medicaid Inspector General.

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

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

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

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

   X Operating agency

Specify:

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

D-2: Service Plan Implementation and Monitoring

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

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

DHS RNs:

DHS RNs monitor each waiver participant's status on an as-needed basis for changes in service need, reassessment (if necessary), and reporting any participant's complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant may invite anyone they choose to participate in the visit. Most often this is the participant's legal guardian, representative or family member.
At each person-centered service planning meeting, the DHS RN provides the participant with their contact information, an Adult Protective Services (APS) brochure to provide information and the toll-free APS hotline for reporting abuse, maltreatment or exploitation. This information may be utilized by the participant or guardians/family members to report any issues they deem necessary, so that DAABHS can ensure prompt follow-up to problems.

ARCHOICES IN HOMECARE PROVIDERS:

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

TARGETED CASE MANAGERS:

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

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

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

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

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

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

INFORMATION EXCHANGE:

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

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

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

b. Monitoring Safeguards. Select one:

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

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

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

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

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

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

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

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

Quality Improvement: Service Plan

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

i. Sub-Assurances

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

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

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

Sampling Approach (check each that applies)
X Representative Sample
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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

Sampling Approach (check each that applies)
X Representative Sample
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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

Sampling Approach (check each that applies)
X Representative Sample
Confidence Interval = 
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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

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

The state currently operates a system of review that assures completeness, appropriateness, accuracy, and freedom of choice. This system focuses on participant-centered service planning and delivery, participant rights and responsibilities, and participant outcomes and satisfaction.
Individual records are reviewed monthly by DAABHS for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report.

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

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

Appendix F: Participant Rights
Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

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

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

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

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

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

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

NOTE: For reassessments, the freedom of choice form is utilized showing no changes are requested by the participant. No signatures are required on the provider listing; however, the freedom of choice form is signed by the participant or their representative.
Appendix F-3: State Grievance/Complaint System

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards
Appendix G-1: Response to Critical Events or Incidents
b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

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

**Reporting requirements for providers:**

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

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

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

**Reporting requirements for DHS employees and contractors:**

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

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

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

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

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

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

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

**Adult Protective Services (APS) Responsibilities:**

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

As required by law, investigations are completed and an investigative determination entered within 60 days. APS notifies the client and other relevant parties, including the offender, of the determination.
APS communicates with the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

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

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

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

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

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

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

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

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

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

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.
The Division of Provider Services and Quality Assurance assumes responsibility for compiling all incident reports from providers for review and action. Incidents are reported to DPSQA staff through submission of Form DPSQA-731.

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

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

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

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

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

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

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

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

DHS RNs reassess participants annually.

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

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

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

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

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

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

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

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

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

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

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

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

DHS RNs reassess participants annually.

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

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

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

**b. Medication Management and Follow-Up.**

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

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

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

The allowed provider types for Respite Care include licensed facilities that may provide respite care in a licensed facility on a round-the-clock basis for a period of time. Medication oversight or administration must be conducted in accordance with state law and the licensure and scope of practice requirements applicable to the particular type of facility and staff.
Appendix G: Participant Safeguards
Quality Improvement: Health and Welfare
i. Sub-Assurances
a. Sub-Assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures:
Number and percent of critical incidents reviews/investigations that were initiated and completed according to program policy and state law; Numerator: Number of critical incident investigations initiated/completed according to policy/law; Denominator: Number of critical incidents reviewed.
Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up; Denominator: Number of critical incidents reviewed.
Number and percent of participant records reviewed where the participant and/or family or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents as specified in the waiver application. Numerator: Number of participants receiving information on abuse, neglect, exploitation and critical incidents; Denominator: Number of records reviewed.
Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents reviewed.

Case Record Review
Sampling Approach (check each that applies)
X Representative Sample
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

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

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

Case Record Review
Sampling Approach (check each that applies)
X Representative Sample
Confidence Interval =
DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Arkansas addresses this assurance with a three-step process that involves record review, ongoing communication with Adult Protective Services (APS), and Division of Medical Services (DMS) audits of waiver participants' records. Monthly record reviews are performed by DHS RN supervisors to assure that DHS RNs report incidences of abuse or neglect, and that safety and protection are addressed at each assessment and reassessment and reported in the Record Review Summary Report. APS reports specific cases of abuse and neglect affecting waiver participants to DAABHS waiver staff. Findings are reported to DMS.

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

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

The process for reporting abuse as established in Arkansas Code Annotated 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows:

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

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

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

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

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

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

As a result of the discovery processes:

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

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

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

b. System Design Changes

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

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

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

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

I-1: Financial Integrity and Accountability

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

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

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

**Appendix I: Financial Accountability**

**Quality Improvement: Financial Accountability**

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

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

      **Sampling Approach (check each that applies)**
      X Other

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

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

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

      **Sampling Approach (check each that applies)**

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**I-2: Financial Integrity and Accountability**
d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

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

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

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

**Level(s) of Care: Nursing Facility**

<table>
<thead>
<tr>
<th>Col. 1</th>
<th>Col. 2</th>
<th>Col. 3</th>
<th>Col. 4</th>
<th>Col. 5</th>
<th>Col. 6</th>
<th>Col. 7</th>
<th>Col. 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Factor D</td>
<td>Factor D'</td>
<td>Total: D+D'</td>
<td>Factor G</td>
<td>Factor G'</td>
<td>Total: G+G'</td>
<td>Difference (Col 7 less Column4)</td>
</tr>
<tr>
<td>1</td>
<td>8504.21</td>
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<td>18170.21</td>
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<td>2520.00</td>
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<td>3</td>
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<td>4</td>
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<td>5</td>
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<td>10782.00</td>
<td>16285.42</td>
<td>53075.00</td>
<td>2811.00</td>
<td>55886.00</td>
<td>39600.58</td>
</tr>
</tbody>
</table>

State: 

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J-2: Derivation of Estimates (1 of 9)
a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Total Unduplicated Number of Participants (from Item B-3-a)</th>
<th>Distribution of Unduplicated Participants by Level of Care (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level of Care:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>Year 1</td>
<td>11350</td>
<td>Year 1</td>
</tr>
<tr>
<td>Year 2</td>
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<td>Year 3</td>
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<td>Year 4</td>
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<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>11350</td>
<td></td>
</tr>
</tbody>
</table>

J-2: Derivation of Estimates (3 of 9)
c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

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

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

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

J-2: Derivation of Estimates (4 of 9)
Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

<table>
<thead>
<tr>
<th>Waiver Services</th>
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</thead>
<tbody>
<tr>
<td>Adult Day Health</td>
</tr>
<tr>
<td>Respite</td>
</tr>
<tr>
<td>Adult Day Services</td>
</tr>
<tr>
<td><strong>Adult Family Home</strong> [delete from table]</td>
</tr>
<tr>
<td>Prevocational Services [Add to table]</td>
</tr>
<tr>
<td>Attendant Care Services</td>
</tr>
<tr>
<td>Environmental Accessibility Adaptations/Adaptive Equipment</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
</tr>
</tbody>
</table>

J-2: Derivation of Estimates (5 of 9)
d. Estimate of Factor D.
ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year:**
**Year 1**

<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>799606.08</td>
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<tr>
<td>Adult Day Health</td>
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<td>63</td>
<td>4068.00</td>
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<tr>
<td>Respite Total:</td>
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<tr>
<td>Respite In-Home</td>
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<td>1.68</td>
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State: 
Effective Date: Request for Amendment: 86
### Request for Amendment to a §1915(c) HCBS Waiver
#### ARChoices in Homecare

<table>
<thead>
<tr>
<th>Service Type</th>
<th>15 Minutes</th>
<th>Rate</th>
<th>Factor D</th>
<th>Total Cost</th>
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<td>Adult Day Services</td>
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<td>Adult Family Home</td>
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<td>- Level A Day</td>
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<td>CSM Transition Costs-1st Year</td>
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<td>Adaptations/Adaptive Equipment</td>
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<td><strong>715864.00</strong></td>
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<tr>
<td><strong>Total:</strong></td>
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<td>Day</td>
<td>5324</td>
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<td>Prevocational Services</td>
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<td>- Skills Development</td>
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<td>- Career Exploration</td>
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**Total Estimated Unduplicated Participants:**
- Factor D: 11350

**Total Estimated Unduplicated Participants:**

**Factor D**
- (Divide total by number of participants): 8504.21

**State:**

**Effective Date:**
**Request for Amendment to a §1915(c) HCBS Waiver**

**ARChoices in Homecare**

| Services included in capitation: | 0 |
| Services not included in capitation: | 8504.21 |
| **Average Length of Stay on the Waiver:** | 276 |

**J-2: Derivation of Estimates (6 of 9)**

d. **Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year:**

**Year 2**

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<td>Minutes</td>
<td>10</td>
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<td>0.56</td>
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State: 

Effective Date: 88
### Environmental Accessibility Adaptations/Adaptive Equipment

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<th>Package</th>
<th>181</th>
<th>1.00</th>
<th>4162.00</th>
<th>753322.00</th>
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</table>

#### Home-Delivered Meals Total:

<table>
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<tr>
<th>Meal</th>
<th>5505</th>
<th>214.00</th>
<th>5.97</th>
<th>7033077.90</th>
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</thead>
</table>

#### Personal Emergency Response System (PERS) Total:

| PERS Installation | One Installment | 938 | 1.00 | 29.90 | 28046.20 |
| PERS Unit Monitoring | Day | 5324 | 257.00 | 1.07 | 1464046.76 |

#### Prevocational Services Total:

| Prevocational - Skills Development | 15 Minutes | 0 | 0.01 | 0.00 |
| Prevocational - Career Exploration | 15 Minutes | 0 | 0.01 | 0.00 |

**GRAND TOTAL**: 87698432.4

| Total: Services included in capitation: | 87698432.4 |
| Total: Services not included in capitation: | 87698432.4 |

#### Total Estimated Unduplicated Participants:

11350

**Factor D** (Divide total by number of participants):

| Services included in capitation: | 0 |
| Services not included in capitation: | 7726.73 |

**Average Length of Stay on the Waiver**: 276

---

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year:**

**Year 3**

---

**State:**

**Effective Date:**

Request for Amendment: 89
## Request for Amendment to a §1915(c) HCBS Waiver

**ARChoices in Homecare**

<table>
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<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<td>10</td>
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<td>214.00</td>
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<td></td>
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<td>PERS Installation</td>
<td>One Installment</td>
<td>938</td>
<td>1.00</td>
<td>29.90</td>
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<td>PERS Unit Monitoring</td>
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<td>257.00</td>
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</table>
J-2: Derivation of Estimates (8 of 9)

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., §1915(a), §1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 4

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<th>Total Cost</th>
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<td>98154.00</td>
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<td>0.00</td>
<td>53.43</td>
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## Request for Amendment to a §1915(c) HCBS Waiver

ARChoices in Homecare

### Prevocational - Career Exploration

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<th>114</th>
<th>120</th>
<th>6.40</th>
<th>87552.00</th>
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**Attendant Care Services Total:** 32724720.00

**Attendant Care Services**

| 15 Minutes | 4200 | 1720 | 4.53 | 32724720.00 |

**Self-directed Attendant Care Transitioning-1st Year**

| 15 Minutes | 0 | 0 | 0.01 | 0.00 |

**CSM Transition Costs-1st Year**

| 1 Month | 0 | 0 | 0.01 | 0.00 |

**Environmental Accessibility Adaptations/Adaptive Equipment Total:** 915640.00

**Environmental Accessibility Adaptations/Adaptive Equipment Package**

| 220 | 1 | 4162 | 915640.00 |

**Home-Delivered Meals Total:** 7429127.20

**Home-Delivered Meals Meal**

| 5815 | 214 | 5.97 | 7429127.20 |

**Personal Emergency Response System (PERS) Total:** 1495548.24

**PERS Installation One Installment**

| 938 | 1 | 29.9 | 28046.20 |

**PERS Unit Monitoring Month**

| 5324 | 8.45 | 32.62 | 1467502.04 |

**GRAND TOTAL:** 53399240.43

**Total: Services included in capitation:** 53399240.43

**Total Estimated Unduplicated Participants:** 11350

**Factor D (Divide total by number of participants):** 4704.78

**Services included in capitation:** 0

**Services not included in capitation:** 4704.78

**Average Length of Stay on the Waiver:** 276

---

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

<table>
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<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<tbody>
<tr>
<td>Adult Day Health Total:</td>
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<td>Adult Day Health</td>
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<td>3.14</td>
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<td>Respite Total:</td>
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State: ___________________

Effective Date: ___________________

Request for Amendment: 92
## Request for Amendment to a §1915(c) HCBS Waiver

**ARChoices in Homecare**

<table>
<thead>
<tr>
<th>Service</th>
<th>15 Minutes</th>
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<tbody>
<tr>
<td><strong>Respite In-Home</strong></td>
<td>1425</td>
<td>1228</td>
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<td><strong>Adult Family Home - Level A</strong></td>
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<td><strong>Adult Family Home - Level C</strong></td>
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<td><strong>Prevocational - Skills Development</strong></td>
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**Total: Services included in capitation:**

**Total: Services not included in capitation:**

**Total Estimated Unduplicated Participants:**

**Factor D (Divide total by number of participants):**

**Services included in capitation:**

**Services not included in capitation:**

**Average Length of Stay on the Waiver:**

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**State:**

**Effective Date:**

Request for Amendment: 93