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):** Living Choices Assisted Living

C. **CMS Waiver Number:** AR.0400

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 Living Choices Assisted Living waiver is being amended as follows:
  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, transition from (a) independent assessments performed by DHS registered nurses (DHS RNs) using the ArPath assessment instrument to (b) independent assessments performed by RNs of the DHS Independent Assessment Contractor using the Arkansas Independent Assessment (ARIA) instrument.
  3. Increases the maximum number of unduplicated participants who are served in Waiver Years 4 and 5 to 1,725 each year.
  5. Various technical revisions are being made to reflect responsibilities of the new DHS Division of Provider Services and Quality Assurance (DPSQA) (a new operating agency), a new name of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (formerly Division of...
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>
</tr>
</thead>
<tbody>
<tr>
<td>X Waiver Application</td>
<td>1.F</td>
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<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>B-6-c, d, e, f, i, and j</td>
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<tr>
<td></td>
<td>B-7-a</td>
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<tr>
<td></td>
<td>B-8</td>
</tr>
<tr>
<td>X Appendix B – Participant Access and Eligibility</td>
<td>C-1/C-3, C-1: 2 of 2, C-2: 1 of 3-a, b, C-2: 3 of 3-f</td>
</tr>
<tr>
<td>X Appendix C – Participant Services</td>
<td>D-1: 3 of 8, 4 of 8, 5 of 8, 6 of 8, 7 of 8, 8 of 8, D-2-a</td>
</tr>
<tr>
<td>X Appendix D – Participant-Centered Service Planning and Delivery</td>
<td>F-1, F-3-b, c</td>
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<tr>
<td>☐ Appendix E – Participant Direction of Services</td>
<td>G-1-b, c, d, e, G-2-a</td>
</tr>
<tr>
<td>X Appendix F – Participant Rights</td>
<td>H-1-a, b</td>
</tr>
<tr>
<td>X Appendix G – Participant Safeguards</td>
<td>I-1</td>
</tr>
<tr>
<td>X Appendix H – Quality Improvement Strategy</td>
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<tr>
<td>X Appendix I – Financial Accountability</td>
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</table>

State: ____________________________
Effective Date: ____________________________
Request for Amendment: 2
## Component of the Approved Waiver

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix J – Cost-Neutrality Demonstration</td>
<td>J-1</td>
</tr>
<tr>
<td></td>
<td>J-2: 1 of 9, 4 of 9, 5 of 9 (d.i.), 6 of 9 (d.i.), 7 of 9 (d.i.), 8 of 9 (d.i.), 9 of 9 (d.i.)</td>
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</table>

### B. Nature of the Amendment.

Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

<table>
<thead>
<tr>
<th>Nature of the Amendment</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modify target group(s)</td>
<td>☐</td>
</tr>
<tr>
<td>Modify Medicaid eligibility</td>
<td>☒</td>
</tr>
<tr>
<td>Add/delete services</td>
<td>☐</td>
</tr>
<tr>
<td>Revise service specifications</td>
<td>☒</td>
</tr>
<tr>
<td>Revise provider qualifications</td>
<td>☐</td>
</tr>
<tr>
<td>Increase/decrease number of participants</td>
<td>☒</td>
</tr>
<tr>
<td>Revise cost neutrality demonstration</td>
<td>☒</td>
</tr>
<tr>
<td>Add participant-direction of services</td>
<td>☐</td>
</tr>
<tr>
<td>Other (specify):</td>
<td>☒</td>
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</tbody>
</table>

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. Provide for a new reimbursement rate determination methodology for Assisted Living Facility services.

3. 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) 682-1197</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>
</tr>
</thead>
<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>
</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) 320-6009</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>
</tr>
</tbody>
</table>
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: ______________________

State Medicaid Director or Designee

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Jay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>Hill</td>
</tr>
<tr>
<td>Title:</td>
<td>Director, Division of Aging, Adult, and Behavioral Health Services</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-530</td>
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<tr>
<td>Address 2:</td>
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<tr>
<td>City:</td>
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<tr>
<td>Telephone:</td>
<td>(501) 320-6009</td>
</tr>
<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 Living Choices 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 Living Choices Assisted Living waiver program allows individuals to live in apartment-style living units in licensed level II assisted living facilities and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity, and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes participants' personal decision-making while protecting their health and safety. The major goal of this program is to delay or prevent institutionalization of these individuals. However, assisted living services are not intended as a substitute for nursing facility or hospital care for individuals needing skilled care, and room and board services are not covered per federal law.

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

   Extended Prescription Drug Coverage is available for Living Choices participants who are eligible for regular Medicaid drug benefits, plus three additional prescriptions. Participants dually eligible for Medicare and Medicaid must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.
The Living Choices waiver is administered by 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 determination of level of care. DPSQA is also responsible for provider certification, compliance, and 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 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.

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</th>
<th>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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<tr>
<td>Splitting one waiver into two waivers.</td>
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<tr>
<td>Eliminating a service.</td>
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<tr>
<td>Adding or decreasing an individual cost limit pertaining to eligibility</td>
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<tr>
<td>Reducing the unduplicated count of participants (Factor C).</td>
<td></td>
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<tr>
<td>Adding new, or decreasing, a limitation on the number of participants served at any point in time.</td>
<td></td>
</tr>
<tr>
<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>
<td>X</td>
</tr>
<tr>
<td>Making any changes that could result in reduced services to participants.</td>
<td>X</td>
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</tbody>
</table>

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

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

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.

Re-assessments of existing participants will be performed through the new ARIA 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).
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 Living Choices program. This change 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.

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 a revolving basis according to the expiration date of their current person-centered service plan and the timing of their next re-assessment. 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 and person-centered service plans.

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

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 WAIVER APPENDICES

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


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 – the Division of Medical Services (DMS, the Medicaid agency), DAABHS, and DPSQA – charged with responsibility for administering both the ARChoices in Homecare (ARChoices) and Living Choices Assisted Living (Living Choices) HCBS waiver programs. This agreement is reviewed annually and updated as needed. DMS, as the Medicaid agency, monitors this agreement on a continuous basis to assure that the provisions specified are executed.

DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS 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, and overseeing the Independent Assessment Contractor.

DPSQA is responsible for provider certification, compliance, and 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 Living Choices waiver applicant and participant using the Arkansas Independent Assessment (ARIA) instrument. The information gathered is used to determine the individual’s level of 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 DPSQA 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.*
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 policies and/or procedures developed by DAABHS, in consultation with DPSQA, that are reviewed and approved by the Medicaid Agency prior to implementation. Numerator: Number of policies and procedures developed by DAABHS Medicaid before implementation; Denominator: Number of policies and procedures developed.

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 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 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 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.

**Performance Measure:**
Number and percent of providers licensed by the Division of Provider Services and Quality Assurance. Numerator: Number of current providers licensed by the Division of Provider Services and Quality Assurance; 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.

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**Appendix A: Waiver Administration and Operation**

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

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

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

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

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

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>1300</td>
</tr>
<tr>
<td>Year 2</td>
<td>1300</td>
</tr>
<tr>
<td>Year 3</td>
<td>1300</td>
</tr>
<tr>
<td>Year 4</td>
<td>1725</td>
</tr>
<tr>
<td>Year 5</td>
<td>1725</td>
</tr>
</tbody>
</table>

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

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

These activities are performed by registered nurses (RNs) licensed by the State of Arkansas under the rules and standards of the State Board of Nursing. Arkansas is a participant in the multi-state Nurse Licensure Compact.
d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

**Level of Care Criteria:**

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

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 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 used 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 Living Choices 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:

The level of care instrument for the Living Choices waiver program will be 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 Office of Long Term Care (OLTC) in DPSQA will use the assessment results to evaluate level of care. 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 performed anytime upon request the participant (or their legal representative or physician), if requested by the DHS RN responsible for the participant’s person-centered service plan, or in cases a participant has experienced a significant change in circumstances, such as a inpatient hospital or skilled nursing facility admission or the loss of a primary caregiver.

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. 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 Living Choices waiver services or nursing facility services.

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

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

These indications notwithstanding, the final determination of Level of Care and waiver 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 or 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 medical necessity 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. This process ensures timely reevaluations prior to the level of care review date and the expiration of the service plan (of care) so that no lapse in service occurs.

Specifically, DAABHS uses a “tickler” file system approach that DAABHS registered nurses (DHS RNs) and RN supervisors use 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 of the independent contractor. 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 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.

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 final 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 redetermination 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 LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed.
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.

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.

The state currently implements a system of monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected from individual participant records, aggregated to produce summation reports, and compared with periodic randomly sampled record reviews and sampled Program Integrity reviews.

Participant records undergo record reviews performed by DHS RN supervisors. Monthly activity reports track assessments and reassessments performed by the Independent Assessment Contractor. DHS RN reports are submitted to program RN supervisors and the Nurse Manager, who then review for timeliness and accuracy. The 45 Day Report tracks all waiver applications and identifies applications pending for more than 45 days. In addition, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) maintains a daily log of assessments and reassessments sent to the Division of Provider Services and Quality Assurance (DPSQA) (operating agency) Office of Long Term Care for medical determination. Data from all assessment and review activity is aggregated to produce an annual Record Review Summary, and Level of Care Monthly Report.

Level of Care is provided to all applicants for whom there is reasonable indication that services may be needed. DHS RN supervisors perform record reviews of individual participants and results are aggregated for the Record Review Summary Report. Enrolled participants are re-evaluated at least annually. The same record review process, described
above, is utilized for the re-evaluation process. Cases are identified for re-evaluation through alerts in the ARIA assessment tool.

The assessment process and instruments described in the waiver are applied appropriately and according to the approved description to determine participant level of care. Record reviews include a review of assessment and reassessment functions, and their alignment with waiver guidelines and timeframes. Findings are aggregated and included in the annual Record Review Summary.

The DHS RN supervisory staff conducts random record reviews, in which all aspects of Living Choices policy are reviewed. The Annual Report is a compilation of the results of the review of the random record selection. The record review allows reviewers to evaluate trends and identify where additional training for DHS RNs is needed. 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 level of care determinations. DHS RN supervisory staff use the Raosoft calculation system to determine appropriate sample size for Record Review. This system provides a statistical valid sample based on a 95% confidence level with a margin of error of +/- 5%. A systematic random sampling of the active cases includes every “nth” name in the population.

The Division of Medical Services (DMS) QA review process includes review of the billing process by Living Choices Medicaid providers. The DMS QA review process reviews 20% of the records reviewed by DAABHS.

In addition to the record review process, an office review is completed by the DHS RN supervisor, at a minimum, annually for each DHS RN. Office reviews include, but are not limited to: Documentation maintained appropriately; Processing system clearly defined and office organized; Forms completed properly; and Required follow-up for any problems or concerns documented.

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 day-to-day 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 assessment. Also, DAABHS requires that all initial assessments and reassessments of level of care are completed by a registered nurse.
Level of Care assessments are required annually using the approved assessment instrument (currently, ArPath instrument, and upon the effective date of this Amendment, the Arkansas Independent Assessment (ARIA) instrument) and applying the level of care criteria. The DHS RN supervisors 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.

The DHS RN supervisors complete a review to evaluate trends and identify where additional training is needed for the RNs and the OLTC staff performing level of care determinations. Remediation in these areas includes ongoing training by DAABHS for the Independent Assessment Contractor’s RNs who perform these assessments conducted correctly, consistent with the assessment instrument and level of care criteria, and that initial and annual re-evaluation of Level of Care are completed within the required timeframes. DHS RN supervisors develop a corrective plan when remediation in this area is needed.

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 Living Choices waiver, discusses the qualified assisted living providers in the state and develops an appropriate person-centered service plan. As part of the service plan development process, the participant (or representative) documents their choice to have services provided in the community setting through the HCBS waiver as opposed to receiving services in an institutional setting. In addition, freedom of choice is explained through a Freedom of Choice form and the applicable qualified provider listing; both are signed by the waiver participant or their representative. This is documented on the service plan, which includes the signature of the waiver participant (or representative) and the DHS 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 Division of Aging, Adult, and Behavioral Health Services (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 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, such as the Division of Services for the Blind, in these instances. When this occurs, it is documented in the participant record.

Appendix C: Participant Services

C-1/C-3: Provider Specifications

Provider Type - Licensed Level II Assisted Living Facility

Provider Qualifications

License (specify)
Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Level II Assisted Living Facility.

Other Standard
Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) as an Assisted Living Level II facility to be eligible to participate in the Arkansas Medicaid Program. A copy of the ALF’s current license must accompany the provider application and Medicaid contract. Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency’s written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client’s condition; and, a client’s right to confidentiality. This training must be provided prior to the delivery of waiver services. The facility must be located within the state of Arkansas. Consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the concurrence of the federal Centers for Medicare and Medicaid Services (CMS), DPSQA may temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers in the Living Choices HCBS waiver program. If DPSQA determines temporary caps,
limits, or moratoria are appropriate and would not adversely impact beneficiaries' access to assisted living facility services, it will initiate the process through filing a Request for State Implemented Moratorium (CMS–10628 Form) with CMS.

Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Provider Services and Quality Assurance?
Frequency of Verification:
Annual

Provider Type - Licensed Class A Home Health Agency
Provider Qualifications
License (specify)
Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Class A Home Health Agency.

Other Standard
Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance as a Class A Home Health Agency to be eligible to participate in the Arkansas Medicaid Program. A copy of the Class A Home Health Agency’s current license must accompany the provider application and Medicaid contract.

Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency’s written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client’s condition; and, a client’s right to confidentiality. This training must be provided prior to the delivery of waiver services.

The facility must be located within the state of Arkansas.
Provider qualifications, licenses, training, education and experience for the staff of Home Health Agencies are the same as Medicaid enrolled Home Health Agencies.

Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Provider Services and Quality Assurance
Frequency of Verification:
Annual

Appendix C: Participant Services
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):

A criminal history record check is required for employees of long-term care facilities, according to Ark. Code Ann. §20-33-213. The Division of Provider Services and Quality Assurance
Request for Amendment to a §1915(c) HCBS Waiver
Living Choices Assisted Living

(DPSQA), Office of Long-Term Care, requires state and national criminal history record checks on employees of long-term care facilities, including assisted living facilities. Employees include any person who has unsupervised access to participants; provides care to participants on behalf of a service provider, under supervision of, or by arrangement with the assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility to provide care to participants. Before making an offer of employment, the assisted living facility shall inform an applicant that employment is contingent on the satisfactory results of criminal history record checks.

When a facility operator applies for licensure to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from the Office of Long Term Care. The forms and appropriate fees shall be submitted to the Office of Long Term Care attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the Office of Long Term Care shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to the Office of Long Term Care for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure.

Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks on applicable employees so that no applicable employee exceeds five years without a new criminal record check.

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

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

Home Health Agencies that contract with the ALF’s must meet the same requirements for initial criminal history record checks.

Criminal history/background investigations in LTC/NF facilities are monitored through the Office of Long Term Care Licensing and Surveying Unit.

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):

The Division of Provider Services and Quality Assurance (DPSQA), Office of Long-Term Care, requires that assisted living facilities conduct adult abuse registry checks on employees prior to licensure. The facility must provide documentation that employees have not been convicted or do not have a substantiated report of abusing or neglecting residents or misappropriating resident property. The facility shall, at a minimum, prior to employing any individual or for any individuals working in the facility through contract with a third party, make inquiry to the Employment Clearance Registry of the Office of Long Term Care and the Adult Abuse Register maintained by the Adult Protective Services Unit within the Division of Aging, Adult, and Behavioral Health Services. Employees must be re-checked every five years. The Office of Long
Term Care requires that each facility have written employment and personnel policies and procedures, which include verification that an adult abuse registry check has been completed.

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

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

When a facility operator applies for licensure to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from the Office of Long Term Care. The forms and appropriate fees shall be submitted to the Office of Long Term Care attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the Office of Long Term Care shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to the Office of Long Term Care for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure.

Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks on applicable employees so that no applicable employee exceeds five years without a new criminal record check.

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

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

Home Health Agencies that contract with the ALF’s must meet the same requirements for initial criminal history record checks.

Criminal history/background investigations in LTC/NF facilities are monitored through the Office of Long Term Care Licensing and Surveying Unit.

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: 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 Living Choices waiver services may be provided by a family member of the participant when the family member is employed by the assisted living facility. Legally responsible family members or caregivers (spouse or legal guardian of the person) are prohibited from receiving reimbursement for direct provision of covered services for the Living Choices participant.

Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual and be licensed as an Assisted Living Level II facility or Class A Home Health Agency.

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

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

The website of the Division of Provider Services and Quality Assurance (DPSQA) lists information for potential Living Choices providers. In addition, the Office of Long Term Care within DPSQA provides information about becoming a waiver provider during the process of licensing facilities, upon request.

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:**

b. **Sub-assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

*Performance Measure:* Number and percent of qualified providers will be licensed by the Division of Provider Services and Quality Assurance. Qualified providers will be offered using the freedom of choice list. Numerator: Number of providers with maintained license; Denominator: Total number of providers.

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.

DPSQA and DAABHS work collaboratively to train providers on 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, DPSQA is responsible for contacting new providers according to program policy. These contacts provide information regarding proper referrals, eligibility criteria, documentation requirements, forms, reporting, general information about the program, Section II of the Medicaid provider manual, and claims processing problems, etc. Within three months of appearing on the provider list, each new provider must meet with the DHS RN face-to-face to discuss all of the above, plus any problems noted in the first three months of participation.

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 compliance.

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

To continue Medicaid enrollment, a waiver provider must maintain certification 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.

Appendix D: Participant-Centered Planning and Service Delivery
D-1: Service Plan Development

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 Division of Aging, Adult, and Behavioral Health Services (DAABHS) registered nurse (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 Living Choices waiver.

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

D-1: Service Plan Development (4 of 8) – Service Plan Development Process

a) DHS RNs will develop initial person-centered service plans for Living Choices 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 Living Choices 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 AND if the DHS RN believes, in his or her professional judgment, the individual meets the level of care criteria. 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 Living Choices 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 a Living Choices 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 Living Choices waiver to the participant, including any applicable benefit limits. All services the participant is currently receiving are discussed and documented on the person-centered service plan. This includes all medical and non-medical services, such as diapers, under pads, nonemergency medical transportation, family support or other services that are routinely provided.

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

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, and service providers. 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 will assess 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 Living Choices Assisted Living 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.

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 each reassessment and during monitoring visits. DHS RNs 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.

Also, participants, family members or the participant's representative may also contact the DHS RN 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 Living Choices Assisted Living 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 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.

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

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency’s approval. DAABHS reviews a statistically valid random sampling of participant records which includes the service plan, and DMS reviews 20% of the records reviewed by DAABHS. Reviewed service plans are compared to policy guidelines, the functional assessment, and the narrative detailing the participant's living environment, physical and mental limitations, and overall needs. All service plans are subject to the approval of the Medicaid Agency and are made available by the operating agency upon request. DMS randomly reviews service plans through several authorities within the Medicaid Agency, such as Program Integrity and the Quality Assurance unit.

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

Each year, DAABHS reports to the DPSQA Waiver Quality Management Administrator the
findings of the service plan review process.

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

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 Living
Choices waiver provider.

D-2: Service Plan Implementation and Monitoring
a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for
monitoring the implementation of the service plan and participant health and welfare; (b) the
monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring
is performed.

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

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

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

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

The Division of Medical Services QA review reflects internal review of the billing process by Living Choices Medicaid providers. DAABHS conducts a record review on a monthly basis to monitor accuracy and completeness of the record, service plan implementation, service delivery, and the health and welfare of the participant, and DMS reviews 20% of the records reviewed by DAABHS. The DAABHS review completes a systematic random sampling of the active case population whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.

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 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 participants’ service plans that address personal goals; Denominator: Number of records reviewed.
         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.
         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 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.

Number and percent of waiver participant records reviewed with an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services.
Numerator: Number of participants' service plans with a choice between institutional care and waiver services and among waiver services;  
Denominator: Number of records reviewed.

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.

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

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

Individual records are reviewed monthly by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report. A Division of Medical Services (DMS) (Medicaid agency) QA audit is also conducted from a review of 20% of the records reviewed by DAABHS, to confirm that service plans are updated and revised as warranted by changes in participants' needs.

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

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

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

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

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

The Division of Medical Services (DMS) QA review reflects internal review of the billing process by Medicaid providers of ALF. DMS conducts a record review on a monthly basis of 20% of the records reviewed by DAABHS to monitor accuracy and completeness of the record, service plan implementation, service delivery, and the health and welfare of the participant.
DAABHS supervisory staff uses the Raosoft calculation system to determine appropriate sample size for Chart 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; and, compliance with program policy regarding all aspects of service plan development, changes and renewal.

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

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

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

   The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency), and the Division of Medical Services (DMS) (Medicaid agency) participate in team meetings 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 related to the service plans as part of 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.

Appeals are the responsibility of the Department of Human Services Appeals and Hearings section. Waiver applicants are advised on the DCO-707 (Notice of Action) or the system-generated Notice of Action by the County Office of their right to request a fair hearing when adverse action is taken to deny, suspend or terminate eligibility for Living Choices. The notice is issued by the LTSS caseworker, and explains the participant's right to a fair hearing, how to file for a hearing and the participant's right to representation. Notices of adverse actions and the opportunity to request a fair hearing are kept in the participant's case record. Applicants must make their request for an appeal no later than 30 days from the date on the DCO-707.

The DCO-707 Notice of Action is kept in the participant's county office case record. If the DCO-707 is a request for information only, the form may be discarded when all the needed information is received. If the information requested is not received, the form may be discarded five years from the month of origin. Otherwise, the DCO-700 will be retained for five years from the date of 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.

Living Choices 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 assisted living facility 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 an appeal of a denial is not in the participant's favor.

During the assessment and 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. At reassessments, if no change in provider is requested, the provider list is not signed by the participant.
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:
   
   Division of Aging, Adult, and Behavioral Health Services

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

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

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

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

   Information entered into the database includes the complaint source and contact information, participant information, person or provider for whom the complaint is being made against, the person who received the complaint, the person to whom the complaint is assigned for investigation, the complaint being made, and the action taken relative to investigation findings. Complaints concerning abuse and neglect are routed to Adult Protective Services immediately for appropriate action.

   The HCBS Complaint Intake Report (AAS-9505) must be completed within five working days of receiving the complaint. Complaints must be resolved within 30 days from the date the complaint was received. If a complaint cannot be resolved by an RN supervisor, the information is forwarded to the DAABHS central office administrative staff to resolve.

   DHS RNs and RN supervisors work to resolve any complaints. This involves contacting all parties involved to obtain all sides of the issue, a participant home visit and a review of the participant's service plan, if necessary. The Nurse Manager at the DAABHS central office may also be asked to assist. Based on the nature of the complaint, the Nurse Manager will use their professional judgment on issues that must be resolved more quickly, such as instances where the participant's health and safety are at risk. Compliance with this policy is tracked and reported through the database. This issue continues to be tracked and reviewed by the RN Supervisors and the Medicaid Quality Assurance staff during the chart review process.
A follow-up call or correspondence is made to the reporter, if appropriate, to discuss how the issue was resolved without violating confidentiality rules. The participant or representative is informed of the right to appeal any decision and that filing a complaint is not a prerequisite or substitute for a fair hearing.

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

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 participant's 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.

The Complaint Intake Report must be completed within five working days from when DAABHS staff receives the complaint. Complaints must be resolved within 30 days. 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.

Appendix G: Participant Safeguards
Appendix G-1:  Response to Critical Events or Incidents

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

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

Ark. Code Ann. § 12-12-1708(a) specifies mandatory reporters who are required to report suspected adult maltreatment, including abuse, exploitation, neglect, or self-neglect of endangered or impaired adults. Mandated reporters include all physicians, nurses, social workers, case managers, home health workers, DHS employees, facility administrators or owners, employees of facilities, and any employee or volunteer of a program or organization funded partially or wholly by DHS who enters the home of, or has contact with an elderly person. Living Choices 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, 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 without limitation 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 five 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.

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 waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation. Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.
APS communicates with the Living Choices waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. DPSQA and Living Choices staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

Division of Provider Services and Quality Assurance (DPSQA) Responsibilities

DPSQA 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 the Division of Medical Services (DMS).

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. Operating agencies and the Medicaid agency, Division of Medical Services (DMS) are informed of the outcomes of incidents reported.
Request for Amendment to a §1915(c) HCBS Waiver
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to APS applicable to waiver participants. There is a Memorandum of Understanding between the operating agency waiver units and the 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 the Medicaid agency, Division of Medical Services (DMS).

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints. (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)
   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 or seclusion. This oversight is conducted through incident reports received and monitoring of the participant by the DHS RN, if needed.

b. Use of Restrictive Interventions. (Select one):
   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 restrictive interventions and how this oversight is conducted and its frequency:
   The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted through incident reports received and monitoring of the participant by the DHS RN, if needed.

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

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 program policy and state law. Numerator: Number of critical incident investigations initiated/completed according to policy/law; Denominator: Number of critical incidents reviewed.

State: ____________________________
Effective Date: ____________________________

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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.

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 the DPSQA QA Unit.

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

The DPSQA QA audit reflects internal review of the billing process by Living Choices Medicaid providers. The DPSQA QA audit completes a systematic random sampling of the active case population whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.

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.

DPSQA analyzes all discovery and remediation results to determine if a system
improvement is necessary. If a possible system improvement is identified, DPSQA will
meet with the operating agency (DAABHS) to discuss what system or program changes
are necessary, if any, based on the nature of the problem (health and safety issue, etc.),
complexity of the solution (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 DPSQA 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 the DPSQA QA Unit monitor the system changes.

As a result of the discovery processes:

The interagency agreements were revised to provide a more visible product to clarify
roles and responsibilities between the Division of Medical Services (Medicaid agency)
and the Division of Aging, Adult, and Behavioral Health Services (operating agency).

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

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

A separate Quality Assurance Unit was formed within DPSQA to monitor and advise the operating agency for Home and Community-Based Waiver Programs.

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 Provider Services and Quality Assurance (DPSQA) 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, DPSQA Program Development and Quality Assurance staff, DPSQA 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, DPSQA QA 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 DPSQA 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 noting desired outcomes. When change in the strategy is indicated, a collaborative effort between DPSQA and DAABHS is set in motion to complete a revision to the Quality Improvement Strategy which may include submission of a waiver amendment. DPSQA QA staff utilizes the Quality Improvement Strategy during all levels of QA reviews.

Appendix I: Financial Accountability
I-1: Financial Integrity and Accountability

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

   In accordance with waiver participants' service plans, sampling is pulled on a random basis as described in the waiver.

   An independent audit is required annually of the provider agency when:
   - State expenditures are $100,000 or more;
Federal expenditures are $300,000 or more; or
The contract the Department of Human Services (DHS) has with the provider agency requires an independent audit, regardless of funding level.

If the federal expenditures are $300,000 or more, the audit must be performed in accordance with OMB Circular A133, which implemented the Single Audit Act as amended. A Government Auditing Standards (GAS) audit must be performed if DHS funding provided is $100,000 or more of federal, state, or federal and state combined.

The DHS Office of Chief Counsel, Audit Section is responsible for reviewing all independent audits. The provider's audit report is reviewed by the Audit Section to determine whether requirements of applicable authorities and those contained in agency policy were met; material weaknesses in internal control exist; material noncompliance with the provision of grants, contracts, and agreements occurred; and the report included findings, recommendations, and responses thereto by management.

Material weaknesses and non-compliance, other findings, recommendations and responses are recorded and communicated to the DAABHS Deputy Director, who will take appropriate action to resolve audit findings within 90 days of the referral of the finding from the Audit Section. If applicable, through audit requirements regarding provider organizations and thresholds of funding, the DHS Office of Quality Assurance (OQA) maintains a database of audit due dates. Each provider selects an independent auditor. The auditor completes a report and submits the report to the provider and to the DHS OQA. The DHS OQA submits a monthly report indicating findings to the DHS Executive Staff.

DPSQA Quality Assurances also reviews the services billed compared to the services listed on a participant's service plan. DPSQA record reviews include a review of the billing by LCAL providers. A systematic random sampling of the active case population is drawn whereby every nth name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the nth integer, the sample is divided by the population. Those names are drawn until the sample size is reached. DAABHS receives a report from DPSQA on a monthly basis with overpayments. DAABHS verifies all overbilling and sends out for recoupment. DAABHS also receives a quarterly overlapping report and no service report. DAABHS reviews and verifies the report for overlapping of services or no services being billed within 30 days.

Quality Improvement: Financial Accountability

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) and the Division of Medical Services (DMS) (Medicaid agency) participate in regular team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAABHS and DPSQA have a
Memorandum of Understanding (MOU) 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’s remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discovery, making system changes and training staff. DAABHS’s remediation for claims for services not specified in the participant's service plan includes revising the participant's plan of care if necessary, recouping payment to the provider, imposing provider sanctions, training providers and conducting a participant monitoring visit to possibly reconsider consumer direction.

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).

Assisted Living Facility Rate Determination Methods: This amended waiver reforms the payment rate determination method for assisted living facilities (ALFs) serving waiver participants. For purposes of this waiver, “assisted living facility” means a Medicaid-certified and enrolled assisted living facility with a Level II license.

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

1. An actuarial analysis by the Arkansas Medicaid program’s contracted actuaries. This included a cost survey of assisted living facilities and consideration of other states’ federally-approved rate methods and rate levels, direct care cost factors (e.g., direct care work wages and benefits, direct care-related supervision and overhead), Arkansas labor market wage levels, rate scenarios, and Arkansas’ minimum and prevailing assisted living facility staffing levels. The actuary’s report is available to CMS upon request through the Division of Aging, Adult, and Behavioral Health Services (DAABHS).

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

The rate methodology excludes reimbursement of room and board costs.

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

Uniform, Statewide Rate Methodology: The rate methodology is uniform and applies statewide to all Level II licensed assisted living facilities serving waiver participants.
Opportunities for Public Comment: Before submitting this amended waiver to CMS for federal review and approval, DHS engaged in various opportunities for public comment and consultations with assisted living facility providers and other interested stakeholders. This includes webinars and regional public meetings. These are in addition to the public comment process for this amended waiver and the revised provider manual. Further, both the amended waiver and the revised provider manual undergo prior review by Arkansas legislative committees.

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

Implementation of New Assisted Living Facility Rates:
Effective after January 1, 2019, assisted living facilities are reimbursed on a fee-for-service basis according to a new single statewide per diem rate, determined by DAABHS according to the rate determination methods (actuarial analysis and negotiations) described in this Appendix.

On the effective date of this amended waiver, the four-tier payment model provided for under the current waiver is discontinued. Thereafter, assisted living facilities will be reimbursed according to the new single, statewide per diem rate method. For purposes of assisted living facility payments, waiver participants will no longer be assigned a rate tier level. The discontinued four-tier payment model was initially developed in 2002 prior to the use of comprehensive assessment instruments, is inconsistent with the new assessment system, is administratively cumbersome and unnecessary, and may foster unintentional incentives misaligned with the objectives of appropriate access and service use, facility efficiency, active and independent living, and optimal medication therapy management.

DAABHS will review the rate methodology on a triennial basis, with the next review in CY 2021. During the last two years of the current 5-year waiver term (CY 2019-2020), as data from the new Arkansas Independent Assessment (ARIA) system and use of the Task and Hour Standards for personal care-type services are accumulated and assessed, DAABHS will consider whether an acuity-adjusted methodology is appropriate. If a methodology change is determined appropriate, it will be addressed in a subsequent waiver amendment or the waiver renewal application.

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

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

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DPSQA staff verifies services were provided.
according to the person-centered service plan through an internal monthly monitoring system. Adjustments are made or cases referred to the Office of Medicaid Inspector General when claims are paid incorrectly.

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

<table>
<thead>
<tr>
<th>Level(s) of Care: Nursing Facility</th>
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<tbody>
<tr>
<td>Col. 1</td>
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</tr>
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<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
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</table>

J-2: Derivation of Estimates (1 of 9)

1. 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>
<thead>
<tr>
<th>Table: J-2-a: Unduplicated Participants</th>
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<tbody>
<tr>
<td>Waiver Year</td>
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<tr>
<td>Level of Care: Nursing Facility</td>
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<tr>
<td>Year 2</td>
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<tr>
<td>Year 4</td>
</tr>
<tr>
<td>Year 5</td>
</tr>
</tbody>
</table>

J-2: Derivation of Estimates (4 of 9)

Component management for a waiver service. Enter the component name in the text box provided and click “Add.” Multiple components can be added to each service. To return to the previous screen select “Return to List of Services.”
Living Choices Assisted Living Services

Component Name

| Tier Level 2 | delete |
| Tier Level 3 | delete |
| Tier Level 4 | delete |
| Tier Level 1 | delete |
| Composite Tier | Add |

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 1

<table>
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<tr>
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<th>Unit</th>
<th># Users</th>
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<th>Avg. Cost/Unit</th>
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**GRAND TOTAL:** 26145883.35

**Total Estimated Unduplicated Participants:** 1300

**Factor D (Divide total by number of participants):** 20112.22

**Average Length of Stay on the Waiver:** 255

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs.
fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

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<thead>
<tr>
<th>Waiver Service/ Component</th>
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<th>Avg. Cost/Unit</th>
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<tr>
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<td>255.00</td>
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**GRAND TOTAL:** 87698432.4

Total Estimated Unduplicated Participants: 11350

Factor D (Divide total by number of participants): 7726.73

Average Length of Stay on the Waiver: 255

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

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**GRAND TOTAL:** 26166283.35

Total Estimated Unduplicated Participants: 1300
**Factor D (Divide total by number of participants):** 20127.91

**Average Length of Stay on the Waiver:** 255

### J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

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**GRAND TOTAL:** 33386644.95

**Total Estimated Unduplicated Participants:** 1725

**Factor D (Divide total by number of participants):** 19354.58

**Average Length of Stay on the Waiver:** 255

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

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

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**GRAND TOTAL:** 26672333.15

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Request for Amendment: 60