

**DEPARTMENT OF HUMAN SERVICES, DIVISION OF AGING, ADULT, AND
BEHAVIORAL HEALTH SERVICES**

SUBJECT: Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals (20 CAR pts. 607, 634)

DESCRIPTION:

Statement of Necessity

This rule streamlines the Personal Care (PC) Medicaid Provider Manual and Arkansas Independent Assessment (ARIA) Medicaid Provider Manual. The resulting changes make the manuals easier to understand and use and result in significant cost savings.

The PC manual currently contains information that is beyond the scope of State Plan Personal Care (SPPC). This rule repeals the current PC manual and issues a new, simplified, and streamlined manual to include only information regarding SPPC, as opposed to services contained in waivers to the state plan. These changes dispel confusion among overlapping programs, waivers, and policies, as well as better describe the parameters of SPPC. All removed information has been cross-referenced and linked to other program manuals to ensure availability of services. The rule also separates services for adults from services for those under twenty-one. And the repeal implements Act 853 of 2025 which moved private care agency certification to the Department of Health.

Currently, the functional eligibility process does not include the beneficiary's Primary Care Provider (PCP) in the referral or decision-making regarding functional needs. Instead, a personal care provider makes a referral, then a contractor conducts an assessment, and then another contractor authorizes any resultant needed services. This rule aims to reintegrate the PCP as a core member in the evaluation process. Further, the rule changes the prior authorization (PA) time period from six (6) months to one (1) year. These two revisions will result in lower assessment costs and PA costs.

The ARIA manual currently contains information on how to administer an independent assessment using the standardized ARIA tool which is used to determine functional eligibility for Home and Community Based Services (HCBS). While an independent assessment is mandatory to determine the functional need for state plan HCBS benefit, a standardized assessment tool (like ARIA) is not required (see 42 CFR Section 441.720). Accordingly, this rule removes the personal care section from the ARIA manual for consistency with the changes summarized above and confirms that use of the ARIA tool is not required. Instead, other approved independent assessment tools may be utilized to determine functional eligibility.

The other change being made to the ARIA Manual is the addition of explicit sections that describe how to administer an independent assessment using the standardized ARIA tool for Arkansas' aging waivers (ARChoices, Living Choices Assisted Living, and Program

of All-Inclusive Care for the Elderly (PACE)). This is a needed update of the ARIA Manual to include information on how the ARIA is utilized for those aging waivers. These processes are already in practice but were not previously included in this manual.

Summary of Changes

Personal Care Manual:

- Repeals the currently promulgated Personal Care Medicaid Manual and creates a new version;
- Streamlines the manual to focus on stand-alone SPPC;
- Mandates that Primary Care Providers initiate and finalize the approval of medical eligibility for SPPC;
- Transitions away from the ARIA tool as the medical and functional assessment test for SPPC and replace it with the functional assessment and treatment plan for SPPC;
- Removes the contractor Optum as the party that performs SPPC independent assessments and reassigns that duty to personal care registered nurses;
- Lengthens time for PAs and Extensions of Benefits (EoB) from six (6) months to twelve (12) months;
- Establishes that PAs will remain in place for all populations receiving SPPC Services;
- Clarifies that the sixty-four (64) hours per month service cap will remain, but that youths may receive over sixty-four (>64) hours per month with EOB;
- Updates processes to implement the following:
 1. The Primary Care Provider (PCP) must complete form 618-ER to request an evaluation to initiate an assessment of functional need;
 2. A registered nurse with the personal care provider will conduct an in-person assessment of the beneficiary's functional needs utilizing a DHS-approved tool;
 3. The Primary Care Provider (PCP) shall complete Form 618-TP to approve the assessment and it will act as a prescription for treatment for the year; and
 4. Requires all forms be submitted for prior authorization.

ARIA Manual:

- Removes reference to SPPC in § 201.000;
- Adds new sections regarding assessments and Tier Logic Tables for the ARChoices (§ 230.000 et seq.), Living Choices Assisted Living (§ 240.000 et seq.), and PACE (§ 250.000 et seq.).

Note: The new sections explain the independent assessment processes that already are in practice and do not constitute new processes.

Post Public Comment Revisions:

The following lists updates to the rule in response to public comments received. During the process, DHS also corrected typographic errors identified internally or by the Bureau of Legislative Research staff.

1. 200.100 Section C.2:
 - Reworded to name the other provider types that can be included: “Obtain a license as a private care agency, and/or be a certified Home Health Agency Class A or B; Assisted Living Facility (ALF) I; or Residential Care Facility (RCF)”;
2. 215.400 Section B.1:
 - Reworded to 20 years of age “and under”;
3. 215.400 Section E.1:
 - Added clarifying phrase “before the expiration of the current Functional Assessment & Treatment Plan”;
4. 220.200 Section A:
 - Struck incorrect numbering not present in this manual; replaced with “220.300”;
5. 220.200 Section B.2:
 - Struck incorrect numbering not present in this manual; replaced with “section 140.000 of this Medicaid manual”;
6. 220.300 Section A:
 - Changed “and” to “or” in sentence defining personal care services (This is as per CMS guidance in “Preventing Medicaid Improper Payments for Personal Care services” <https://www.cms.gov/medicare-medicaid-coordination/fraudprevention/medicaid-integrity-education/downloads/pcs-prevent-improperpaymentbooklet.pdf> (p. 4 Description); and
 - Included reference to CMS statute 42 C.F.R. § 441.505 that defines activities of daily living or instrumental activities of daily living;
7. 220.300 Section B.12:
 - Struck incorrect numbering not present in this manual; replaced with “220.400”;
8. 220.300 Section D:
 - Struck incorrect numbering not present in this manual; replaced with “205.200”;
9. 220.300 Section E:
 - In response to request from public comments, re-inserted definition (in currently promulgated manual) to clarify and define ‘qualified supervisor’. “A qualified supervisor must be a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.”;

10. 220.400 Section B:
 - Closed brackets at end of subdivision;
11. 220.400 Section E:
 - In response to request from public comments, re-inserted transportation rules (in currently promulgated manual) and this original section was referenced by #7 in the list above, and thus needed to be re-added for clarification purposes;
 - Corrected use of colons, semicolons and periods for stylistic consistency; and
 - Spelled out twenty-one and added parentheses around digits;
12. 220.700 Section A:
 - Added “RCFs or ALF I’s” to the sentence – “This section does not apply to school-based personal care providers, RCFs or ALF I’s.”;
13. 220.700 Section B:
 - Struck incorrect numbering not present in this manual;
14. 220.700 Section C.3:
 - Amended phrasing to read “until the last day of the second month”;
 - Amended example to read “until June 30th so new provider can begin services July 1st”;
15. 220.700 Section D:
 - Added “and” between the two listed items;
16. 230.300 Section B:
 - Struck repeated sentences in middle of paragraph as they are already present at end of paragraph; and
 - Added numerical (30) before “calendar days”;
17. 250.000 Reimbursement Section: In response to requests from public comments emphasizing need for clarification regarding billing and rounding, DHS restores currently promulgated rules which necessitated reorganization and renumbering of 250.000 throughout as follows:
 - 250.100: Deleted “A” and “B” as those processes are now covered and expanded in restoration of currently promulgated rules now found in sections 250.200, 250.300, and 250.440;
 - 250.100: Maintained currently proposed language formerly in “C” parts 3-7 and renumbered 250.100 accordingly;
 - Added 250.200 Unit Billing, 250.300 Calculating Units, and 250.400 Rounding into proposed rule (these sections were copied from the current rule manual being repealed found in sections 262.310, -311, and -312); and
 - Renumbered Fee Schedules and Electronic Visit Verification sections as 250.500 and 250.600 respectively.

PUBLIC COMMENT: A public hearing was held on this rule on November 19, 2025. The public comment period expired on December 7, 2025. The agency provided a public comment summary which, due to its length, is attached separately.

The proposed effective date is April 1, 2026.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, this rule will result in a reduction in cost. The total reduction in cost is \$1,543,260 for the current fiscal year (\$771,630 in general revenue and \$771,630 in federal funds) and \$6,173,037 for the next fiscal year (\$3,086,519 in general revenue and \$3,086,519 in federal funds). The total estimated reduction in cost for a state, county, or municipal government is \$771,630 for the current fiscal year and \$3,086,519 for the next fiscal year.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Act 853 of 2025. The Act, sponsored by Representative Jack Ladyman, removed the certification process of the Department of Human Services from licensure as a private care agency.

DHS Responses to Public Comments Regarding Rule 289 – Personal Care And Arkansas Independent Provider Manuals

Cathy Robertson – Owner

1SourceSeniorCare

**RECEIVED
BLR
16 DEC 2025**

Comment: Following are my comments regarding the proposed Personal Care Provider Manual.

1. Section 210.200 A 2 b – states that the client’s Medicaid ID and date of birth be on the service log for caregivers. I think that is going to allow for a lot of fraud and identity theft. Anyone that has access to a caregiver’s phone would have access to a client’s name, address, phone, date of birth and Medicaid number. I have no issues with that information being on the log that is produced at the provider agency’s office but putting that information on the in-home caregiver’s phone app/service log is opening up a world of possibilities for illegal activities.
2. Section 220.300 E – refers to a “qualified supervisor” but there is no clarification on what a qualified supervisor is or what their qualifications must be. That needs to be specified.
3. Section 220.700 B 2 a – states the newly selected personal care provider must notify the current provider of the beneficiary’s decision to switch personal care providers. Will DHS be providing contact information for all of the agencies? We do not have a central database showing the contact person or email address for every other agency. If we are required to keep proof that notification has been given, we need a way to get to the correct person in each agency. Not all agencies are willing to give out that information to other agencies – just like some agencies refuse to do a verification of employment for an employee.
4. Section 220.700 B 3 – says that services are to be performed by the current provider until the 1st day of the month. The example also says that the 1st day of the month is to be included in the service. Does that mean that all authorizations and requests should not be dated from the 2nd day of the month through the 1st day of the month or should the manual read that the services are rendered until the last day of the calendar month and the new provider starts services on the 1st day of a calendar month. That needs to be clarified because if our authorizations are from the 1st through the end of the month but the manual says the old provider is to provide services on the 1st, they will not be able to bill for the services because the manual dates do not match the authorization dates. That needs to be clarified.
5. Section 220.700 B 3 a – says the current provider must forward the service record but does not specify how. If that record is put in the mail 3 days prior to the start of services, the new agency will not receive that information in time to have it in their files by the 1st day of service delivery.
6. Section 230.300 – states that reviews will be completed by DHS within 15 working days. The current wait period is 60 days. Who do we contact to enforce that 15 day turnaround time?

Comment: Following are my comments for the Proposed Personal Care Provider Manual.

Section 215.300 B – can we see that form and is it open for public comment?

Section 215.500 C – can we see that form and is it open for public comment?

Section 230.200 A – can we see that form and is it open for public comment?

Section 215.400 B 1 and 2 - #1 says “under 20” and #2 says “21 and over”. The wording for these 2 paragraphs does not include the age 20. Can you clarify which form to complete?

Section 220.200 A – refers to sections 222.100-224.000 and those sections do not exist in the new manual. We need clarification on that.

Section 220.200 B 2 – refers to section 202.00 and that section does not exist in the new manual. We need clarification on that.

Section 220.300 B 12 – refers to section 223.000 and that section does not exist in the new manual. We need clarification on that.

Section 220.300 D – refers to section 202.100 and that section does not exist in the new manual. We need clarification on that.

Section 220.700 A – refers to section 226.000 and that section does not exist in the new manual. We need clarification on that.

Comment: I am writing to express strong opposition to the change in the rounding rule found in Section 250.100 C. I formally oppose the proposed change for Personal Care billing and urge we keep the current method of rounding.

1. This is not the current practice. Currently rounding is used – see existing manual 262.312. Removing the rule will be a long-term issue involving clarity and consistency for agencies.
2. CMS and nationally accepted coding standards recognize and rely on rounding rules for time-based billing for personal care – the “8 minute rule”.
3. State and Federal labor regulations require payment to employees for any actual time worked. Removing the rounding rule will cause an administrative and financial burden on home care providers which are already operating at a smaller margin for direct care than many states. As an example: If our caregiver works 14 minutes into a unit, by law, if our caregivers are employees and not contractors, we have to pay them for that time. Under the new rule, we would not be able to bill for that time. This will put an additional financial burden on the agency.
4. Removing the rounding gives an unfair advantage to agencies that use independent contractors because they have the ability to form a contract with the caregiver stating that they will only pay for services rendered that are actually billed and paid. Agencies using employees do not have that advantage. Agencies in compliance with Federal mandates using employees as home care aides, must pay for every minute worked, regardless of what is billed and/or paid by Medicaid.

5. The Federal Department of Labor does not recognize the job our caregivers do as being that of an independent contractor because of the amount of control agencies have over their workflow. Arkansas does recognize them as independent contractors. Each agency would then be forced to choose between a huge financial and administrative impact that may not be sustainable with the reimbursement rate and moving to an independent contractor model which is at odds with the Federal rule on using independent contractors as home care workers.
 - a. If this rule goes into effect, I anticipate agencies switching to independent contractors because of the huge financial loss they will face to stay in compliance with payment rules for employees. That means all agencies will have to choose to be out of compliance with the Federal government in order to avoid the loss of revenue if they maintain their caregivers as employees. That is also going to be a financial impact with regard to State and Federal taxes – no State or Federal taxes will be withheld from employee paychecks, and no FICA will be paid by employers if all agencies in Arkansas convert to independent contractors.
 - b. The quality of care for Medicaid clients would decrease significantly as independent contractors are not bound by the same standard of high level of care for Medicaid clients as employee caregivers are.
6. The current State mandated EVV system Authenticare calculates units based on the current rounding rule. Authenticare will need to update their system, and it will need to be tested prior to implementation.

While this rule makes sense in an environment like a facility, it does not make sense in a homecare environment where caregivers are paid from the time they get to the home, until the time they leave, and there is not a one-to-one ratio of the agency being able to bill for the time paid. There is no documented reason to remove a rule that has been in place and is working well. Policy and procedure changes should be made to correct problems that have been identified. Changing this rule would create a problem where none currently exists.

I hope that the current rule that is working will remain in place and the new rule will not be implemented when the manual is rewritten.

Response: Thank you for your feedback. We will take your comments under advisement.

While DHS-required forms are not part of the promulgation process and therefore not subject to public comment, DHS has sent drafted forms to the requestor for their review and understanding.

Regarding your comments on Section 210.200, this is a requirement of Medicaid State Plan services. All personal data and identifiers are required to be secured. The Personal Care providers are expected to protect and secure PHI per HIPAA requirements

Regarding your comments on Section 220.700, the new provider transfer process has been established to ensure a smooth transfer of continuous services between providers and to act in the best interest of the recipient. Each agency has the flexibility to determine the method of transferring the client's file securely and within the policy timelines.

For provider contact information, please refer to the most up to date list of publicly available agency-provided contact information via DHS' Freedom of Choice List of Providers website, here:

<https://humanservices.arkansas.gov/divisions-shared-services/provider-services-quality-assurance/information-about-our-licensed-providers/freedom-of-choices>

Regarding your comments on Section 230.300, DMS monitors compliance with contract regulations.

DHS is integrating back into the manual original language on rounding and unit calculation.

Jennifer Mieirs

Comment: I am reviewing the updated manual and had a few questions and concerns.

Regarding the functional assessment, will it require a subjective assessment component (similar to the FASI from CMS)? A subjective approach may better reflect client needs compared to an exclusively objective assessment (the current ARIA). It appears that the new manual intends to rely solely on the PCS provider RN and PCP agreement with the treatment plan, but what prevents documentation that may not be accurate because a client wants personal care?

Personal care appears to be poorly understood by many PCP's as to the scope of what is or is not medically necessary, or even what PCS is under CMS guidance and rules that were reflected in the previous manual, but are missing in this draft. If a PCP orders PCS only when IADLS are needed, or to comply with their appointments, I don't see anything that would prevent the PCS provider from completing an assessment saying someone needs assistance with an ADL to get approval, nor is this in the manual as a requirement, even though it is evident in the elder choices portion of the ARIA manual that is part of the qualifications.

While we have the medicaid fraud control unit, how would we have controls in place if the sole determination rests on documentation from the PCS provider being reimbursed for the service and a signed treatment plan? Most of the current convictions related to personal care are only at the aide level and billing for care not given and not directed towards actions taken by the RN or company that may have inflated the hours and needs. Arkansas spends many millions of taxpayer money on personal care annually, and while many need and deserve the service, the state needs to make sure it's appropriately being used. There seems to be more controls with the waiver programs, but not much for personal care alone.

Page 9 (section 220.200) references sections 222.1–224.000 as covered services, which do not appear in the current draft of the manual, with these sections repealed from the old manual. Will this be updated?

Also the new forms are not yet available. Will they provide further guidance on assessment and changes in what providers will provide or will the same 618 be used with minor changes? While I applaud the attempt of making things simpler, this manual is significantly condensed in material and clarity.

Previous guidance referenced the THS as evidence-based on approving units, but the current manual does not clarify how units will be approved. Will this information be forthcoming? If not, how is the state determining personal care hours?

In relation to the ARIA changes, I have no concerns with the changes, but rather with the lack of objective assessment within the process. Evidence-based assessment should be both objective and subjective, and the current process lends itself to risks of exaggerated responses in order to receive what maybe perceived as more services, and just as strongly lends itself to underreported symptoms that may inaccurately reflect needs.

Tiering really should be based on records or objective clinical assessment and what the client or their guardian report. While a referral maybe required to get the ARIA, it alone should not be the sole clinical component. Even though the assessment is done by a clinician, no clinical judgment is used in the process.

Response: Thank you for your feedback. We will take your comments under advisement.

DHS has sent drafted forms to the requestor for their review and understanding of how personal care units and hours are determined.

Jennifer Jorgensen Vannoy, RN, BSHM

Medicaid In The Schools RN

Comment: Thank you for sending the proposed PCS Manual for review prior to making final changes. I'd like to ask some clarifying questions on behalf of my school district.

1. In the Notice of Rulemaking, the proposed effective date is listed as April 1, 2026. This proposed timeline may be problematic for schools to switch processes and forms, as well as training.

* Will current PAs carry through until the expiration before the new process would take effect for those students?

* Would it be a possible consideration to wait until August for the next school year for School Districts that enroll students in MITS?

2. Will the DMS-618 ER be required for students already receiving personal care?

3. Currently, personal care in the schools is done the same for all students, regardless of the Medicaid plan that they are enrolled in. We know private insurance does not pay for personal care provided in the school. We bill the same for all plans.

* Is it necessary to separate out the individual plans and have more than one process for the students at school? I foresee parents complaining that they still have to complete Optum assessments when the neighbors do not.

* Can it be considered to have all school aged students receiving personal care in the school setting go to the new State Plan requirements? (Section II-5215.300.B & C)

* Will a parent/guardian signature still be required on the functional needs assessment? (Provided we have a Medicaid consent form already signed by the parent.)

4. Our District utilizes EdPlan for our documentation and billing services. Currently, the billing is submitted on a monthly basis. It is separated by service type, however ambulation/transfers are lumped together, as are cleaning/laundry/and shopping. Do these need to be further separated out for logging purposes?

* Service types such as personal hygiene at school may not be a daily need, and will not likely use a full unit of service in one day.

* We have recently been instructed to request units of service based on a full month when submitting for a PA. Is it necessary to submit each service type separately on each day for schools?

* Can schools be allowed to submit time rolled up on a monthly basis as some service types are provided daily and some are prn? The Changes needed for programming development for the vendor will take time.

5. Section II-3; 210.200 A.2.c.ii. *It is not necessary to itemize the time spent on each ADL..., provided these tasks were performed by the same personal care aide on the same visit on the same day and at the same location.*

* How does this apply to school-based care? For our logging purposes, we currently log each service type separately with a start and stop time. How does this work if we have to separate each service type, or is this not necessary?

6. Section II-3; 210.200A.2.c.iv. *If a personal care aide does not perform a scheduled treatment plan task, the personal care aide must document and justify why the task was not performed as scheduled.*

* For school-based services that are not needed everyday such as personal hygiene, laundry, and dressing for instance, is this a daily requirement?

* Gastric tube feeding has been excluded for reimbursement. As a student is obviously not able to do this for themselves and the service is delegatable in the schools per the Nurse Practice Act, can this be reconsidered? Eating is a large part of a student's medically required ADL's.

* Per Section II.220.300.D. *All personal care services must be performed by a certified personal care aide.* Just to clarify - this means for it to be billable, correct?

7. Section II.220.300.E. Supervision:

* We currently have a two-fold supervision set up in our large District. The paras are initially trained by the District Medicaid Nurse to reach their MITS certification qualifications. For individual care skills training, they are trained at their school buildings by the nurse at that school responsible for the care of those particular students.

* To clarify, the "supervisor" referred to in E1.a-d is the school nurse responsible for each particular school - correct? I'm specifically asking - referencing the documentation log reviews.

* Our second line of supervision is the District Medicaid RN making yearly (or more) on-site visits and documenting a Supervisory visit separate from the monthly visits done by the school nurse.

8. Can you please clarify who will submit the Personal Care Functional Assessment and Treatment Plan from the physician? Will this be the school requesting services, or the physician's office once they receive the Personal Care Functional Assessment from the school's RN?

9. Clarification please: We were recently instructed by Acentra that Reconsiderations will no longer be accepted only if submitted within 30 days, but we will now have 65 days. The manual states in Section II,230.300.B. - 30 calendar days.

10. Clarification please: Section II-250.100C.6. We have been previously instructed that documentation of a service can be included in the service time. I want to make clear that what this statement means is that we should not document a separate entry for documentation time as a separate service. Correct?

Thank you for your time and consideration,

Response: Thank you for your feedback. We will take your comments under advisement.

Trainings will be provided to all providers prior to the April 1, 2026 effective date to cover specific topics and questions related to implementation. The following responses address comments submitted about the manual:

1. The DMS 618-ER Form is only required for students seeking school-based personal care services for the first time.
2. The documentation requirements listed in the manual apply to all providers. This manual does not address individual practices or internal processes used in school-based billing or service documentation.
3. If services are not delivered on the intended day and/or frequency according to the student's Treatment Plan, the service log should reflect why the services were not delivered.
4. Skilled care is not part of personal care services, per state and CMS guidelines. Skilled care cannot be billed as personal care.
5. The RN at the school is responsible for performing documentation log reviews.
6. The manual discusses the reconsideration process, which is a request for more or revised supporting documentation within 30 days in order to gain prior authorization for an Assessment & Treatment Plan.
7. Time spent on documentation is not a reimbursable service in Personal Care. It should not be entered as a separate service entry.

Katie Raines Chief Executive Officer

Comment: Please see information below from Kathy Weatherl regarding the changes to the Independent assessment regulations. Can you confirm how IDD assessments are going to occur? Are they now in the same category as BH? If so then this change is more prescriptive and certainly will not save the money that was listed in these proposed regs. I look forward to hearing from you.

KATHY'S REVIEW

1. Under section 210.100 it states reassessments will occur annually unless a change in circumstances requires a new assessment. - Aren't we currently on a 3-year reassessment schedule? Makes no sense to go back to yearly assessment for IDD and I didn't see an exception listed for IDD. Behavioral Health and/or aging more frequent assessment might make sense but for true IDD with no other issues, yearly is too much. Conditions are static, rarely improve or change.
2. They updated from the last manual dated 1/1/24 - but there is stuff in that manual that is not in this manual, and this notice of rulemaking doesn't show those changes for the ARIA.

Old manual had a section 220.00 that was labeled Developmental/Intellectual disability services, but this proposed one doesn't have that at all. (Below pic is what I am talking about in the old manual). In this proposed one, I do not even see where it talks about how a referral is made for IDD, only for Behavioral and Aging, unless I am overlooking it somewhere. We serve folks with IDD who have no behavioral health needs.

In proposed manual there is mention under 220.300 Tiering Logic B that simply states DDS tier logic is organized by categories of needs as follows:

Safety: Your ability to remain safe and out of harm's way

b. Behavior: Behaviors that could place you or others in harm's way

c. Self-Care: Your ability to take care of yourself, such as bathing yourself, getting dressed, preparing your meals, shopping, or going to the bathroom

And then the chart starts for Tier 2 and 3

220.100 Independent Assessment Referral Process

1-1-24

A. Independent assessment referrals are initiated by the DHS Division of Developmental Disabilities (DDS) when a beneficiary has been determined, at one time, to meet the institutional level of care. DDS will send the referral for a Developmental Disabilities (DD) assessment to the current ARIA vendor. DDS will make referrals for the following populations:

- 1. Beneficiaries receiving services under the Community and Employment Supports (CES) 1915(c) Home and Community-Based Services Waiver.*
- 2. Beneficiaries on the CES Waiver waitlist.*
- 3. Beneficiaries applying for or currently living in a private Intermediate Care Facility (ICF) for individuals with intellectual or developmental disabilities.*
- 4. Beneficiaries who are applying for placement at a state-run Human Development Center (HDC).*

To continue to receive services within these populations, all individuals referred must undergo an independent assessment annually. A reassessment will be completed by staff employed by the independent assessment contractor utilizing the current approved assessment instrument (ARIA), which was approved prior to April 1, 2021, to assess functional need. An interview will be conducted in person for initial assessments, with the option of using telemedicine to complete reassessments for members with

intellectual or developmental disabilities. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

B. All populations, except for those served at an HDC, will be reassessed every three (3) years.

- 1. An individual can be reassessed at any time if there is a change of circumstances that requires a new assessment.*
- 2. Individuals in an HDC only will be assessed or reassessed if they are seeking transition into the community.*

Response: Thank you for your feedback. We will take your comments under advisement.

These updates to the ARIA manual do not have any impact on DD Independent Assessments at this time. Only sections of the ARIA manual that were updated were included in the public comment posting, not the entire manual. No deletions or changes were made to the sections the commenter references.

Discussion of cost-savings in the Rule is related to changes to the Personal Care manual, not the ARIA manual.

Jonathan Fry, Owner

J & S Fry Enterprises, Inc., Home Instead, Not Home Alone, Inc.

Comment: I am writing to voice significant concern regarding the proposal to eliminate the long-standing rounding rule from the Medicaid Provider Manual for Personal Care services. After reviewing the practical, financial, and compliance implications, it is clear that removing this rule does not resolve an existing issue—rather, it creates multiple new challenges for DHS, providers, and Medicaid recipients.

1. The Current Rounding Rule Provides Needed Consistency — Eliminating It Reduces Accuracy

The rounding approach currently in place has been relied upon for many years because it promotes clarity, uniformity, and predictability when billing time-based services. The proposed removal offers no replacement guidance, which would mean:

- Each provider must independently determine how to convert minutes to units.
- Billing teams will inevitably apply different standards.
- DHS will see more disputed claims, audit discrepancies, and processing slowdowns.

Instead of one clear expectation, DHS would be left with countless individual interpretations—inviting confusion rather than improving efficiency.

2. The Proposal Conflicts With Established CMS Expectations

CMS has long supported the use of standardized rounding practices for time-based billing across multiple service categories. The most widely recognized example—the 8-minute rule—serves as a national benchmark across Medicare, Medicaid, and private insurance.

Removing the rounding rule would place Arkansas Medicaid outside of alignment with:

- CMS billing conventions
- National coding and documentation requirements
- Federal compliance and actuarial assumptions

In effect, DHS would be asking providers to bill in a manner that contradicts the very standards their claims could later be measured against. This creates operational and regulatory conflict.

3. The Change Adds Administrative Burden Rather Than Reducing It

If the rounding rule is removed, providers will be required to:

- Redesign billing and software systems
- Retrain staff statewide
- Manually verify thousands of daily clock-in and clock-out entries
- Respond to an inevitable rise in denied or questioned claims

This is not a minor revision. It is a substantial administrative overhaul that increases costs for providers and generates new complexities for DHS—without producing a clear benefit.

At a time when direct care providers are already stretched thin, removing a rule that streamlines workflow actively undermines the goals of rate-review reform.

4. The Change Increases the Risk of Accidental Non-Compliance

Without a clear rounding policy, even a one-minute variance below a unit threshold could lead to:

- consistent underbilling
- varying interpretations across agencies
- unintentional overbilling
- increased audit exposure
- inconsistent claim decisions on the DHS side

Eliminating the rule essentially forces providers to guess how DHS wants time converted—an unsafe and unnecessary position for any regulated entity.

5. There Is No Identified Problem That This Change Solves

The proposal does not present evidence of:

- compliance concerns linked to the rounding rule

- fraud, waste, or abuse facilitated by its use
- cost savings for DHS
- measurable improvements for beneficiaries

Policy changes should address documented issues. In this case, the change introduces risk and ambiguity into a process that currently works as intended.

6. The Result Is Fewer Resources Directed Toward Patient Care

Every new administrative requirement pulls time, staffing, and financial resources away from serving Medicaid members. Eliminating the rounding rule is not a harmless adjustment—it adds operational strain at a moment when the long-term-care industry is already facing workforce shortages and cost pressures.

Conclusion

The rounding rule is not the source of a problem. Removing it would destabilize a functioning billing framework, conflict with federal norms, and add significant administrative burden for both DHS and providers.

For program stability, regulatory alignment, and continued quality of care, I respectfully urge DHS to retain the current rounding rule.

Thank you for considering these concerns. I strongly encourage DHS to withdraw the proposed change and maintain the existing, clear rounding standards that providers have relied on for years.

Response: Thank you for your feedback. We will take your comments under advisement. DHS is integrating back into the manual original language on rounding and unit calculation.

Noel Morris, Franchise Owner, Three Rivers Senior Services, Inc.

Home Instead, Inc.

Comment: I am submitting this comment in strong opposition to the proposed elimination of the longstanding rounding methodology for billing Personal Care services in the Medicaid Provider Manual.

After carefully reviewing the proposal, I am convinced that removing this rule does not resolve any existing issue; instead, it will create significant new operational, financial, and compliance problems for DHS, providers, and the Medicaid beneficiaries we all serve.

1. The Current Rounding Rule Provides Clarity and Consistency – Eliminating It Will Create Chaos

For years, the established rounding standard has given providers and DHS a predictable, uniform way to convert service minutes into billable units. The proposal offers no replacement guidance. The predictable result will be:

- Hundreds of providers developing their own ad-hoc conversion methods
- Widespread inconsistency in claims submission
- A sharp increase in claim denials, payment delays, disputes, and audits

Replacing one clear, statewide standard with thousands of individual interpretations is the opposite of simplification.

2. The Change Puts Arkansas Out of Step with Federal CMS Expectations

The Centers for Medicare & Medicaid Services (CMS) expressly permits and relies on rounding methodologies (most notably the widely adopted 8-minute rule) for time-based services in Medicare, Medicaid, and private insurance nationwide.

By deleting its rounding rule without a replacement, Arkansas would be forcing providers to bill in a manner that conflicts with the very federal standards CMS auditors use. This creates unnecessary legal and compliance risk for both providers and the state.

3. Far from Reducing Burden, This Change Dramatically Increases It

Providers across Arkansas will be required to:

- Overhaul billing software and internal processes
- Conduct statewide retraining of billing and scheduling staff
- Manually review tens of thousands of daily clock-in/clock-out records
- Defend a surge in claim rejections and payment disputes

These are not minor adjustments—they represent a costly, system-wide disruption at a time when the home- and community-based services workforce is already stretched thin.

4. Removing the Rule Invites Inadvertent Errors and Audit Exposure

When a caregiver's shift ends just one or two minutes short of the next unit threshold, the absence of a rounding rule will lead to inconsistent decisions—some providers will round down (underbilling), others may inadvertently round up (risking overbilling allegations). Without explicit guidance, honest mistakes become almost inevitable, exposing everyone to greater audit liability.

5. No Problem Has Been Identified That Justifies This Change

The notice provides no evidence that the current rounding rule has caused compliance violations, enabled fraud, generated overpayments, or harmed beneficiaries. In the absence of a documented problem, introducing widespread uncertainty and new costs is unjustified.

6. Resources Will Be Diverted from Care to Paperwork

Every hour spent rewriting policies, retraining staff, and fighting claim denials is an hour not spent delivering care to Arkansas's most vulnerable citizens. At a time of severe direct-care workforce shortages and tight margins, this proposal moves resources in exactly the wrong direction.

Conclusion

The existing rounding rule is a proven, efficient, and federally aligned standard that supports accurate billing and program integrity. Eliminating it without a replacement will inject confusion, increase costs, heighten compliance risk, and ultimately harm the beneficiaries the Medicaid program exists to serve.

I respectfully urge the Arkansas DHS to withdraw this proposed change and retain the clear, consistent rounding methodology that has served the state well for many years.

Thank you for considering my comments during this public comment period.

Response: Thank you for your feedback. We will take your comments under advisement. DHS is integrating back into the manual original language on rounding and unit calculation.

Matt McClure, Ed.D.

Arkansas Home and Community Based Services- Board Chairman

Comment: I am writing to express strong opposition to the proposed removal of the long-standing rounding rule from the Medicaid Provider Manual for Personal Care services. After reviewing the operational, financial, and regulatory consequences, it is clear that this change does **not** solve a problem—but instead creates several new ones for DHS, providers, and beneficiaries alike.

1. The Current Rounding Rule Works — Removing It Damages Accuracy

The existing rounding methodology has been used for years because it ensures clarity, consistency, and predictability in billing time-based services. The proposed removal provides no alternative standard, which means:

- Each provider will be forced to interpret how to convert minutes into units.
- Billing staff will inevitably apply different methods, creating inconsistent claims.
- DHS will face increased claim disputes, audits, and administrative delays.

This change replaces one clear rule with *thousands of individual interpretations*—a recipe for confusion, not efficiency.

2. The Proposal Conflicts with Federal CMS Standards

CMS explicitly recognizes rounding methodologies for time-based billing across many benefit categories. The most well-known example—the 8-minute rule—is foundational for Medicare, Medicaid, and commercial payers nationwide.

Removing the rounding rule would put Arkansas Medicaid out of alignment with:

- CMS billing practices
- National coding and documentation standards
- Actuarial expectations used for federal compliance

In essence, DHS would be asking providers to bill in a way that directly contradicts the standards against which their claims may later be audited. That makes no operational or legal sense.

3. The Change Increases Administrative Burden, Not Reduces It

The proposed change will force providers to:

- Rebuild internal billing systems
- Retrain staff statewide
- Review thousands of daily clock-in/clock-out entries manually
- Address increases in denied or questioned claims

This is not a small adjustment. It is a massive administrative undertaking, introducing new costs for providers and new oversight headaches for DHS—without any identified benefit.

At a time when direct care providers are already overburdened, removing a rule that *improves efficiency* runs counter to the goals of the system and the intent of the rate review reforms.

4. It Opens the Door to Unintentional Non-Compliance

Without a rounding rule, something as simple as a clock stopping one minute short of a billing unit could lead to:

- systematic underbilling
- inconsistent interpretations
- accidental overbilling
- audit risk for providers
- adjudication inconsistencies for DHS

A lack of guidance forces providers to “guess” DHS’s intent—something no stakeholder wants.

5. There Is No Documented Reason to Remove the Rule

The proposal does not identify:

- a compliance issue the rule creates
- any fraud, waste, or abuse the rule enables
- a measurable financial benefit to DHS
- any operational improvement for beneficiaries

Policy changes should fix identifiable problems; this one simply introduces risk and confusion in an area that was functioning as designed.

6. It Ultimately Diverts Resources Away From Patient Care

Every additional administrative burden takes time, money, and attention away from serving Medicaid beneficiaries. Eliminating the rounding rule is not a neutral change—it directly raises operational costs at a time when the industry is already strained by workforce shortages and reimbursement pressures.

Conclusion

The rounding rule is not the problem. Removing it would destabilize a billing structure that providers and DHS rely on, contradict federal norms, and increase administrative burden for everyone involved.

For the sake of program integrity, regulatory alignment, and continuity of care, I strongly urge DHS to preserve the existing rounding rule.

Thank you for the opportunity to share these concerns. I respectfully request that DHS withdraw this proposed change and maintain the clear and consistent rounding standards currently in place.

Response: Thank you for your feedback. We will take your comments under advisement. DHS is integrating back into the manual original language on rounding and unit calculation.

Cody Garrison, Vice President, MHA, MSN, RN

Co-Owner/Operator – Genesis Partners, LLC dBa Arkansas Home Helpers

Comment: I am writing to formally oppose the proposed change to the Department of Human Services Medicaid Provider Manual for Personal Care that would eliminate the established rounding rule used for billing time-based services. This change has significant implications for administrative accuracy, provider compliance, and alignment with federal standards governing Medicaid claims.

The current rounding rule provides clarity, consistency, and administrative efficiency for both providers and the Department. Removing this rule introduces ambiguity regarding how units of service should be calculated, increasing the likelihood of billing errors, inconsistencies in claims adjudication, and unintentional non-compliance. Time-based codes—particularly those aligned with CPT and HCPCS standards—require clear and uniform guidance to ensure that billing practices remain accurate and auditable.

Furthermore, the Centers for Medicare & Medicaid Services (CMS) continues to recognize and rely on rounding rules for time-based billing across multiple service categories, including evaluation and management codes, therapy services, and other time-dependent procedures. CMS guidance and nationally accepted coding standards commonly reference the use of rounding—for example, the “8-minute rule” and other established methodologies—to determine appropriate billing units. Maintaining a rounding mechanism within the state Medicaid manual is therefore essential to preserve consistency

with federal expectations and industry norms. Removing the rounding rule would place Medicaid providers at odds with the very standards that CMS uses to evaluate claims and could lead to unnecessary confusion, administrative burden, and potential claim denials.

Additionally, the proposed change risks impacting federal and state labor regulations. The loss of a clear rounding standard will introduce avoidable operational costs and increase the administrative burden on staff, diverting time and resources away from direct patient care.

For these reasons, I strongly urge the Department to retain the existing rounding rule. Maintaining alignment with federal billing guidelines protects the integrity of the Medicaid program, supports provider compliance, and ensures the continued availability of high-quality services for Medicaid beneficiaries.

Thank you for the opportunity to comment on this proposed change. I respectfully request that the Department reconsider this modification and preserve a clear and consistent rounding rule within the provider manual.

Response: Thank you for your feedback. We will take your comments under advisement. DHS is integrating back into the manual original language on rounding and unit calculation.

Catherine Burks, RN

Chief Compliance Officer

Comment: Public Comment Opposing Proposed Changes to Section 220.700: Transitioning Personal Care Providers

I respectfully submit the following comments in opposition to the proposed rule changes regarding the transition process between personal care providers. While the intent of ensuring continuity of care is understandable, these specific procedures introduce significant risks and challenges for beneficiaries, caregivers, and care-coordinating professionals. For the reasons outlined below, I urge that these changes not be implemented as written.

1. The proposed process creates unnecessary friction and communication barriers between competing providers.

Requiring new providers to notify and communicate directly with the incumbent provider places two competing agencies in a position where cooperation may be strained or even hostile. In practice, agencies are often reluctant to share client information or coordinate in good faith when competition for staffing and client retention is involved. This rule presumes a level of willingness and transparency that does not always exist, and it sets the stage for conflict rather than smooth transitions.

2. The plan forces beneficiaries into the middle of provider-to-provider conflict.

Because agencies have a natural desire not to lose clients, any required direct communication between old and new providers creates an incentive for the current provider to delay or discourage the transition.

This places the beneficiary—who may already be vulnerable—in the uncomfortable and potentially stressful position of being caught between two agencies trying to retain or acquire their case. Beneficiaries should never be subject to this pressure.

3. Inter-agency transfer of service records is not always feasible or reliable.

The expectation that one provider will seamlessly supply another with the beneficiary's complete service record (including assessments, treatment plans, and required forms) is unrealistic. Providers use different systems, documentation standards, and internal workflows. Delays, omissions, or incomplete records are common when transferring documentation between agencies, and the beneficiary ultimately bears the consequences. Missing or delayed paperwork could directly interrupt care.

4. Lack of a new assessment when a new provider take over poses clinical and safety concerns.

Each provider employs its own clinical staff, with its own RN supervisors, caregivers, and quality standards. A beneficiary's needs may appear consistent on paper, but in reality, a safe and effective care plan requires each RN to assess the client directly. Not requiring a new assessment bypasses a critical clinical safeguard: allowing the newly responsible RN to independently verify functional needs and ensure the treatment plan is appropriate, accurate, and safe. A plan written by one agency's nurse should not automatically be adopted by a different agency's team without confirmation.

5. Care transitions should be coordinated by the authorizing party—not by competing providers.

The responsibility for initiating, approving, and coordinating a change in providers should rest with the authorizing entity, such as the client's primary care provider (PCP) or DHS. These parties have no competitive stake in the outcome and can ensure that transitions protect the beneficiary's rights, medical needs, and continuity of care. Direct inter-provider communication places the process in the hands of parties with conflicting business interests.

6. The delayed transition timeline unnecessarily prolongs care under an unwanted provider.

Requiring clients to remain with their current provider until the first day of the second month after notification prolongs a relationship that the beneficiary has already elected to end. Clients typically seek a new provider due to unmet needs, dissatisfaction, or changes in circumstances. Extending their time under the old agency may compromise their well-being and undermines their stated freedom of choice.

Conclusion

While continuity of care is essential, the proposed rule changes introduce problematic inter-agency communication requirements, place clients in the middle of provider disputes, risk incomplete documentation transfer, and eliminate essential clinical assessments. Most importantly, they shift control of the transition process away from neutral authorizing entities and into the hands of competing providers.

For these reasons, I respectfully urge reconsideration of these proposed changes and recommend that any transition process preserve beneficiary choice, maintain clinical safety, and ensure that coordination is handled by impartial authorizing parties, not by competing agencies.

Thank you,

Response: Thank you for your feedback. We will take your comments under advisement.

The provider transfer process has been established to ensure a smooth transfer of continuous services between providers and to act in the best interest of the recipient. This policy allows, but does not require, the new provider to utilize the unexpired Assessment & Treatment Plan and 618-TP from the outgoing provider. Freedom of Choice mandates that the beneficiary is at the center of decision-making for choice in providers and care delivery. This DHS policy does in fact mandate more coordination of transitions, as per the authority of DHS.

Luke Mattingly, CEO/President

CareLink

Comment: Public Comment

Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals CareLink response

December 4, 2025

Section II 250.100 C. 1. 2. 3. The following standard reimbursement rules apply to all services.

This change in billing procedure deviates from decades of precedence and the In-Home Services industry standard of following the CMS 8-minute (or rule of 8) rounding rule.

This change is unnecessary and arbitrary. It will require the retraining of thousands of in-home aides (for which there is no ability to bill or reimbursement for providers), the reprogramming of numerous software systems used by various providers (again for with there is no reimbursement mechanism), and the shifting of some costs, that were previously billable, to providers of the service in a time when reimbursement rates for these services are inadequate and already threaten the viability and sustainability of Medicaid in-home services.

Strike the proposed change and return the language in this section to reflect procedures in the current manual, which correlates with the CMS 8-minute rounding rule.

Section II 250.100 C. 5. Rest, toileting, or other break times between service delivery is not billable.

Not providing reimbursement for break times is totally understandable. However, specifically including toileting is antiquated and harkens back to being on the manufacturing production lines in the 1930's, 40's and 50's. Expecting an in-home Aide to clock-out and then clock-in again with an EVV system to take a 2-minute bathroom break is ridiculous. I question whether the heavily Medicaid funded nursing home industry requires staff to clock out to go and urinate or for that matter the publicly funded facilities operated by the State of Arkansas, the answer of course is no.

This language further demonstrates policy makers lack of understanding of operational concerns for Home and Community based services and in this case common sense.

While we are updating the manual, the word toileting should be eliminated from Section 250.200 Fee

Schedules

There is no problem with the fee schedules per se, the problem is with the fee reimbursement rate. The reimbursement rate for Personal Care, Attendant Care, and Respite is woeful and in desperate need of revision. The current rate endangers the sustainability of these home and community-based services. Inflationary pressures affecting labor, insurance, benefits, software and a plethora of other factors impacting businesses are not being addressed in the reimbursement rate. A cyclical rate review by DHS has been cancelled or indefinitely postponed creating a critical situation where these services and providers are effectively on life support, to use a healthcare analogy. The variation in spending between facility-based care and home and community-based care in Arkansas continues to widen in favor of facilities. This is partially because of concessions made to facility-based care during COVID that remained in affect even after the pandemic was in control and partially because nursing home facilities have a regulatory mechanism to annually address cost increases.

The Great State of Arkansas needs to commit to healthy thriving Home and Community Based services. Other than the Hutchinson administration, which initiated a three-year rate review cycle, rates have only been adjusted when a crisis arises. Crisis management as a policy does not build a system of sustainable high-quality services.

Providers of these services will tell you; “we are in a crisis now”.

INCREASE THE RATE FOR PERSONAL CARE, ATTENDANT CARE, and RESPITE CARE IMMEDIATELY.

Response: Thank you for your feedback. We will take your comments under advisement.

Reimbursement rates are outside of the scope of the Personal Care manual.

Regarding your comments on 250.100, this policy is to prevent billing for personal time spent away from the beneficiary.

DHS is integrating back into the manual original language on rounding and unit calculation.

Shanna Maguffee Deputy Director

White River Area Agency on Aging

Comment Section 200.100, B. 2 and 3

While we completely understand and agree the importance of background checks for client safety, we do question the reduction of Child and Adult Maltreatment from five to two years.

Section 210.200 A. 3

This asks for “weekly or more frequent progress notes” but does not take into consideration the EVV system of documentation. There is very limited ability to have free type. Please, when completing this manual, explain exactly what types of “beneficiary conditions” are expected and allow for less condition comments for those who are stable and are not dealing with changes in condition or issues.

Section 215.400 Section B

Starting at this section, it appears there is an assessment (DMS618) and then later in manual, it appears duplicative information is required two additional times.

ADLs and IADLs documented in Section V

Summary of level of need again in narrative in Section VII

Describe ADL and IADL need in the Treatment Plan Section in Section X

RN assessment is vital, but the time and repetitive nature that appears to be required here should be reviewed.

Section 215.400 E. 1 and Section 220.700 3.

The expectation that all information, assessments, service planning will be shared with another provider, in the event that a beneficiary chooses to change providers, seems to be asking for proprietary information and processes. Additionally, some providers likely will not willingly share the information to assure a smooth transition for the beneficiary. The outcome will likely be that beneficiaries who need care will have a lapse in service.

Section Section 220.300 E. 1 and 2

Staff changes have occurred since the manual changes that allowed for a “qualified supervisor” that did not have to be a registered nurse. In this section, there is language that appears to intermingle the two roles (RN and QS). We respectfully request maintaining the qualified supervisor duties and not increasing RN duties. It is important to point out that there is no reimbursement for any RN duties (other than we are aware that it is stated that the RN costs are built into the rate, but the rate is so desperately low that it no longer can be mathematically stated that it is.)

Section 215.400 F.

Confusion exists in the verbiage of section F. Please clarify.

Section 250.100 C. 1, 2, 3

It appears that this section deviates from CMS 8-minute ruling and it also does not take into consideration the business type of home and community based services. This creates a monumental burden of retraining of staff and restructuring of software services that have been created under a long-standing accepted rule.

Section 250.100 C. 5

This section appears to be asking a caregiver to clock out for a brief break and using the restroom. If we are reading this incorrectly, please re-word for clarification. If we are reading this correctly, this seems to be a ridiculous request. What industry or work place expects such a requirement? As difficult as it is to hire good caregivers at this time, and as low as the reimbursement rate is that restricts what caregivers can be paid, it seems like a final knock-out blow to tell them they must now clock out for the five minute trip to the restroom.

Section 250.200 Fee Schedule

This seems to be the most appropriate place to note this comment. We respectfully request an increase in the rate for home and community based services. The rate has not come close to keeping up with salary costs, additional unfunded mandates, and general inflation and cost of living increases.

Response: Thank you for your feedback. We will take your comments under advisement.

While forms are not part of the promulgation process and therefore not subject to public comment, DHS has sent drafted forms to the requestor for their review and understanding.

Regarding your comments on Section 200.100, Act 853 was enacted in the last legislative session. It removed the certification process by the Division of Provider Services & Quality Assurance at DHS for private care agencies. As a result, personal care providers are now deemed high-risk providers by Arkansas Medicaid. The change in frequency of checks is in line with this change.

Regarding your comments on Section 215.400, included in the Transition Request Form is the option to request an "Emergency Transfer," which would include changing providers due to a loss of services. Please see Section 220.700 of the manual. DHS and its contractors will work to ensure clients do not have a gap in services.

Regarding your comments on Section 250.100, this policy is to prevent billing for personal time spent away from the beneficiary.

Reimbursement rates are outside of the scope of the Personal Care manual.

Brad Bailey

Area Agency on Aging of Northwest Arkansas

Comment: Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals

Area Agency on Aging of Northwest Arkansas Response

Change of Providers seems punitive to Medicaid recipients. Clients will have to wait until the first of the second month after they switch providers. Eg. Client decides they want to change providers on May 15th. They will not be able to start with a new provider until July 1. This is too long and the client suffers. Generally if they are wanting to switch it's because there is not a PCA available. They will be going month and a half without services.

If there is a switch of providers I do not agree with having the current provider to hand over their care plan to the new provider. We don't want to give our care plans to other providers

And do not feel comfortable with using some other providers care plans. Providers should do their own care plan upon referral of new clients. There could be changes that have occurred since the last provider has seen the client and the enforcement of this proposal will be difficult if not impossible. I would think that professional liability insurance providers would require a new care plan if they are assuming the liability. Claims could possibly be denied if errors were made by a prior provider and new providers use the old care plan.

Section II 250.100 C. 1. 2. 3. The following standard reimbursement rules apply to all services.

This change in billing procedure deviates from decades of precedence and the In-Home Services industry standard of following the CMS 8-minute (or rule of 8) rounding rule. I feel the change is unnecessary.

Section II 250.100 C. 5. Rest, toileting, or other break times between service delivery is not billable.

Not providing reimbursement for break times is totally understandable. Requiring employees to clock out to clock in and out to take a short bathroom break is unreasonable. Plus how would this ever be policed. Recipients complain about PCAs that are not doing their job and wasting time and can be addressed through that means.

Section 250.200 Fee Schedules

There is no problem with the fee schedules per se, the problem is with the fee reimbursement rate. The reimbursement rate for Personal Care, Attendant Care, and Respite is woeful and in desperate need of revision. The current rate endangers the sustainability of these home and community-based services. Inflationary pressures affecting labor, insurance, benefits, software and a plethora of other factors impacting businesses are not being addressed in the reimbursement rate. A cyclical rate review by DHS has been cancelled or indefinitely postponed creating a critical situation where these services and providers are effectively on life support, to use a healthcare analogy. The variation in spending between facility-based care and home and community-based care in Arkansas continues to widen in favor of facilities. This is partially because of concessions made to facility-based care during COVID that remained in affect even after the pandemic was in control and partially because nursing home facilities have a regulatory mechanism to annually address cost increases.

Response: Thank you for your feedback. We will take your comments under advisement.

Regarding your comments on Section 215.400, included in the Transition Request Form is the option to request an "Emergency Transfer," which would include changing providers due to a loss of services. Please see Section 220.700 of the manual. DHS and its contractors will work to ensure clients do not have a gap in services.

Reimbursement rates are outside of the scope of the Personal Care manual.

Regarding your comments on 250.100, this policy is to prevent billing for personal time spent away from the beneficiary.

Alycia Stroud RN, CEO

1st Choice Home Care, Inc

Comment: Impact of Arkansas Medicaid Personal Care New Rules on 1st Choice Home Care Costs

Overview of New Arkansas Medicaid Rules

The state of Arkansas has introduced new rules for its Medicaid program, which are anticipated to have a significant effect on home health care providers, including 1st Choice Home Care. While the specifics of the new regulations are still being analyzed, the primary areas of impact are related to reimbursement structures, administrative requirements, and patient eligibility criteria.

The effective date for these changes is Apr 1, 2026. A detailed summary of the new regulations is available in the appendix, <https://humanservices.arkansas.gov/wp-content/uploads/Personal-Care-and-Arkansas-Independent-Assessment-Provider-Manuals.pdf>.

Projected Additional Costs for 1st Choice Home Care

The implementation of these new rules will introduce several additional costs for 1st Choice Home Care. These costs can be categorized into administrative overhead, direct patient care expenses, and compliance and training.

1. Administrative and Compliance Costs

New regulations will necessitate updates to our internal processes and increased administrative oversight.

Area of Cost	Description	Estimated Impact
Staff Training and new hires (approx. 11 new RNs)	Mandatory training for all staff on new documentation and compliance standards. Hire new RNs to replace LPN's/other medical professionals	Increased expenditure on training sessions and materials. Due to the new staff replacing all current LPN's/Health professionals that are qualified to do assessments and supervisory forms. (Must hire all

Area of Cost	Description	Estimated Impact
	(*The average RN salary in Arkansas is approximately \$61,530 to \$74,474 annually, with hourly rates ranging from about \$35.16 to \$39.83.)	RN's) *LPN's, Medical professionals and RN's that we pay now, annually \$1,070,014.40 compared to if we had all RN's doing patient assessments, supervisory visits and VA. (* RN pay is based on \$40/hr) \$1,664,000.00 That is a difference of +\$593,985.60 more annually that will have to be paid in wages.
Layoffs for all LPN's/Medical professionals that were allowed to assess patients/supervisory visits	Any staff that is NOT a RN due to the new rules. Only an RN is able to Assess for DMS-618	Significant cost in unemployment insurance will have to be paid to staff that will be laid off due to new rules. (Est. Cost layoffs of 11 employees if we figured that at the maximum benefit amount of \$451 for the 12 weeks that would be a total of \$59,532.00)
Auditing and Reports	Increased frequency and complexity of internal and external audits required by the new rules. (Running state background checks every 5 yrs, Adult and child maltreatment every 2 yrs (used to be 5 yrs) All caregivers and staff must also have a sexual offender registry every 2 yrs.	Additional staff hours dedicated to compliance and reporting. (Difference of \$180,000 more in a 10-year span. Extra cost of \$18,000 a year.) \$22.50 Arkansas Background, \$10 each maltreatment check Adult and Child = \$42.50 each Sexual Predator background is free so that is not an extra cost.
Fee Schedules in Personal Care, AR Choice Waivers, (attendant care, respite) Targeted case management= TCM	Last updated fee schedule for personal care, attendant care and respite is 1/1/2021 at \$5.12 unit. (Unit=15 minutes) Which is \$20.48/hr. Last fees update 4/27/16 TCM \$7.50 unit/ \$30.00 hr. <u>*Criteria for TCM employment:</u> Licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Certified Social Worker),	Vet Assist pays \$26.00/hr. for personal care VA or Veteran services pay \$37.00/hr. for personal care, respite, homemaker/attendant care. <u>Personal Care Fee Schedules in Neighboring States.</u> Missouri Reimbursement Fee Schedule (Unit=15min) \$8.16 unit=\$32.64hr

Area of Cost	Description	Estimated Impact
	a registered nurse or a licensed practical nurse. Have a bachelor's degree from an accredited institution in a health and human services or related field; or Have two years' experience in the delivery of human services, including without limitation having performed satisfactorily as a case manager for a period of two (2) years (experience must be within the past three (3) years).	Tennessee Reimbursement Fee Schedule (Unit=15min) \$6.49 unit=\$25.96hr Oklahoma Reimbursement Fee Schedule (Unit=15min) \$6.58 unit=\$26.32hr **RN assessments and supervisory visits are not reimbursed through Arkansas Medicaid.

2. Direct Patient Care Costs

Changes to patient eligibility and service definitions may lead to changes in service delivery.

- Increased Documentation Approval Time: The new rules require a PCP/Physician signature before it is turned in with Atrezzo Registration to apply for a preapproval number for services. (Services cannot start until we have obtained the number for approval)

The New Documentation and Process:

Client/Patient Eligibility, Process of Admission and Supervision

Initial DMS-618ER "Evaluation Referral"

- Required initially when entering the personal care program but not annually
- Only required again if the client is not serviced for 120 days
- Must be signed by a PCP
- Functional Needs Assessment & Treatment Plan
 - Will replace our current DMS-618
 - Youth - under 20 years of age - "Youth Personal Care Functional Assessment & Treatment Plan"
 - Adult - above 21 years of age - "Adult Personal Care Functional Assessment & Treatment Plan"
 - Must be completed, signed, dated by RN
 - Only done annually, not needed when switching providers
- DMS-618TP "Treatment Prescription"
 - Must be signed by PCP
 - Valid for 1 year, renew annually
 - New DMS-618TP is not required if client switches PCP or companies
- Supervisory Visits
 - Must be performed by an RN
 - Must be done 1x annually but no limit on frequency if more completed

Transitioning Personal Care Providers

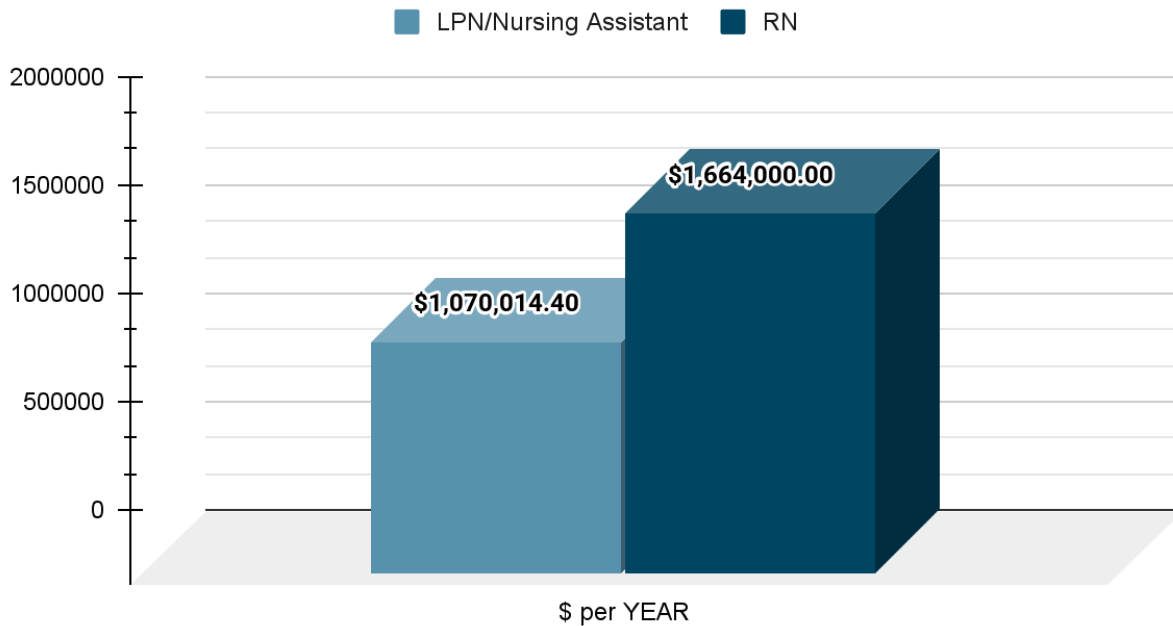
- Beneficiary Requirements
- Must complete a “Personal Care Provider Transition Request Form”
- New Provider Requirements
 - Must notify current provider of transition
 - Must provide current provider with the client’s Transition Form
 - Must keep proof that transition notification was sent, date and time, in client file
- Current Provider Requirements
 - Must continue servicing clients/patients until the 1st day of the second month after notification was sent to them
 - If notification is sent May 11, the current provider will continue services until July 1st
 - Must provide the new provider with a complete “Service Record”
 - Service records include:
 - DMS-618ER - “Evaluation Referral”
 - Current Assessment & Treatment Plan
 - Active signed DMS-618TP - “Treatment Prescription”
- Revised RN-Staff: If new rules mandate staffing all Registered Nurses, certain levels of care, additional hiring will be required, impacting on overall payroll costs. A meeting to discuss these changes has been set in place to discuss all changes.
- Enhanced Service Requirements/reports: New mandates for specific types of requirements for background checks more frequently or specialized training for care staff will lead to higher operational costs per patient. The multistep process to approve a client/patient for services can severely impede the care of the client/patient. As of now, it is taking months to get a PA (preapproval) due to the steps with OPTUM and Atrezzo. As of 4/1/26, OPTUM will no longer be a step in the process, but several steps are added to the providers to get the approval for services.

3. Financial Implications

Based on preliminary analysis, the overall financial burden is projected to increase.

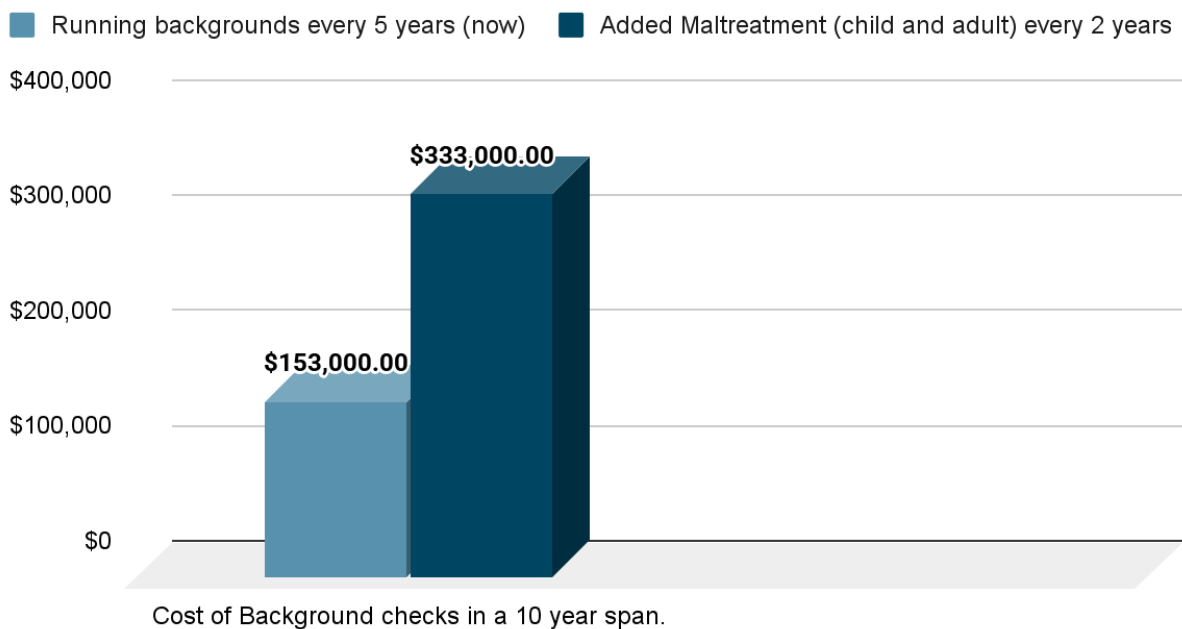
[A detailed financial projection table showing increased operating expenses due to the new Medicaid rules]

LPN/Nursing Assistant <> RN Pay per year (19 Offices)



LPN's, Medical Professionals and RN's that we pay now, compared to if we had all RN's doing clients assessments, supervisory visits and VA. RN pay is based on \$40 ph.

Based on 1,800 Caregiver Background Checks



Difference of \$180,000 more in a 10-year span. Extra cost of \$18,000 a year. \$22.50 Arkansas Background, \$10 each maltreatment check Adult and Child = \$42.50each

Sexual Predator background is free so that is not an extra cost.

3. Direct Client/Patient Care Impact

- Longer waiting time for approval
- Change in continuity of care, due to the impact of changing staff (LPN/Medical Professionals to all RNs)
- Lack of care due to the time of waiting for approvals. Many clients/patients will go without care due to the wait and several steps that need to be approved for services.
- Changing providers can be a hindrance to client/patient if the old provider does not comply with the new rules. This is a strain on the client/patient, which can be a window for harassment or lack of care.

3. Arkansas Medicaid Personal Care Proposal from 1st Choice Home Care, Inc.

- Fee schedule increase to adjust to the increase of cost to provider
- Grandfather in LPN's/Medical professionals to do assessments/supervisory visits but it must be supervised and signed off by an RN.
- Instead of the PCP/Physician signing off on all assessments, making it mandatory to have documentation from hospitals/physicians' clinics, or therapists (physical or mental health) to reflect services rendered or requesting and patient condition and diagnosis.
- Atrezzo should have a time limit to approve clients/patients, it should not take 2-3 months for approvals. Better communication from Atrezzo, when a client/patient changes provider or any change needs to be communicated better to the provider.

Next Steps

To mitigate the financial impact, 1st Choice Home Care is taking the following actions:

- Staff Briefing: A mandatory meeting for all supervisory staff will be held at our administration office, 120 N 2nd Street Paragould AR 72450, to review the changes.
- System Review: An internal team is assessing the necessary updates to background checks, new assessments, and new regulations for approvals and change in providers.
- Advocacy: We will be reaching out to state representatives across the state to discuss collective action regarding reimbursement rates/fee schedules and the impact on providers and Arkansas Medicaid personal care recipients.

I hope you took the time to look over our proposal and information that was collected to help with the impact on Arkansas Medicaid Personal Care and providers and the Medicaid recipients across the state of Arkansas.

Response: Thank you for your feedback. We will take your comments under advisement.

DHS acknowledges the concerns raised regarding administrative burden, staffing requirements, financial impact, and delays in prior authorization. These rules are intended to strengthen patient safety, ensure clinical appropriateness, and align with federal compliance standards.

MegAnne Townsend Corporate Operations Manager

Townsend Healthcare and Townsend Healthcare of Eastern Arkansas

Comment: This memo presents public comments from a Provider of Care regarding the proposed changes to the State Plan Personal Care Program.

Before the specific comments are made, we would like to make some general comments to set the framework for the many revisions to the current plan. These general comments are summarized below:

- The overall goal of the revisions by the State should be to streamline and reduce, if possible, the regulations to allow the Providers to comply with the intent of the Personal Care Program (i.e. take care of the Clients ADL's to allow them to remain at home and not in institutions) but not become more burdensome and increase the cost of compliance to the Providers with unnecessary regulations which are, in effect, unfunded mandates.
- The proposed revisions consistently are written using phrases such as "treatment prescription", "treatment plan", "progress notes" and other medical terms and requirements that lend themselves to higher levels of care than Personal Care Companies are licensed to provide. Personal Care Companies can only provide unskilled services (ADLs) with primarily unskilled workers (i.e. CNA's, PCA's, etc.) These workers are not trained to assess or write progress notes, etc. No medical services can be provided under our license.
- The Federal Guidelines for Personal Care are more permissive than the Proposed State Plan regarding Personal Care Supervision and Transportation.

Section II-STATE PLAN PERSONAL CARE CONTENTS

200.000 GENERAL INFORMATION

200.100 Participation Requirements for State Plan Personal Care Providers 1-1-26

B. Each employee must successfully pass the following:

- 1. A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann. § 20-38-103;*
- 2. An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;*
- 3. An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years.*
- 4. An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and*

Comment Summary Response:

- Background and Registry Checks cost \$22.00 State / \$13.00 FBI for federal checks.

- Medicaid Provider Enrollment is provided by Gainwell Technologies who also completes background checks to determine whether a Provider Identification Number (PIN) number is issued to a Practitioner.
- This process should be streamlined since Gainwell Technologies already does background checks. There is no need for the Personal Care Providers to duplicate this process.
- The above also includes the Arkansas Sex Offender Central Registry which should be done for both Aides as well as Clients.

Request: Gainwell Technologies should be the one stop for all background checks to assure compliance with the regulations.

210.000 DOCUMENTATION REQUIREMENTS

210.200 State Plan Personal Care Provider Documentation Requirements 1-1-26

A. State Plan Personal Care providers must maintain in each beneficiary's service record:

d. The initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP) (see section 212.200);

e. All treatment prescriptions (see section 212.300);

g. All treatment plans;

Comment Summery Response:

- Use of "Treatment" and "Prescription" would assume Personal Care is a Skilled Medical Service by a Credentialed Provider.
- Treatment Prescription is a Referral for Non-Medical Unskilled Services by an Uncredentialed Provider (Personal Care Aide)

Request: To Utilize Non-Medical language in place of Skilled Medical Language in the Rules for Personal Care.

210.000 DOCUMENTATION REQUIREMENTS

210.200 State Plan Personal Care Provider Documentation Requirements 1-1-26

2. Treatment plan service log documentation, which must be completed at the time-of service delivery and at a minimum include:

b. Beneficiary's Medicaid ID number and date of birth;

i. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.

iii. If the personal care aide discontinues or interrupts the beneficiary's service-plan-required activities at one location to begin service-plan required activities at another location, the aide must record the beginning and ending times of service at each location.

iv. If a personal care aide does not perform a scheduled treatment plan task, the personal care aide must document and justify why the task was not performed as scheduled;

- e. Any service performance difficulties;*
- f. Notes on the beneficiary's condition or other data or criteria required by the treatment plan;*
- g. When an emergency or special circumstances requires a personal care aide to perform a task not included on the personal care treatment plan, documentation describing:*
 - i. The nature of the emergency or special situation;*
 - ii. The action or task required to resolve the emergency or special situation;*
 - iii. The date, start time, end time, location, nature and scope of the unscheduled task performed;*
 - iv. When supervisor approval for the unscheduled task was obtained; and*
 - v. If supervisor approval was not obtained prior to performing the unscheduled task, justification for why pre-approval was not possible*
- h. Name(s), credential(s), and signature(s) of the personal care aide who performed the service; and*
- 3. Weekly or more frequent progress notes outlining the condition of the beneficiary;*
- 4. If service delivery involves delivering services to multiple beneficiaries, the following additional service log documentation requirements apply:*
 - a. When service delivery involves two (2) beneficiaries concurrently (i.e. cleaning a bathroom shared by two beneficiaries), then the personal care aid must also document in each beneficiary's service delivery log the name of the other individual who received the concurrent personal care service;*
 - b. When service delivery is in a congregate setting (i.e. involves more than two (2) beneficiaries), then the personal care aide must:*
 - i. Record the date and time the congregate service began and ended; and*
 - ii. The name of each individual who received congregate services;*
 - c. The provider must equally split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took twenty (20) minutes, the personal care aide would document ten (10) minutes to each beneficiary for the service).*

Comment Summery Response:

- To implement these changes according to Arkansas State Plan will be a financial burden to Personal Care Agencies.
- The current EVV system is on phones and not tablets. This will not allow for the extensive additional documentation necessary for implementation of the proposed changes.
- Authenticare 2.0 will not adequately provide the capabilities to implement these changes.
- Authenticare 2.0 does not include the beneficiary's DOB in the Aide Service log or Worker Activity Report
- Providing both Medicaid ID and DOB to the Personal Care Aide could impact HIPAA.
- Providing both Medicaid ID and DOB of another patient's service log could impact HIPAA.

- The extensive time for an aide to enter the requested documentation on a smart phone after clocking out is an unfunded mandate to a PCA.
- Authenticare cannot cumulatively add a day's clock in and out times. Each clock in and out is identified as an individual claim. MMIS will reject the duplication of more than 1 claim per day. To process this claim would take additional work and expense to process by splitting and manually adjusting the split shift.
- The above system needs to reflect the rules and regulations not adding to these unrealistic additions (i.e. having to clock in and out for bathroom breaks).
- Any service performance difficulties the aide would be documenting would be related to the tasks that they themselves performed: Cooking, Housekeeping, Shopping, etc.
- Notes on the beneficiary's condition or treatment plan for are beyond the scope of practice of the uncredentialed PCA whose tasks are for nonmedical tasks only.
- Name, credential (s) and signature of the personal care aide who performed the service is not a feature of the State's Authenticare 2.0 EVV system as the aide is non credentialed.
- Weekly or more frequent progress notes outlining the condition of the beneficiary are beyond the scope of practice for a PCA. They are to assist with unskilled, non-medical tasks and are unqualified to determine treatment progress of a Beneficiary.
- The listed ADL on both the Authenticare 2.0 App and the care plan is either completed or not completed by the checked box on the app. i.e.: Personal Grooming, Bathing, Meal Preparation, Toileting, Housekeeping, Ambulation, Medication, Shopping, Dressing/Undressing and Laundry. Any service delivery difficulty the aide would be documenting would be how well they completed the task of i.e. cooking and cleaning.

Request: Personal Care Aides should not make progress notes on a Beneficiary.

215.100 PROGRAM ELIGIBILITY

215.400 Functional Needs Assessment

C. All Personal Care Functional Assessment & Treatment Plan functional needs assessments must be completed, signed, and dated by a licensed Registered Nurse.

Comment Summery Response:

- Per the Office of the Inspector General: "Personal care services (PCS) is a Medicaid benefit for the elderly, people with disabilities, and people with chronic or temporary conditions. It assists them with activities of daily living and helps them remain in their homes and communities. Examples of PCS include bathing, dressing, light housework, money management, meal preparation, and transportation."
- As can be seen from the above list, all these activities are unskilled and do not require any medical intervention of any kind. The plan of care does not include any skilled or medical intervention by the caregiver. An LPN is fully qualified to determine the needs of a Beneficiary.

Request: LPNs should be allowed to do Assessments and Service Plans

215.500 Treatment Prescription

A. Personal care services require a treatment prescription signed by the beneficiary's primary care provider (PCP). The frequency, intensity, and duration of the prescribed personal care services must be medically necessary based on the results of the assessment and realistic for the age of the beneficiary.

B. A treatment prescription for personal care services is valid for one (1) year unless a short period is specified on the treatment prescription.

C. A treatment prescription for personal care services must be on form DMS-618 TP "State Plan Personal Care Services Treatment Prescription."

Comment Summery Response:

- Use of "Treatment" and "Prescription" would assume Personal Care is a Skilled Medical Service by a Credentialed Provider.
- Treatment Prescription is a Referral for Non-Medical Unskilled Services by an Uncredentialed Provider (Personal Care Aide)

Request: Referrals and not Prescriptions will be required from the PCP.

220.300 Personal Care Services

B.

12. Transportation to and from employment (or seeking employment) meets the requirements of section 223.000 of this Medicaid manual (no mileage cost associated with the transportation would be covered).

Comment Summery Response:

- Medical Appointments are not included in the Treatment Plan but is imperative in keeping the elderly in their homes and out of institutions.
- According to a study by ACHI, more than one-third of Arkansans live in Health Professional Shortage areas.
- Medical Appointments are necessary to maintain the health of this aging population. Verida, Inc. transports Beneficiaries with a 48 hour notice which is not always possible with this fragile population. Allowing personal care aide to transport a client to their physician rather than the expense of an emergency room visit would be a cost savings to Medicaid.

Request: Transportation should be allowed in the Personal Care Service Plan.

220.300 Personal Care Services

E. The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered:

1. The qualified supervisor must complete the following at least monthly:

2. A supervising registered nurse must conduct an on-site evaluation of a day's service delivery to a beneficiary as required in the treatment plan, but no less often than annually. On each on-site evaluation, the supervising registered nurse must:

a. *Observe and document.*

iii. *The interaction and relationship between the beneficiary and the personal care aide; and*

Comment Summery Response:

- The definition of a Qualified Supervisor is not defined by the Arkansas State Plan.
- Referencing the CMS document “Preventing Medicaid Improper Payments for Personal Care Services: “Approved supervising entities may include nurses (both Registered Nurses and Licensed Practical Nurses), PCS agency staff, case managers, other agency staff deemed qualified, and in some cases the beneficiary.”
- A Registered Nurse to complete an on-site evaluation of a day’s service delivery to a beneficiary of non-skilled activities such as meal preparation, housekeeping and laundry for 3-5 hours is an unfunded mandate. It is not defined as a Supervisory Visit.
- Registered Nurse must complete an updated Personal Care Function Assessment & Treatment Plan which is an unfunded mandatory requirement. Both Home Health and the Veterans Administration allow this to be a billable expense.
- The State of Arkansas should not create a more regulatory burden than the Federal Government. As can be seen from the above CMS document, the CMS language is clearly permissive language by saying “may” not “shall”. It also refers to “other Personal Care Provider staff who are deemed qualified.” We believe that we should allow and define “other approved supervising entities” so that this person, versus a Registered Nurse, could perform these services. This would reduce costs to the Personal Care Provider while ensuring compliance with the regulation. The State of Arkansas already has a Registered Nurse Shortage; this would add to that problem without any measurable benefit.

Request: Define a Qualified Supervisory Entity other than a Registered Nurse.

220.700 Transitioning Personal Care Providers

Comment Summery Response:

- The Vender, Atrezzo manages the Authorization Process through its database. Atrezzo has implemented a process of transitioning Clients by submitting the 9511 for Discharge with Total Billed Units for the Month which the current Personal Care Provider must provide.

Request: Not allowing Atrezzo to implement processes before they have been approved.

250.000 REIMBURSEMENT

A. *Reimbursement for personal care services is the lesser of the billed amount per unit of service or Medicaid’s maximum allowable fee (herein also referred to as “rate” or “the rate”) per unit.*

B. *Reimbursement for Arkansas Medicaid state plan Personal Care services are based on a fifteen (15-) minute unit of service.*

C. *The following standard reimbursement rules apply to all services:*

1. *A full unit of service must be rendered to bill a unit of timed service.*

2. Partial units of a timed service may not be rounded up and are not reimbursable. State Plan Personal Care Section II

3. Non-consecutive periods of service delivery over the course of a single day may be aggregated when computing a unit of a timed service.

4. Concurrent billing is not allowed unless specifically permitted herein. It is considered concurrent billing when multiple practitioners bill Medicaid for services provided to the same beneficiary during the same time increment.

5. Rest, toileting, or other break times between delivery service is not billable.

6. Time spent on documentation alone is not billable as a treatment service.

Comment Summery Response:

- Partial units of a timed service are currently rounded up or down to the nearest 15-minute unit.
- AuthentiCare applies rounding rules to actual hours by rounding the total hours worked to the next quarter hours, which is shown as the number of units on an EVV Visit. Within each quarter-hour increment, the EVV system rounds up to the next quarter-hour when the total actual time is eight minutes or more and rounds down to the previous quarter hour when the total actual time worked is seven minutes or less.
- Examples of rounding rules are:
- If worker works 2 hours and 53 minutes, the adjusted pay hours will round up to 3 hours.
- If worker works 2 hours and 52 minutes, the adjusted pay hours will round down to 2.75 hours.
- If worker works 4 hours and 10 minutes, the adjusted pay hours will round up to 4.25 hours.
- Not rounding up or down to the nearest unit will result in unpaid work time for the PCA who has worked.
- Partial Units of the timed service are currently being calculated following DHS guidelines. All the Approved EVV systems (Authenticare 2.0, HHAexchange and Carebridge) are configured with rounding to the nearest 15-minute unit.
- The functionality of the Electronic Devices makes it extremely difficult if not impossible to clock out at a precise unit of time.
- Nonconsecutive periods of service delivery in a single day are not billable as a single claim and would be denied.
- Rest and toileting breaks would require clocking in and out in a single day, the Authenticare 2.0 system cannot determine that this is not a duplicate claim and there will deny the claims.
- The proposed evaluation and progress notes completed on the mobile phone will be a very slow process.
- The Interactive Voice Response (IVR) method will not allow the required documentation proposed, therefore it will have to be manually written which would be an unpaid mandate for the PCA.

- Time spent on documentation should be allowed if it is considered part of the service.

Request: No change to the current “Rounding Rules” should be made.

Response: Thank you for your feedback. We will take your comments under advisement.

Regarding your comments on Section 200.100, Act 853 was enacted in the last legislative session. It removed the certification process by the Division of Provider Services & Quality Assurance at DHS for private care agencies. As a result, personal care providers are now deemed high-risk providers by Arkansas Medicaid. The change in frequency of checks is in line with this change.

Regarding your comments on Section 215.400, the Arkansas Nursing Board has advised that specific domains and required criteria within the Functional Assessment & Treatment Plan fall under the professional scope of a Registered Nurse (RN).

Regarding your comments on Section 220.300, there is no change from the original policy regarding personal care assistance going to/from medical appointments. Transportation to medical appointments is a separate service provided to eligible Medicaid recipients. More training will be provided prior to April 1, 2026 effective date on this topic.

DHS is integrating back into the manual original language on rounding and unit calculation.

Quincy Hurst

Superior Senior Care

Comment: We appreciate the opportunity to provide comments to the recent proposed regulation changes. We welcome changes that better the system and create a more sustainable future; however, we feel some of the proposed changes would negatively impact the programs and its recipients. Our comments on the proposal are as follows:

200.100 Participation Requirements for State Plan Personal Care Providers **4-1-26**

1. *Federal fingerprint-based checks in accordance with 42 CFR 455.434 and 42 CFR 455.50(c). All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq.*

SSC Response: We want to ensure fingerprinting is only required for those who have lived outside Arkansas within the last 5 years. Fingerprinting is a lengthy process that could impact the timeliness in which beneficiaries receive care.

- ii. *Each employee must successfully pass the following:*

- *A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann. § 20-38-103;*
- *An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;*
- *An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;*
- *An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and*
- *At least a five (5) panel drug screen upon hiring and prior to any contact with clients, and as required thereafter by Ark. Code Ann. §20-77-128(b).*

SSC Response:

- A. Many staff members have no direct or physical contact with clients. We request that the word “direct” or “physical” be inserted before the word “contact” throughout this section to avoid unintended inclusion of administrative staff.
- B. We recommend maintaining the current five-year schedule for all screening checks. This reduces administrative burden, aligns with existing processes, and ensures consistency. Requiring certain screenings every two years adds unnecessary cost and delays without evidence of increased safety.
- C. Maltreatment registry results can take up to four weeks. During a national caregiver shortage, requiring providers to wait for results before a caregiver may begin work could significantly delay care. We oppose the proposed requirement and request that caregivers be allowed to work contingent upon results, as is the current practice.

205.200 Personal Care Aide 4-1-26

An individual must meet the following requirements to serve as a personal care aide for a personal care services provider:

- A. *Have one of the following active certifications in good standing:*
1. *Certified Nursing Assistant (CNA);*
 2. *Home Health Aide; or*
 3. *Certified Personal Care Aide;*

SSC Response: We request clarification on the use of the phrase “*active certifications in good standing*” as it relates to Certified Nursing Assistants (CNAs). Many CNAs have extensive industry experience but may choose not to renew their license. Their prior CNA certification is verifiable in the Employment Clearance Registry and confirms that they received the required training under Private Care Agency Regulations. We request that these individuals qualify as a personal care aide.

215.300 Evaluation Referral 4-1-26

- *Personal Care services require an initial evaluation referral signed and dated by the beneficiary’s primary care provider (PCP).*

- *An initial evaluation referral for personal care services is required to be on a DMS-618 ER “State Plan Personal Care Services Initial Evaluation Referral.” [View or print the form DMS-618 ER](#).*
- *A DMS-618 ER evaluation referral is only required to perform a beneficiary initial evaluation for state plan personal care services.*
- *No DMS-618 ER is required for a provider to perform the annual functional needs assessment necessary to demonstrate a beneficiary’s continued eligibility for state plan personal services, unless there is a significant break in services. A significant break in service is defined as not receiving state plan personal care within the prior one hundred twenty (120) days.*

SSC Response: We believe the requirement for a DMS-618 ER form is redundant. If a physician does not support personal care services, they would simply decline to sign the DMS-618. It is unclear what additional value this new form provides.

Additionally, we request confirmation that providers will have access to all newly created forms prior to implementation.

220.300 Personal Care Services 4-1-26

B. A personal care provider may be reimbursed for performing the following medically necessary personal care services in accordance with the beneficiary’s treatment plan:

- 1. Bathing;*
- 2. Dressing;*
- 3. Feeding/eating;*
- 4. Grooming;*
- 5. Toileting;*
- 6. Transferring;*
- 7. Walking;*
- 8. Cleaning;*
- 9. Laundry;*
- 10. Preparing meals;*
- 11. Shopping; and*
- 12. Transportation to and from employment (or seeking employment) that meets the requirements of section 223.000 of this Medicaid manual (no mileage costs associated with the transportation would be covered).*

SSC Response: Current regulations allow assistance to and from medical appointments and community activities. These supports are essential to beneficiary well-being and community integration. We strongly request that these activities remain reimbursable under the updated regulations.

- *The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered:*
 - *The qualified supervisor must complete the following at least monthly:*
 - *Review the beneficiary's service delivery logs and documentation;*
 - *Document the time and date of their service documentation review;*
 - *Actively train or assist assigned personal care aide with personal care service delivery when necessary;*
 - *Document any training or assistance provided to an assigned personal care aide.*

SSC Response: We request a definition of “qualified supervisor” for clarity and consistency across providers.

220.700 Transitioning Personal Care Providers

4-1-26

The new provider should maintain verifiable proof of the date and method of its required notification and transition request form delivery.

- B. *The current personal care service provider will continue to provide services to the beneficiary in accordance with this Medicaid manual until the first day of the 2nd month after the month the new provider completed the notification and delivery requirements in subpart (2.) directly above (i.e. if notified on May 11th, then current provider would continue providing personal care services until July 1st).*
- *The current provider is responsible for forwarding the beneficiary's complete service record to the newly selected personal care provider before the current provider's last day of service, as described in subpart (3.) directly above.*
 - *The beneficiary's complete service record includes, at minimum: The beneficiary's signed 618-ER; the beneficiary's active current Assessment and Treatment Plan; the beneficiary's active, signed 618-TP.*
- Switching from one personal care provider to another personal care provider does not automatically require a new:*
- *Treatment prescription;*
 - *Functional needs Assessment and Treatment Plan.*

SSC Response: Beneficiaries typically change providers due to staffing challenges. Under the proposed transition timeline, beneficiaries could wait up to two months before services begin with their new provider. This could significantly disrupt care.

Currently, beneficiaries sign a new Freedom of Choice form, providers upload it to the Ascentra portal, and Ascentra issues notifications with start and end dates. Because providers will still upload 618s into the Ascentra portal, we believe a more efficient transition process is to allow new providers access to the 618 through the portal. This mirrors current processes and eliminates delays caused by providers not releasing documentation.

Regarding section (3)(a), requiring the transfer of records only by the day before the transition does not provide sufficient time for providers to staff cases effectively. Ensuring earlier access to documentation—

or allowing retrieval directly from the portal—mitigates this risk. We also request clarification on corrective actions for providers who fail to submit documentation in a timely manner

250.100 Reimbursement Methods 4-1-26

A. *Reimbursement for personal care services is the lesser of the billed amount per unit of service or Medicaid's maximum allowable fee (herein also referred to as "rate" or "the rate") per unit.*

B. *Reimbursement for Arkansas Medicaid state plan personal care services is based on a fifteen (15-) minute unit of service.*

C. *The following standard reimbursement rules apply to all services:*

- 2. A full unit of service must be rendered to bill a unit of a timed service.*
- 3. Partial units of a timed service may not be rounded up and are not reimbursable.*

SSC Response: We strongly oppose eliminating current rounding rules. The existing methodology aligns with FLSA guidance, which requires compensating employees for time worked beyond seven minutes. The proposed rule would result in up to fourteen minutes of unreimbursed services per shift, which could violate federal labor requirements and create financial hardship for providers.

Additionally, revising rounding rules would require costly changes to timekeeping systems and would deviate from standard business and industry practices. We respectfully urge DHS to retain the current rounding standards.

Thank you again for the opportunity to provide feedback. As a statewide HCBS provider serving Arkansas for more than 40 years, we understand both the importance of these programs and the real-world implications of regulatory changes on the vulnerable populations we serve. We are committed to working collaboratively to ensure sustainable, effective, and accessible care for all Arkansans.

Response: Thank you for your feedback. We will take your comments under advisement.

While forms are not part of the promulgation process and therefore not subject to public comment, DHS has sent drafted forms to the requestor for their review and understanding.

Regarding your comments on Section 200.100, Act 853 was enacted in the last legislative session. It removed the certification process by the Division of Provider Services & Quality Assurance at DHS for private care agencies. As a result, personal care providers are now deemed high-risk providers by Arkansas Medicaid. The change in frequency of checks is in line with this change.

Regarding your comments on Section 205.200, a personal care aide must have "one" of the active certifications in good standing. If not the CNA license, then the aide must have either a currently active certification as a Home Health Aide or Certified Personal Care Aide and that certification must be in good standing.

Regarding your comments on Section 220.300, there is no change from the original policy regarding personal care assistance going to/from medical appointments. Transportation to medical appointments is a separate service provided to eligible Medicaid recipients. More training will be provided prior to April 1, 2026 effective date on this topic.

Regarding your comments on Section 220.700, under the proposed provider transition timeline, the current provider agency remains responsible for delivering Personal Care Services until the transition date, when the new receiving agency assumes services. This timeline is designed to ensure sufficient time for documentation and prior authorizations to be completed and in place for the receiving agency.

DHS is integrating back into the manual original language on rounding and unit calculation.

Barbara Flowers | Executive Director

Area Agency on Aging of West Central Arkansas, Inc.

Comment: Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals

Section II 250.100 C. 1. 2. 3. The following standard reimbursement rules apply to all services:

I don't see the advantage of changing the standard reimbursement rules. This will be confusing to our aides and a nightmare to record. I would like to see this language remain as it is in the current manual.

Section II 250. 100 C. 5. Rest, toileting, or other break times between service delivery is not billable:

I don't think there would be any disagreement with aides clocking out for breaks, however, clocking in and out for bathroom (toileting) breaks is not even reasonable. I know I wouldn't want to tell our aides, "sorry, but you're not allowed to use the bathroom, unless you're clocked out."

The immediate need is an increase in reimbursement rates. The expenses to provide services and to conduct the required background checks, and other required checks are not addressed in the reimbursement rate. Benefits, insurance and most operating cost have increased, but rates have not. Now, I understand that the rate reviews are on hold. Please help us and don't make it more difficult for us to provide for our most vulnerable population, since that is our mission and the reason the Older Americans Act was established.

Thank you,

Response: Thank you for your feedback. We will take your comments under advisement.

Regarding your comments on 250.100, this policy is to prevent billing for personal time spent away from the beneficiary.

DHS is integrating back into the manual original language on rounding and unit calculation.

Marshall and Rebecca Brashear | RCF Owner

Comment: Hello,

We own and operate an RCF in Dardanelle, Arkansas, and upon reviewing the proposed updates to the Medicaid personal care provider manual by DHS we have a couple of questions. Since the proposed update removes the entirety of the previous Section II of the manual, the section that listed RCF as a personal care provider type no longer exists, and the new language has three options for licensing as a personal care provider. The new Section II 200.100 C. 2. States that in order to be a licensed personal care provider we have to "Obtain a private care agency or home health class A or B license". I see no language stating RCF's have any other options, as these are the only licenses listed in the proposed manual update. Is this the case or has the RCF Medicaid personal care provider language been moved to somewhere else? Are RCF's no longer allowed to participate in Arkansas Medicaid and in order to do so we have to license as one of these 3 entities?

There is another section that raises a major question for our future operation, 220.700 C. 3. States: "The current personal care service provider will continue to provide services to the beneficiary in accordance with this Medicaid manual until the first day of the 2nd month after the month the new provider completed the notification and delivery requirements in subpart (2.) directly above (i.e. if notified on May 11th, then current provider would continue providing personal care services until July 1st."

I have no idea how an RCF could comply with this section if a beneficiary decided to change providers, and move to a new facility, as we don't have the ability or staffing capability to provide services across the state for up to 2 months. Does this section apply to RCF's? I see no exceptions or exclusions anywhere in this proposal that would imply that we are exempt from this regulation.

Thanks, Marshall

Response: Thank you for your feedback. We will take your comments under advisement.



Office of Policy and Rules

P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437

P: 501.320.6383 F: 501.404.4619

November 6, 2025

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Attorney III
Office of Policy and Rules

Attachments

**QUESTIONNAIRE FOR FILING PROPOSED RULES WITH
THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Aging, Adult and Behavioral Health Services
BOARD/COMMISSION DIRECTOR Jay Hill
CONTACT PERSON Mac Golden
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203-1437
PHONE NO. (501) 320-6383 EMAIL Mac.E.Golden@dhs.arkansas.gov
NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING Jay Hill
PRESENTER EMAIL(S) Jay.Hill@dhs.arkansas.gov

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

1. What is the official title of this rule?
Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals
2. What is the subject of the proposed rule? 20 CAR 607 & 634
3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☒

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☐

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes ☐ No ☒

If yes, please provide the year of the act(s) and act number(s).

11. What is the reason for this proposed rule? Why is it necessary?

This rule simplifies and streamlines the two manuals in regards to state plan personal care services. This rule aims to reintegrate Primary Care Providers and expand the assessment tools available in the evaluation process. The rule changes the prior authorization time period from six (6) months to one (1) year. The changes make the manuals easier to use and understand, and result in significant cost savings.

The repeal of the current Personal Care manual also implements Act 853 of 2025. The Act removes private care agency certification to the Department of Health.

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

<https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/>

13. Will a public hearing be held on this proposed rule? Yes ☒ No ☐

If yes, please complete the following:

Date: [11/19/2025](#)

Time: [10:00 am](#)

Place: [ar.gov/dhspublichearings](#)

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. [12/07/2025](#)

15. What is the proposed effective date for this rule? [April 1, 2026](#)

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

[Unknown.](#)

19. Is the rule expected to be controversial? Yes ☐ No ☒

If yes, please explain.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129. The proposed effective date is April 1, 2026.

The Director of the Division of Aging, Adult and Behavioral Health Services proposes a rule revising the Personal Care (PC) Medicaid Provider Manual and Arkansas Independent Assessment (ARIA) Medicaid Provider Manual. This rule repeals the current PC manual and issues a new, simplified, and streamlined one. The changes make the manuals easier to understand, remove overlapping language across programs, and result in significant cost savings. And the repeal implements Act 853 of 2025 which moved private care agency certification to the Department of Health. The projected annual cost savings is (\$6,173,037.00), split equally between the state and federal government.

The updates to the PC manual streamlines it to focus on stand-alone State Plan Personal Care (SPPC), reintegrates Primary Care Providers in the assessment and eligibility process, transitions away from a single assessment tool and replaces it with a functional assessment and treatment plan for SPPC, removes a single contractor for SPPC independent assessments and reassigns that duty to personal care registered nurses, lengthens time for PAs and Extensions of Benefits (EOB) from six months to twelve months, establishes that PAs will remain in place for all populations receiving SPPC Services, clarifies that the sixty-four hours per month service cap will remain, but that youths may receive over sixty-four hours with EOB, and institutes new processes and forms to implement the changes to the program.

Revisions to the ARIA manual include removal of references to SPPC; clarifies that reassessments may be conducted in person or through the use of telehealth; deletes language inconsistent with current processes; creates new sections detailing current process related to referral, tiering and outcomes in the Provider-Led Arkansas Shared Saving Entity program (PASSE) that align with the PASSE Provider manual; removes all references to the Battelle Developmental Screening process; and adds new sections regarding assessments and tier logic for other programs (ARChoices, Living Choices Assisted Living, and Program of All-Inclusive Care for the Elderly) that clarify and detail current practices.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than December 7, 2025. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held by remote access through Microsoft Teams. Public comments may be submitted at the hearing. The details for attending the Microsoft Teams hearing appear at ar.gov/dhspublichearings.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. 4502292178

Jay Hill, Director
Division of Aging, Adult and Behavioral Health Services

From: [Legal Ads](#)
To: [Renita Jones](#)
Cc: [Mac Golden](#); [Jack Tiner](#); [Lakeya Gipson](#); [Elaine Stafford](#)
Subject: Re: Full Run AD (Rule #289)
Date: Thursday, November 6, 2025 2:21:33 PM
Attachments: [image001.png](#)

[EXTERNAL SENDER]

This version is scheduled, instead of the earlier version, for Sat 11/8, Sun 11/9, and Mon 11/10. Thanks.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>
To: "Legal Ads" <legalads@arkansasonline.com>
Cc: "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>, "Renita Jones" <Renita.Jones@dhs.arkansas.gov>
Sent: Thursday, November 6, 2025 2:01:23 PM
Subject: RE: Full Run AD (Rule #289)

Please see attached revised public notice.

Please run the attached ad in the Arkansas Democrat-Gazette on the following days:

- Saturday November 8, 2025
- Sunday November 9, 2025
- Monday November 10, 2025

Thank you,



Renita Jones

Rules and Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.320.3949

Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

Privacy Notice: This email may contain confidential information protected by state/federal laws. If you are not the intended recipient, please let the sender know, and delete the message/attachment(s) from your system.

From: Legal Ads <legalads@arkansasonline.com>

Sent: Thursday, November 6, 2025 1:46 PM

To: Renita Jones <Renita.Jones@dhs.arkansas.gov>

Cc: Mac Golden <Mac.E.Golden@dhs.arkansas.gov>; Jack Tiner <jack.tiner@dhs.arkansas.gov>; Lakeya Gipson <Lakeya.Gipson@dhs.arkansas.gov>; Elaine Stafford <elaine.stafford@dhs.arkansas.gov>

Subject: Re: Full Run AD (Rule #289)

Importance: High

[EXTERNAL SENDER]

I'm sorry, but I've been backlogged this week (computer/email issues), and I'm just now getting to this request.

Unfortunately, deadline for Fri 11/7 was 12 noon yesterday, and I cannot get this in for Fri 11/7.

However, I can still schedule this for Sat 11/8, Sun 11/9, and Mon 11/10.

Please advise ASAP.

My apologies for any inconveniences this has caused.

Thanks,

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>

To: "Legal Ads" <legalads@arkansasonline.com>

Cc: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Wednesday, November 5, 2025 8:15:42 AM
Subject: Full Run AD (Rule #289)

Good morning,

Please Reply to this email using REPLY ALL.

Please run the attached ad in the Arkansas Democrat-Gazette on the following days:

- Friday November 7, 2025
- Saturday November 8, 2025
- Sunday November 9, 2025

A public hearing by remote access only will be held through Microsoft Teams. I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**
OPR, ATTN: Lakeya Gipson
P.O. Box 1437, Slot S295
Little Rock, AR 72203-8068
(Lakeya.Gipson@dhs.arkansas.gov)

Thank you,



Renita Jones

Rules and Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.320.3949

Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

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From: [Renita Jones](#)
To: register@sos.arkansas.gov
Cc: [Renita Jones](#); [Jack Tiner](#); [Mac Golden](#); [Lakeya Gipson](#); [Amanda Cox](#); [JAMIE EWING](#)
Subject: DHS/DAABHS - Proposed Filing - Personal Care and Arkansas Independent Assessment Provider Manuals (Rule #289)
Date: Thursday, November 6, 2025 2:48:00 PM
Attachments: [image001.png](#)
[Initial Filing - Sec. of State - Rule #289.pdf](#)

Good afternoon,

Please see attached proposed filing. The public notice will run:

Saturday, November 8th

Sunday, November 9th

Monday, November 10th

The public comment period will end on December 7th.

Thank you,



Renita Jones

Rules and Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.320.3949

Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

Privacy Notice: This email may contain confidential information protected by state/federal laws. If you are not the intended recipient, please let the sender know, and delete the message/attachment(s) from your system.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services

BOARD/COMMISSION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Updates to the Personal Care and Arkansas Independent Assessment Provider

1. Does this proposed, amended, or repealed rule have a financial impact?
Yes ☒ No ☐
2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
Yes ☒ No ☐
3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

If no, please explain:

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

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

(c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

(d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:
 - (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

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

Current Fiscal Year

General Revenue (\$771,630) _____
 Federal Funds (\$771,630) _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total -\$ 1,543,260.00 _____

Next Fiscal Year

General Revenue (\$3,086,519) _____
 Federal Funds (\$3,086,519) _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total -\$ 6,173,037.00 _____

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

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

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

Current Fiscal Year

\$ -771,630.00 _____

Next Fiscal Year

\$ -3,086,519.00 _____

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

Yes ☐ No ☒

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

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
 - (a) the rule is achieving the statutory objectives;
 - (b) the benefits of the rule continue to justify its costs; and
 - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Statement of Necessity and Rule Summary

Updated Personal Care Manual/Independent Assessment Provider Manual

Statement of Necessity

This rule streamlines the Personal Care (PC) Medicaid Provider Manual and Arkansas Independent Assessment (ARIA) Medicaid Provider Manual. The resulting changes make the manuals easier to understand and use and result in significant cost savings.

The PC manual currently contains information that is beyond the scope of State Plan Personal Care (SPPC). This rule repeals the current PC manual and issues a new, simplified, and streamlined manual to include only information regarding SPPC, as opposed to services contained in waivers to the state plan. These changes dispel confusion among overlapping programs, waivers, and policies, as well as better describe the parameters of SPPC. All removed information has been cross-referenced and linked to other program manuals to ensure availability of services. The rule also separates services for adults from services for those under twenty-one. And the repeal implements Act 853 of 2025 which moved private care agency certification to the Department of Health.

Currently, the functional eligibility process does not include the beneficiary's Primary Care Provider (PCP) in the referral or decision-making regarding functional needs. Instead, a personal care provider makes a referral, then a contractor conducts an assessment, and then another contractor authorizes any resultant needed services. This rule aims to reintegrate the PCP as a core member in the evaluation process. Further, the rule changes the prior authorization (PA) time period from six (6) months to one (1) year. These two revisions will result in lower assessment costs and PA costs.

The ARIA manual currently contains information on how to administer an independent assessment using the standardized ARIA tool which is used to determine functional eligibility for Home and Community Based Services (HCBS). While an independent assessment is mandatory to determine the functional need for state plan HCBS benefit, a standardized assessment tool (like ARIA) is not required (see 42 CFR Section 441.720). Accordingly, this rule removes the personal care section from the ARIA manual for consistency with the changes summarized above and confirms that use of the ARIA tool is not required. Instead, other approved independent assessment tools may be utilized to determine functional eligibility.

The other change being made to the ARIA Manual is the addition of explicit sections that describe how to administer an independent assessment using the standardized ARIA tool for Arkansas' aging waivers (ARChoices, Living Choices Assisted Living, and Program of All-Inclusive Care for the Elderly (PACE)). This is a needed update of the ARIA Manual to include information on how the ARIA is utilized for those aging waivers. These processes are already in practice but were not previously included in this manual.

Summary of Changes

Personal Care Manual:

- Repeals the currently promulgated Personal Care Medicaid Manual and creates a new version.
- Streamlines the manual to focus on stand-alone SPPC;
- Mandates that Primary Care Providers initiate and finalize the approval of medical eligibility for SPPC;
- Transitions away from the ARIA tool as the medical and functional assessment test for SPPC and replace it with the functional assessment and treatment plan for SPPC.
- Removes the contractor Optum as the party that performs SPPC independent assessments and reassign that duty to personal care registered nurses;
- Lengthens time for PAs and Extensions of Benefits (EOB) from six (6) months to twelve (12) months;
- Establishes that PAs will remain in place for all populations receiving SPPC Services;
- Clarifies that the sixty-four (64) hours per month service cap will remain, but that youths may receive over sixty-four (>64) hours per month with EOB;
- Updates processes to implement the following: (1) the Primary Care Provider (PCP) must complete form 618-ER to request an evaluation to initiate an assessment of functional need; (2) a registered nurse with the personal care provider will conduct an in-person assessment of the beneficiary's functional needs utilizing a DHS-approved tool; (3) the Primary Care Provider (PCP) shall complete Form 618-TP to approve the assessment and it will act as a prescription for treatment for the year; and (4) requires all forms be submitted for prior authorization.

ARIA Manual

- Removes reference to SPPC in § 201.000;
- Adds new sections regarding assessments and Tier Logic Tables for the ARChoices (§ 230.000 et seq.), Living Choices Assisted Living (§ 240.000 et seq.), and PACE (§ 250.000 et seq.). *Note:* The new sections explain the independent assessment processes that already are in practice and do not constitute new processes.

Post Public Comment Revisions

The following lists updates to the rule in response to public comments received. During the process, DHS also corrected typographic errors identified internally or by the Bureau of Legislative Research staff.

1. 200.100 Section C.2:
 - Reworded to name the other provider types that can be included: "Obtain a license as a private care agency, and/or be a certified Home Health Agency Class A or B; Assisted Living Facility (ALF) I; or Residential Care Facility (RCF)";
2. 215.400 Section B.1:
 - Reworded to 20 years of age "and under";
3. 215.400 Section E.1:
 - Added clarifying phrase "before the expiration of the current Functional Assessment & Treatment Plan";
4. 220.200 Section A:
 - Struck incorrect numbering not present in this manual; replaced with "220.300";
5. 220.200 Section B.2:
 - Struck incorrect numbering not present in this manual; replaced with "section 140.000 of this Medicaid manual";
6. 220.300 Section A:
 - Changed "and" to "or" in sentence defining personal care services (This is as per CMS guidance in "Preventing Medicaid Improper Payments for Personal Care

services” <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-booklet.pdf> (p. 4 *Description*); and

- Included reference to CMS statute 42 C.F.R. § 441.505 that defines activities of daily living or instrumental activities of daily living;
7. 220.300 Section B.12: Struck incorrect numbering not present in this manual; replaced with “220.400”;
 8. 220.300 Section D: Struck incorrect numbering not present in this manual; replaced with “205.200”;
 9. 220.300 Section E:
 - In response to request from public comments, re-inserted definition (in currently promulgated manual) to clarify and define ‘qualified supervisor’. “A qualified supervisor must be a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.”;
 10. 220.400 Section B:
 - Closed brackets at end of subdivision;
 11. 220.400 Section E:
 - In response to request from public comments, re-inserted transportation rules (in currently promulgated manual) and this original section was referenced by #7 in the list above, and thus needed to be re-added for clarification purposes;
 - Corrected use of colons, semicolons and periods for stylistic consistency; and
 - Spelled out twenty-one and added parenthesis around digits;
 12. 220.700 Section A
 - Added “RCFs or ALF I’s” to the sentence- “This section does not apply to school-based personal care providers, RCFs or ALF I’s.”;
 13. 220.700 Section B:
 - Struck incorrect numbering not present in this manual;
 14. 220.700 Section C.3:
 - Amended phrasing to read “until the last day of the second month”;
 - Amended example to read “until June 30th so new provider can begin services July 1st”;
 15. 220.700 Section D:
 - Added “and” between the two listed items;
 15. 230.300 Section B
 - Struck repeated sentences in middle of paragraph as they are already present at end of paragraph; and
 - added numerical (30) before “calendar days”;
 16. 250.000 Reimbursement Section – In response to requests from public comments emphasizing need for clarification regarding billing and rounding, DHS restores currently promulgated rules which necessitated reorganization and renumbering of 250.000 throughout as follows:
 - 250.100: deleted “A” and “B” as those processes are now covered and expanded in restoration of currently promulgated rules now found in sections 250.200, 250.300, and 250.440;
 - 250.100: Maintained currently proposed language formerly in “C” parts 3-7 and renumbered 250.100 accordingly;
 - Added 250.200 Unit Billing, 250.300 Calculating Units, and 250.400 Rounding into proposed rule (these sections were copied from the current rule manual being repealed found in sections 262.310, -311, and -312); and
 - Renumbered Fee Schedules and Electronic Visit Verification sections as 250.500 and 250.600 respectively.

SECTION II – STATE PLAN PERSONAL CARE

CONTENTS

TOC required

200.000 GENERAL INFORMATION

200.100 Participation Requirements for State Plan Personal Care Providers **4-1-26**

- A. State Plan Personal Care providers are designated high-risk providers based on the lack of licensure or certification from the Department of Human Services and the potential for fraud, waste, and abuse. As such, and as a condition of enrollment in the Arkansas Medicaid program, Arkansas Medicaid requires State Plan Personal Care providers to have:
1. On-site visits conducted by Arkansas Medicaid in accordance with 42 CFR 455.432, which includes pre-enrollment and post enrollment site visits as well as unannounced on-site inspections of any provider location.
 2. Federal fingerprint-based checks in accordance with 42 CFR 455.434 and 42 CFR 455.50(c). All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq.
- B. Each employee must successfully pass the following:
1. A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann. § 20-38-103;
 2. An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;
 3. An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;
 4. An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and
 5. At least a five (5) panel drug screen upon hiring and prior to any contact with clients, and as required thereafter by Ark. Code Ann. §20-77-128(b).
- C. A provider must meet the following participation requirements to qualify as a State Plan Personal Care provider under Arkansas Medicaid:
1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual; and
 2. Obtain a license as a private care agency, or be a certified Home Health Agency Class A or B; Assisted Living Facility (ALF) I; or Residential Care Facility (RCF).

200.200 Participation Requirements for Personal Care Providers that are School Districts or Education Service Cooperatives **4-1-26**

- A. A school district or education service cooperative must meet the following participation requirements to qualify as a State Plan Personal Care provider under Arkansas Medicaid.
1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual; and
 2. Be certified as a Local Educational Agency (LEA) by the Arkansas Department of Education.

3. School personnel providing billable Personal Care services must be trained and certified by the Division of Elementary and Secondary Education (DESE).

200.300 Personal Care Services at School

4-1-26

- A. Beneficiaries under the age of twenty-one (21) may receive personal care services when attending school. For these purposes:
1. A "school" is an entity accredited by the Arkansas Department of Education to provide elementary or secondary education services;
 2. A school setting is not limited to just the school-building or campus as long as the setting is related to the beneficiary's receipt of educational services from the school (i.e. attending a field trip to a museum);
 3. The beneficiary's home is not considered a "school" place of service when a parent elects to home school.
- B. Medicaid Program requirements are the same as for services delivered in the beneficiary's home.
- C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the beneficiary receives services.
- D. Beneficiaries receiving personal care in schools may receive a number of services in accordance with an Individualized Education Program (IEP).
1. The IEP may not supersede or substitute for the personal care treatment plan.
 2. The Personal Care Program requires a distinct and separate assessment and treatment plan.

200.400 Out-of-State Limited Services Personal Care Providers

4-1-26

Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and they have a claim or claims to file with Arkansas Medicaid. To enroll, providers must download an Arkansas Medicaid application and contract from the DMS website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. **View or print the provider enrollment and contract package (Application Packet).** A provider number will be assigned upon approval of the provider application and Medicaid contract. **View Medicaid Provider Enrollment Unit contact information.**

205.000 PERSONAL CARE AIDE PARTICIPATION REQUIREMENTS

205.100 Personal Care Aide Participation Requirements

4-1-26

205.200 Personal Care Aide

4-1-26

An individual must meet the following requirements to serve as a personal care aide for a personal care services provider:

- A. Have one of the following active certifications in good standing:
1. Certified Nursing Assistant (CNA);
 2. Home Health Aide; or
 3. Certified Personal Care Aide;

- B. Enroll as an Arkansas Medicaid rendering provider unless employed as school personnel and certified by the Division of Elementary and Secondary Education (DESE).
- C. School personnel providing billable school-based Personal Care services must be trained and certified by the Division of Elementary and Secondary Education (DESE).

210.000 DOCUMENTATION REQUIREMENTS

210.100 Documentation Requirements for all Medicaid Providers

4-1-26

See section 140.000 of this Medicaid manual for the documentation that is required for all Arkansas Medicaid providers.

210.200 State Plan Personal Care Provider Documentation Requirements

4-1-26

- A. State Plan Personal Care providers must maintain in each beneficiary's service record:
 - 1. The beneficiary's:
 - a. Applicable medical records;
 - b. Age and Date of Birth;
 - c. Medicaid ID number;
 - d. The initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP) (see section 212.200);
 - e. All treatment prescriptions (see section 212.300);
 - f. All DMS-618 functional assessments;
 - g. All treatment plans;
 - h. Frequency of In-home Supervisory visits; and
 - i. Discharge notes and summary, if applicable.
 - 2. Treatment plan service log documentation, which must be completed at the time-of-service delivery and at a minimum include:
 - a. Beneficiary name;
 - b. Beneficiary's Medicaid ID number and date of birth;
 - c. The date and beginning and ending time for each personal care service performed each day;
 - i. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.
 - ii. It is not necessary to itemize the time spent on each activity of daily living (ADL) or instrumental activity of daily living (IADL) task for a given beneficiary, provided these tasks were performed by the same personal care aide on the same visit on the same day and at the same location;
 - iii. If the personal care aide discontinues or interrupts the beneficiary's service-plan-required activities at one location to begin service-plan-required activities at another location, the aide must record the beginning and ending times of service at each location.
 - iv. If a personal care aide does not perform a scheduled treatment plan task, the personal care aide must document and justify why the task was not performed as scheduled;
 - d. The location where the service was performed;
 - e. Any service performance difficulties;
 - f. Notes on the beneficiary's condition or other data or criteria required by the

treatment plan;

g. When an emergency or special circumstances requires a personal care aide to perform a task not included on the personal care treatment plan, documentation describing:

i. The nature of the emergency or special situation;

ii. The action or task required to resolve the emergency or special situation;

iii. The date, start time, end time, location, nature and scope of the unscheduled task performed;

iv. When supervisor approval for the unscheduled task was obtained; and

v. If supervisor approval was not obtained prior to performing the unscheduled task, justification for why pre-approval was not possible

h. Name(s), credential(s), and signature(s) of the personal care aide who performed the service; and

3. Weekly or more frequent progress notes outlining the condition of the beneficiary;

4. If service delivery involves delivering services to multiple beneficiaries, the following additional service log documentation requirements apply:

a. When service delivery involves two (2) beneficiaries concurrently (i.e. cleaning a bathroom shared by two beneficiaries), then the personal care aid must also document in each beneficiary's service delivery log the name of the other individual who received the concurrent personal care service;

b. When service delivery is in a congregate setting (i.e. involves more than two (2) beneficiaries), then the personal care aide must:

i. Record the date and time the congregate service began and ended; and

ii. The name of each individual who received congregate services;

c. The provider must equally split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took twenty (20) minutes, the personal care aide would document ten (10) minutes to each beneficiary for the service).

B. Every personal care provider must maintain the required employment, certification, and licensure records for all individuals employed or contracted to provide personal care services on behalf of the provider. If an individual performs personal care services on behalf of a personal care provider pursuant to a contract, then a copy of the contractual agreement must be maintained.

210.300 Electronic Signatures

4-1-26

Arkansas Medicaid will accept electronic signatures in compliance with Arkansas Code Ann. § 25-31-103 et seq.

215.000 PROGRAM ELIGIBILITY

215.100 Scope

4-1-26

Arkansas Medicaid will reimburse enrolled providers for covered personal care services when such services are provided to a treatment plan to beneficiaries who meet the eligibility requirements of this Medicaid manual. Medicaid reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

215.200 Beneficiary Eligibility Requirements

4-1-26

215.300 Evaluation Referral

4-1-26

- A. Personal Care services require an initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP).
- B. An initial evaluation referral for personal care services is required to be on a DMS-618 ER "State Plan Personal Care Services Initial Evaluation Referral." **View or print the form DMS-618 ER.**
- C. A DMS-618 ER evaluation referral is only required to perform a beneficiary initial evaluation for state plan personal care services.
- D. No DMS-618 ER is required for a provider to perform the annual functional needs assessment necessary to demonstrate a beneficiary's continued eligibility for state plan personal services, unless there is a significant break in services. A significant break in service is defined as not receiving state plan personal care within the prior one hundred twenty (120) days.

215.400 Functional Needs Assessment**4-1-26**

- A. Personal care services must be medically necessary as demonstrated by the results of an annual functional needs assessment.
 - 1. A diagnosis alone is not sufficient to demonstrate medical necessity.
 - 2. A beneficiary is no longer eligible for personal care services if the annual functional needs assessment demonstrating medical necessity in accordance with this section 212.200 is not renewed within twelve (12) months.
- B. A functional needs assessment for personal care services must be completed using the approved DHS functional assessment form:
 - 1. A beneficiary twenty (20) years of age **and under** must use the "Youth Personal Care Functional Assessment & Treatment Plan" (**View or print the Youth Personal Care Functional Assessment & Treatment Plan**); and
 - 2. A beneficiary twenty-one (21) years of age or older must use the "Adult Personal Care Functional Assessment & Treatment Plan" (**View or print the Adult Personal Care Functional Assessment & Treatment Plan**).
- C. All Personal Care Functional Assessment & Treatment Plan functional needs assessments must be completed, signed, and dated by a licensed Registered Nurse.
- D. All aspects of the Assessment for personal care services, including the administration, must be communicated and conducted in the beneficiary's primary or preferred language.
- E. A new Personal Care Functional Assessment & Treatment Plan is not required when a beneficiary:
 - 1. Transitions from one personal care provider to another personal care provider **before the expiration of the current Functional Assessment & Treatment Plan; or**
 - 2. Changes primary care providers.

215.500 Treatment Prescription**4-1-26**

- A. Personal care services require a treatment prescription signed by the beneficiary's primary care provider (PCP). The frequency, intensity, and duration of the prescribed personal care services must be medically necessary based on the results of the assessment and realistic for the age of the beneficiary.
- B. A treatment prescription for personal care services is valid for one (1) year unless a short period is specified on the treatment prescription.

- C. A treatment prescription for personal care services must be on form DMS-618 TP "State Plan Personal Care Services Treatment Prescription." **View or print form DMS-618 TP.**
- D. An existing treatment prescription would remain valid through its date of expiration and a new DMS-618 TP treatment prescription is not required when a beneficiary:
 - 1. Changes PCPs; or
 - 2. Transitions from one personal care provider to another personal care provider.

220.000 PROGRAM SERVICES

220.100 Non-covered Services

4-1-26

- A. Personal care services can only supplement, and are prohibited from being used to supplant, otherwise available beneficiary resources.
- B. Personal care cannot be provided to individuals:
 - 1. Admitted to an inpatient hospital,
 - 2. Admitted to a nursing facility,
 - 3. Enrolled in the Living Choices Waiver
 - 4. Admitted to intermediate care facility for individuals with intellectual disabilities (ICF/IID); or
 - 5. Admitted to an institution for mental diseases (IMD).
- C. Arkansas Medicaid will not reimburse for personal care services performed by a member of the beneficiary's family. The following individuals are considered a member of the beneficiary's family:
 - 1. A spouse.
 - 2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent.
 - 3. Legal guardian of the person of the beneficiary; and
 - 4. Attorney-in-fact granted authority to direct the beneficiary's care.
- D. Arkansas Medicaid will not reimburse for personal care services delivered via telehealth. Telehealth means the use of electronic documentation and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a beneficiary.

220.200 Covered Services

4-1-26

- A. Arkansas Medicaid will only reimburse for the personal care services listed in Section **220.300** delivered in a manner in compliance with the treatment plan and this Medicaid manual, manual update transmittals, and official program correspondence.
- B. A provider of personal care services must contract with or employ the personal care aides that perform personal care services on its behalf.
 - 1. The provider must identify the personal care aide performing the personal care services as the performing provider on the claim when billing Arkansas Medicaid for the service.
 - 2. Each personal care aide listed as the performing provider on a personal care provider claim must be enrolled with Arkansas Medicaid, as per section **140.000** of this Medicaid manual.

220.300 Personal Care Services**4-1-26**

- A. Personal care services are medically necessary services that assist a beneficiary with assessed physical dependency needs in the performance of their routine activities of daily living or instrumental activities of daily living. 42 C.F.R. § 441.505
- B. A personal care provider may be reimbursed for performing the following medically necessary personal care services in accordance with the beneficiary's treatment plan:
1. Bathing;
 2. Dressing;
 3. Feeding/eating;
 4. Grooming;
 5. Toileting;
 6. Transferring;
 7. Walking;
 8. Cleaning;
 9. Laundry;
 10. Preparing meals;
 11. Shopping; and
 12. Transportation to and from employment (or seeking employment) that meets the requirements of section 220.400 of this Medicaid manual (no mileage costs associated with the transportation would be covered).
- C. Medical necessity for personal care services is established by:
1. The results of Personal Care Functional Assessment & Treatment Plan completed in accordance with this Medicaid manual; and
 2. A treatment prescription on a DMS-618 TP "State Plan Personal Care Services Treatment Prescription." **View or print form DMS-618 TP.**
- D. All personal care services must be performed by a certified personal care aide. See section 205.200 of this Medicaid manual.
- E. The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered. A qualified supervisor must be a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.
1. The qualified supervisor must complete the following at least monthly:
 - a. Review the beneficiary's service delivery logs and documentation;
 - b. Document the time and date of their service documentation review;
 - c. Actively train or assist assigned personal care aide with personal care service delivery when necessary;
 - d. Document any training or assistance provided to an assigned personal care aide.

2. A supervising registered nurse must conduct an on-site evaluation of a day's service delivery to a beneficiary as required in the treatment plan, but no less often than annually. On each on-site evaluation, the supervising registered nurse must
 - a. Observe and document:
 - i. The condition of the beneficiary;
 - ii. The type and quality of the personal care aide's service provision;
 - iii. The interaction and relationship between the beneficiary and the personal care aide; and
 - iv. Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.
 - b. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
 3. An individual who provides personal care services to a beneficiary may not supervise another personal care aide providing personal care services to that same beneficiary.
- F. A provider must obtain the following before initiating a permanent change to personal care service delivery:
1. A registered nurse must complete an updated Personal Care Functional Assessment & Treatment Plan; and
 2. Obtain a new DMS-618 TP treatment prescription
- G. Personal care services are reimbursable on a per unit basis. See section 230.000 of this Medicaid manual regarding submitting a request for a prior authorization.

220.400 Employment-Related Personal Care Outside the Home**4-1-26**

Outside of the home personal care services may be included in a beneficiary's treatment plan when it allows a beneficiary to obtain or retain employment and each of the following requirements are met:

- A. The beneficiary is sixteen (16) years of age or older;
- B. The beneficiary must be "disabled" as defined by Social Security/SSI [20 CFR 404.1505];
- C. The beneficiary must be working (or be actively seeking employment where they would be working):
 1. At least forty (40) hours per month; and
 2. In an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability); and
- D. The beneficiary is earning at least minimum wage (or be actively seeking employment that pays at least minimum wage);
- E. Employment-related personal care associated with transportation is covered as follows:
 1. Aides may assist beneficiaries with transportation to and from work or job-seeking and during transportation to and from work or for job-seeking;
 2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; in the service plan and all pertinent service documentation;
 3. Medicaid does not cover mileage associated with any personal care service;

4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is included in the 64-hour per month personal care benefit limit for beneficiaries aged twenty-one (21) and older.

220.500 Personal Care Services at School**4-1-26**

- A. Beneficiaries under the age of twenty-one (21) may receive personal care services when attending school. For these purposes:
 1. A "school" is an entity accredited by the Arkansas Department of Education to provide elementary or secondary education services;
 2. A school setting is not limited to just the school-building or campus as long as the setting is related to the beneficiary's receipt of educational services from the school (i.e. attending a field trip to a museum);
 3. The beneficiary's home is not considered a "school" place of service when a parent elects to home school.
- B. All other aspects of personal care service delivery at school are the same as for personal care services delivered at the beneficiary's home.

220.600 Concurrent Treatment Service Delivery by Different Providers**4-1-26**

Personal care services must be delivered by a single provider, unless a beneficiary is receiving personal care services outside the home as permitted in sections 223.000 and 224.000 of this Medicaid manual, in which case a second provider may deliver those allowable outside the home personal care services included in the beneficiary's treatment plan.

220.700 Transitioning Personal Care Providers**4-1-26**

- A. This section does not apply to school-based personal care providers, RCFs, or ALF I's.
- B. A beneficiary has freedom of choice in selecting a personal care provider. However, the requirements of this section must be followed to ensure the continuity and smooth transition of personal care services when a beneficiary selects a new personal care provider.
- C. Personal Care providers must comply with each of the following when a beneficiary elects to transition from one provider to another:
 1. The beneficiary or, if applicable, the beneficiary's parent or legal guardian, must complete a personal care provider transition request form. **View or print a Personal Care Provider Transition Request form.**
 2. The newly selected personal care provider must:
 - a. Notify the current provider of the beneficiary's decision to switch personal care providers; and
 - b. Deliver the current provider a copy of the completed Personal Care Provider Transition Request form.

The new provider should maintain verifiable proof of the date and method of its required notification and transition request form delivery.

3. The current personal care service provider will continue to provide services to the beneficiary in accordance with this Medicaid manual **until the last day of the second month** after the month the new provider completed the notification and delivery requirements in subpart (2.) directly above (i.e. if notified on May 11th, then current provider would continue providing personal care services **until June 30th so new provider can begin services July 1st).**

- a. The current provider is responsible for forwarding the beneficiary's complete service record to the newly selected personal care provider before the current provider's last day of service, as described in subpart (3.) directly above.
 - b. The beneficiary's complete service record includes, at minimum: The beneficiary's signed 618-ER; the beneficiary's active current Assessment and Treatment Plan; the beneficiary's active, signed 618-TP.
- D. Switching from one personal care provider to another personal care provider does not automatically require a new:
- 1. Treatment prescription; and
 - 2. Functional needs Assessment and Treatment Plan.

230.000 PRIOR AUTHORIZATION

- A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries.
- B. Prior authorization does not guarantee payment for the service.
 - 1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.
 - 2. The provider must follow the billing procedures in this manual.
- C. A Personal Care Functional Assessment & Treatment Plan is the assessment instrument used by registered nurses of personal care providers to collect information used in determining the beneficiary's physical dependency needs for hands-on services and in calculating the number of personal care hours that can be requested for the beneficiary. This Personal Care Functional Assessment & Treatment Plan must be accompanied by an approved Treatment Prescription from the beneficiary's Primary Care Provider (PCP).

230.100 Prior Authorization Responsibility

4-1-26

- A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization (PA) of personal care services for beneficiaries.
- B. DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's completed Functional Assessment & Treatment Plan and the PCP's Treatment Prescription submitted for personal care services. Based on the information within, they prior authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.
- C. DHS professional staff or contractor(s) designated by DHS have a right to review the beneficiary's medical information.

230.200 Personal Care PA Request Procedure

4-1-26

- A. Providers must use the form designated by DHS to request PA.
 - 1. **View or print the form designated by DHS (English)** (PA request on last page).
 - 2. **View or print the form designated by DHS (Spanish)** (PA request on last page).
- B. Providers should submit prior authorization forms to the contractor(s) designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff.

- C. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals will be retroactive to the beginning date of service if the request is received within the 30-day time frame.
- D. There will be no prior authorization, including any retroactive prior authorization, if the beneficiary is assessed to not require medically necessary services.

230.300 Provider Prior Authorization Notification Procedure**4-1-26**

Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

- A. For approved cases, an approval letter will be mailed to the requesting provider, detailing the procedure codes approved, total number of service time increments, beginning and ending dates and the authorization number.
- B. For denied or partially denied cases, a denial letter with reason for denial will be mailed to the beneficiary and the requesting provider. The letter shall specify why the prior authorization request was denied or partially denied and shall give the beneficiary notice of the right to file a request for a fair hearing and where to file the request. Reconsideration of the denial may be requested within thirty (30) calendar days of the denial date. **Requests for reconsideration must be made in writing and include additional documentation.**

230.400 Duration of Prior Authorization**4-1-26**

Personal Care PAs are generally assigned for twelve (12) months from the date of the last Treatment Prescription signed by the beneficiary's Primary Care Provider, or for the life of the Treatment Plan, whichever is shorter, unless the beneficiary has a change in condition.

230.500 Administrative Reconsideration and Appeals**4-1-26**

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

230.600 Reserved**4-1-26****240.000 EXTENSION OF BENEFITS****240.100 Extension of Benefits for Personal Care Services****4-1-26**

- A. If a beneficiary requires more hours of personal care than what has been prior authorized on their Treatment Plan, the personal care provider can submit a request for an extension of benefits for medically necessary personal care services.
- B. For beneficiaries twenty (21) years of age and older, the maximum monthly limit for state plan personal care is two hundred fifty-six (256) units per month. If an adult beneficiary requires more extensive care, the beneficiary should apply for HCBS Waiver services. See: <https://humanservices.arkansas.gov/newsroom/hcbs>
- C. For beneficiaries twenty (20) years of age and younger, the maximum monthly limit for state plan personal care noted in part B can be exceeded if determined medically necessary. Medicaid Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)

mandates coverage of all services that are medically necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions (42 U.S.C. § 1396d(r)).

250.000 REIMBURSEMENT

250.100 Reimbursement Methods

4-1-26

- A. Concurrent billing is not allowed unless specifically permitted herein. It is considered concurrent billing when multiple practitioners bill Medicaid for services provided to the same beneficiary during the same time increment.
- B. Rest, toileting, or other break times between service delivery is not billable.
- C. Time spent on documentation alone is not billable as a treatment service.
- D. Providers may bill the total units of service for a single date of service but may not bill for units of service that span over more than one date of service. Each calendar date must be billed separately. For example, a provider may provide personal care services to an eligible beneficiary on Monday and then again on Tuesday. The provider may, then, bill for the total amount of time spent on Monday and a separate claim-line, or separate claim, for the total amount of time spent on Tuesday, but may not bill for the total amount of time spent both days on a single claim-line.

250.200 Unit Billing

4-1-26

- A. Fifteen (15) minutes of authorized, documented and logged personal care equals one unit of personal care aide service.
- B. Providers may not bill for less than fifteen (15) minutes of service; however personal care aides' time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day, and the sum—in minutes—divided by 15 to calculate the number of units of service provided during that day.
- C. The estimated daily maximum service time in the beneficiary's service plan is the upper limit for daily billing.
- D. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary.
- E. There is no "carryover" of time from one day to another or from one beneficiary to another.
- F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

250.300 Calculating Units

4-1-26

- A. Personal Care providers must bill Medicaid by 15-minute units.
- B. Total the daily personal care service-time for a single beneficiary in minutes, using the beginning and ending service times from the service logs.
- C. Set your calculator to compute to three decimal places.
- D. Divide the total time (expressed in minutes) by fifteen and
- E. Bill for the lesser of:

1. The rounded, whole-number quotient of the division or
2. The maximum time estimate in the service plan.

250.400 Rounding**4-1-26**

When a quotient contains decimals, look at the numbers after the decimal point.

- A. If the number after the decimal point is 500 (e.g., 3.500) or less (e.g., 3.495) round downward to the whole number displayed before the decimal point (3, in this example)
- B. If the number after the decimal is 501 (e.g., 3.501) or greater (e.g., 3.576) round upward to the whole number one greater than the whole number displayed before the decimal point (4 in this example, because it is a whole number one greater than 3).

250.500 Fee Schedules**4-1-26**

Arkansas Medicaid provides **fee schedules on the DMS website**. The fees represent the fee-for-service reimbursement methodology.

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

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

250.600 Electronic Visit Verification (EVV)**4-1-26**

- A. In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) has implemented electronic visit verification (EVV) for in-home personal care services paid by Medicaid. Refer to **Provider Manual Section I, General Policy**, subsection 145.000 for complete EVV requirements regarding personal care services.
- B. An EVV system is a telephone, computer, or other technology-based system under which visits conducted as part of personal care services.
- C. All personal care services are electronically verified with respect to:
 1. The type of service(s) performed;
 2. The individual receiving the service(s);
 3. The date of the service(s);
 4. The location of service delivery;
 5. The individual providing the service(s); and
 6. The time the service(s) begins and ends.
- D. The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

TOC required**201.000 Arkansas Independent Assessment (ARIA) System Overview****44-1-246**

The Arkansas Independent Assessment (ARIA) system is comprised of several parts that are administered through separate steps for each eligible Medicaid individual served through one of the state's waiver programs ~~or state plan Personal Care services~~. The purpose of the ARIA system is to perform a functional-needs assessment to assist in the development of an individual's Person-Centered Service Plan (PCSP), ~~Personal Care services plan~~ and for certain populations to establish the per member per month payment to a managed care entity. As such, it assesses an individual's capabilities and limitations in performing activities of daily living, including bathing, toileting, and dressing. It is not a medical diagnosis, although the medical history of an individual is an important component of the assessment as a functional deficiency may be caused by an underlying medical condition. In the case of an individual in need of behavioral health services, or waiver services, the independent assessment does not determine whether an individual is Medicaid eligible. That determination is made prior to and separately from the assessment of an individual.

Federal statutes and regulations require states to use an independent assessment for determining eligibility for certain services offered through Home and Community-Based Services (HCBS) waivers. It also is important to Medicaid beneficiaries and their families that any type of assessment is based on tested and validated instruments that are objective and fair to everyone. In 2017, Arkansas selected the ARIA system. It has been phased in over time for different population groups. When implemented for a population, the ARIA system replaces and voids any previous IA systems.

The ARIA system is administered by a vendor under contract with the Arkansas Department of Human Services (DHS). The basic foundation of the ARIA system is MnCHOICES, a comprehensive functional assessment tool originally developed by state and local officials in Minnesota for use in assessing the long-term services and supports (LTSS) needs of elderly individuals. Many individuals with developmental disabilities (DD)/intellectual disabilities (ID) and individuals with severe behavioral health needs also have LTSS needs. Therefore, the basic MnCHOICES tool has common elements across the different population groups. DHS and its vendor further customized MnCHOICES to reflect the Arkansas populations.

The assessment is administered by professional assessors who have successfully completed the vendor's training curriculum. The assessor training is an important component of ensuring the consistency and validity of the tool. The assessment tool is a series of more than 300 questions that might be asked during an in-person interview. The interview may include family members and friends as well as the Medicaid beneficiary. How a question is answered may trigger another question. Responses are weighted based on the service needs being assessed. The MnChoices assessment is computerized and uses computer program language based on logic (an algorithm) to generate a tier assignment for each individual. An algorithm is simply a sequence of instructions that will produce the exact same result to ensure consistency and eliminate interviewer bias. [Reassessments may be conducted in person or through the use of telehealth.](#)

The results of the assessment are provided to the individual and program staff at DHS. The results packet includes the individual's tier result, scores, and answers to all questions asked during the assessment. [Click here to see an example results packet.](#) Individuals can review those results and may contact the appropriate division for more information on their individual results, including any explanations for how their scores were determined. Depending upon which program the individual participates in, the results also may be given to service providers. The results will assign an individual into a tier which subsequently is used to develop the individual's PCSP. The tiers and tiering logic are defined by DHS and are specific to the population served. DHS and the vendor provide internal quality review of the assessment results as part of the

overall process. The tier definitions for each population group/waiver group are available in the respective section of this Manual. In the case of an individual whose services are delivered through the Provider-led Arkansas Shared Savings Entity (PASSE); the tier is used in the determination of the actuarially sound global payment made to the PASSE. ~~Beginning January 1, 2019, e~~Each PASSE is responsible for its network of providers and payments to providers are based on the negotiated payment arrangements.

~~For beneficiaries receiving state plan personal care, the assessment results determine initial eligibility for services, then are used to inform the amount of services the beneficiary is to receive.~~

For beneficiaries who receive HCBS services, the assessment results are used to develop the PCSP with the individual Medicaid beneficiary. ~~and establishes the per member per month payment to a managed care entity. The Medicaid beneficiary (or a parent or guardian on the individual's behalf) will sign the PCSP. Depending upon which program the individual participates in, department staff or a provider is responsible for ensuring the PCSP is implemented.~~ The DHS ARIA vendor does not participate in the development of the PCSP, nor in the provision of services under the approved plan.

There are four key features of every HCBS waiver:

- A. It is an alternative to care in an institutional setting (hospital, nursing home, intermediate care facility for individuals with developmental disabilities), therefore the individual must require a level of services and supports that would otherwise require that the individual be admitted to an institutional setting;
- B. The state must assure that the individual's health and safety can be met in a non-institutional setting;
- C. The cost of services and supports is cost effective in comparison to the cost of care in an institutional setting; and;
- D. The PCSP should reflect the preferences of the individual and must be signed by the individual or the individual's designee.

~~The PCSP, as agreed to by the Medicaid beneficiary, therefore represents the final decision for setting the amount, duration, and scope of HCBSs for that individual.~~

201.100 — Developmental Screen Overview

4-1-24

~~Additionally, the vendor will perform developmental screens for children seeking admission into an Early Intervention Day Treatment (EIDT) program, the successor program to Developmental Day Treatment Clinic Services (DDTCS) and Child Health Management Services (CHMS) described in Act 1017 of 2013. Ark. Code Ann. § 20-48-1102.~~

~~The developmental screen is the Battelle Developmental Inventory screening tool, which is a norm-referenced tool commonly used in the field to screen children for possible developmental delays. The state has established a broad baseline and will use this tool to screen children to determine if further evaluation for services is warranted. The screening results can also be used by the EIDT provider to further determine what evaluations for services a child should receive.~~

~~The developmental disabilities screening process will sunset April 1, 2024.~~

210.100 Referral Process

41-1-246

Independent ~~a~~Assessment (IA) referrals are initiated by the Division of Aging, Adult, and Behavioral Services (DAABHS) and Behavioral Health (BH) ~~s~~Service providers identifying an beneficiary individual who may require services in addition to behavioral health counseling services and medication management. ~~Requests for functional assessment shall be transmitted~~

to the Department of Human Services (DHS) or its designee. Supporting documentation related to treatment services necessary to address functional deficits may be provided.

DHS or its designee will review the request and make a determination to either:

- A. Finalize a referral and send it to the vendor for a BH independent assessment
- B. Provide notification to the requesting BH service provider that more information is needed
- C. Provide notification to the requesting entity

Reassessments will occur annually unless a change in circumstances requires a new assessment. A reassessment will be completed by staff employed by the independent assessment contractor utilizing the current approved assessment instrument (ARIA), which was approved prior to April 1, 2021, to assess functional need. An interview will be conducted in person for initial assessments, with the option of using telemedicine to complete Behavioral Health reassessments. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

210.300 Tiering

14-1-246

- A. Tier Definitions:
 1. Tier 1 ~~means~~ indicates the score reflected that the individual can continue Counseling and Medication Management services but is not eligible for the additional array of services available in Tier 2 ~~or~~ and Tier 3.
 2. Tier 2 ~~means~~ indicates the score reflected difficulties with certain functional behaviors allowing eligibility for a full array of ~~non-residential~~ services to help the ~~beneficiary individual~~ function in home and community settings and move towards recovery.
 3. Tier 3 ~~means~~ indicates the score reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the individual move towards reintegrating back into the community, function in home and community settings, and including 24 hours a day/7 days a week residential services, to help the beneficiary move towards recovery ~~reintegrating back into the community.~~
- B. Tier Logic
 1. Beneficiaries aged 18 and over

	Tier 1 – Counseling and Medication Management Services	Tier 2 – Counseling, Medication Management, and Support Services	Tier 3 – Counseling, Medication Management, Support, and Residential Services
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score of 4 AND Intervention Score of 1 or 2 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others,	Mental Health Diagnosis Score of 4 AND Intervention Score of 3 or 4 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others,

		Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA	Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 4 or 5 in any ONE of the following Psychosocial Subdomains: Difficulties Regulating Emotions Susceptibility to Victimization Withdrawal Agitation Impulsivity Intrusiveness	
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> Intervention Score of 1, 2, 3 or 4 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5 in the following Psychosocial Subdomain: Psychotic Behaviors	
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> Intervention Score of 4 <u>AND</u> Frequency Score of 4 or 5 in the following Psychosocial Subdomain: Manic Behaviors	

		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> PHQ-9 Score of 3 or 4 (Moderately Severe or Severe Depression) <u>OR</u> Geriatric Depression Score of 3 $\Rightarrow (\geq 10)$	
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> Substance Abuse or Alcohol Use Score of 3	

When you see “**AND**”, this ~~means~~ indicates you must have a score in this area **AND** a score in another area. When you see “**OR**”, this ~~indicates~~ means you must have a score in this area **OR** a score in another area.

2. Beneficiaries Under Age 18

	Tier 1 – Counseling and Medication Management Services	Tier 2 – Counseling, Medication Management, and Support Services	Tier 3 – Counseling, Medication Management, Support, and Residential Services
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score $\Rightarrow \geq 2$ <u>AND</u> Injurious to Self: Intervention Score of 1, 2 or 3 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score $\Rightarrow \geq 2$ <u>AND</u> Injurious to Self: Intervention Score of 4 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5
		<u>OR</u>	
		Mental Health Diagnosis Score $\Rightarrow \geq 2$ <u>AND</u> Aggressive Toward Others, Physical: Intervention Score of 1, 2 or 3 <u>AND</u>	Mental Health Diagnosis Score $\Rightarrow \geq 2$ <u>AND</u> Aggressive Toward Others, Physical: Intervention Score of 4 <u>AND</u>

		Frequency Score of 1, 2, 3, 4 or 5	Frequency Score of 2, 3, 4 or 5
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Aggressive Toward Others, Verbal/Gestural Wandering/Elopement	Mental Health Diagnosis Score ≥ 2 <u>AND</u> Psychotic Behaviors: Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 3, 4 or 5
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intervention Score of 2, 3 or 4 <u>AND</u> Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Socially Unacceptable Behavior Property Destruction	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Agitation Anxiety Difficulties Regulating Emotions Impulsivity	

		Injury to Others, Unintentional Manic Behaviors Susceptibility to Victimization Withdrawal	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> PICA: Intervention Score of 4	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intrusiveness: Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 4 or 5	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Psychotic Behaviors: Intervention Score of 1 or 2 <u>AND</u> Frequency Score of 1 or 2	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Psychosocial Subdomain Score ≥ 5 and ≤ 7 <u>AND</u> Pediatric Symptom Checklist Score > 15	

210.400 Possible Outcomes**44-1-246**

- A. For a beneficiary receiving a Tier 1 determination:
1. Eligible for Counseling and Medication Management services and may continue Tier 1 services with a certified behavioral health service provider or Independently Licensed Practitioner (ILP).

2. Not eligible for Tier 2 or Tier 3 services.
 3. Not eligible for ~~auto~~-assignment to a Provider-led Arkansas Shared Savings Entity (PASSE) or to continue participation with a PASSE.
- B. For a beneficiary receiving a Tier 2 or Tier 3 determination:
1. Eligible for services contained in Tier 1 and ~~Tier 2~~higher.
 - ~~2. Not eligible for Tier 3 services.~~
 23. Eligible for ~~auto~~-assignment to a PASSE or to continue participation with a PASSE.
 - a. ~~On January 1, 2019, t~~The PASSE ~~began will~~ receiveing a PMPM that corresponds to the determined rate for the assigned tier.
 - b. The PASSE ~~is will be~~ responsible for providing care coordination ~~and~~ assisting the beneficiary in accessing all needed services and, ~~after January 1, 2019, for~~ providing those services.
- ~~C. For a beneficiary receiving a Tier 3 determination:~~
- ~~1. Eligible for services contained in Tier 1, Tier 2 and Tier 3.~~
 - ~~2. Eligible for auto-assignment to a PASSE or to continue participation with a PASSE.~~
 - ~~a. On January 1, 2019, the PASSE began receiving a PMPM that corresponds to the determined rate for the assigned tier.~~
 - ~~b. The PASSE is responsible for providing care coordination and assisting the beneficiary in accessing all needed services and, after January 1, 2019, for ensuring those services are provided.~~

220.300

Tiering

14-1-246

- A. Tier Definitions:
1. Tier 2 ~~means indicates that the beneficiary scored high enough in certain areas to be eligible for paid services and supports, reflected difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings.~~
 2. Tier 3 ~~means indicates that the beneficiary scored reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings. high enough in certain areas to be eligible for the most intensive level of services, including 24 hours a day/7 days a week paid supports and services.~~
- B. Tiering Logic:
1. DDS tier logic is organized by categories of need, as follows:
 - a. Safety: Your ability to remain safe and out of harm's way
 - b. Behavior: Behaviors that could place you or others in harm's way
 - c. Self-Care: Your ability to take care of yourself, such as bathing yourself, getting dressed, preparing your meals, shopping, or going to the bathroom

Tier 2: Institutional Level of Care	Tier 3: Institutional Level of Care and may need 24 hours a day/7 days a week paid supports and services to maintain current placement
<u>Safety Level High</u> A. Self-Preservation Score ≥ 4	A. Self-Preservation Score ≥ 16 <u>AND</u>

<u>AND</u> B. Caregiving Capacity/Risk Score ≥ 6 <u>AND</u> C. Caregiving/Natural Supports Score ≥ 6 <u>AND</u> D. Mental Status Evaluation Score (in the home) = 3 or 4 <u>AND</u> E. Mental Status Evaluation Score (in the community) = 2	B. Caregiving Capacity/Risk Score = 11 <u>AND</u> C. Caregiving/Natural Supports Score of = 7 <u>AND</u> D. Mental Status Evaluation Score (in the home) Score = 5 <u>AND</u> E. Mental Status Evaluation Score (in the community) Score = 3
<u>Safety Level Medium</u> A. Self-Preservation Score ≥ 4 <u>AND</u> B. Caregiving Capacity/Risk Score ≥ 6 <u>AND</u> C. Caregiving/Natural Supports Score ≥ 6 <u>AND</u> D. Mental Status Evaluation Score (in the home) = 2 <u>AND</u> E. Mental Status Evaluation Score (in the community) = 2	
<u>Safety Level Low</u> A. Self-Preservation Score ≥ 4 <u>AND</u> B. Caregiving Capacity/Risk Score ≥ 6 <u>AND</u> C. Caregiving/Natural Supports Score ≥ 6 <u>AND</u> D. Mental Status Evaluation Score (in the home) = 1 <u>AND</u> E. Mental Status Evaluation Score (in the community) Score = 1	
<u>Behavior Level High</u> A. Neurodevelopmental Score of 2 <u>AND</u>	<u>Behavior Level High</u> A. Neurodevelopmental Score of 2 <u>AND</u>

B. Psychosocial Subdomain Score of ≥ 5 - ≤ 7 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement; AND C. Caregiving Capacity/Risk Score of ≥ 6 AND D. Caregiving/Natural Supports Score of ≥ 5 OR A. Neurodevelopmental Score of 2 AND B. Psychosocial Subdomain Score of ≥ 5 - ≤ 7 in at least THREE of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. AND at least one of the following scores: Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 5	B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement OR A. Neurodevelopmental Score of 2 AND B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 in at least THREE of the following Subdomains: Aggressive Toward Others Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Verbal/Gestural; Withdrawal
Behavior Level Low A. Neurodevelopmental Score of 2	Behavior Level Low A. Neurodevelopmental Score of 2

<u>AND</u> B. Psychosocial Subdomain Score of ≥ 3 - ≤ 4 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement C. <u>AND</u> at least one of the following scores: Caregiving Capacity/Risk Score of ≤ 8 Caregiving/Natural Supports Score of ≤ 3 <u>OR</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of ≥ 5 - ≤ 7 in at least one of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. <u>AND</u> at least one of the following scores: Caregiving Capacity/Risk Score of ≤ 8 Caregiving/Natural Supports Score of ≤ 3	<u>AND</u> B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement] <u>OR</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal
<u>Self-Care Level High</u> A. Neurodevelopmental Score of 2	<u>Self-Care Level High</u> A. Neurodevelopmental Score of 2

<u>AND</u> B. <u>Scores within stated range in at least THREE of any of the following:</u> <u>ADL's:</u> Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers <u>Functional Communication:</u> Score of 2 or 3 in Functional Communication <u>IADLs:</u> Score of 3 in any of the following IADLs (Meal Preparation, Housekeeping, Finances, Shopping) <u>Safety:</u> Self-Preservation Score of ≥ 4 <u>AND a score in at least one of the following areas:</u> Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 4 Treatment/Monitoring Score of at least 2	<u>AND</u> B. Treatments/Monitoring Score of at least 2 C. <u>AND at least one of the following scores:</u> Caregiving Capacity/Risk Score ≥ 10 Caregiving/Natural Supports Score of ≥ 7
<u>Self-Care Level Medium</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. <u>Scores within stated range in at least THREE of any of the following:</u> <u>ADLs:</u> Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers <u>Functional Communication:</u>	

Score of 1 in Functional Communication 3. <i>IADLs</i> Score of 3 in any of the following IADLs: (Meal Preparation, Housekeeping, Finances, Shopping) 4. <i>Safety:</i> Self-Preservation Score of ≥ 2 AND a score in at least one of the following areas: Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 4	
<u>Self-Care Level Low</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. <u>Scores within stated range in at least THREE of any of the following combinations:</u> Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers] <u>OR</u> Neurodevelopmental Score of 2 <u>AND</u> Score of ≥ 1 in any of the following: IADLs (Meal Preparation, Housekeeping, Finances, Shopping)	<u>Self-Care Level Low</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. <u>Scores within stated range in at least THREE of any of the following combinations:</u> Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers C. <u>AND</u> at least one of the following scores: Caregiving Capacity/Risk Score of ≥ 10 Caregiving/Natural Supports Score of 7

When you see “**AND**”, this indicates means you must have a score in this area **AND** a score in another area. When you see “**OR**”, this indicates means you must have a score in this area **OR** a score in another area.

~~220.410 — Battelle Developmental Inventory Screen~~

~~1-1-24~~

~~A. — The screening tool that will be used by the vendor is the most recent edition of the Battelle Developmental Inventory (BDI) Screening Tool. The BDI screens children in the following five domains: adaptive, personal/social, communication, motor, and cognitive.~~

~~B. — Definitions used for the screening process:~~

- ~~1. Cut Score—The lowest score a beneficiary could have for that age range and standard deviation to pass a particular domain.~~
 - ~~2. Pass—The child's raw score is higher than the cut score, and the child is not referred for further evaluation~~
 - ~~3. Refer—The child's raw score is lower than the cut score, and the child is referred for further evaluation of service need~~
 - ~~4. Age Equivalent Score—The age at which the raw score for a subdomain is typical~~
 - ~~5. Raw Score—Is the score the child received on that domain. It is compared to the cut score to determine if the child receives a pass or refer.~~
 - ~~6. Standard Deviation—A measurement used to quantify the amount of variation; the standard deviation will be applied to the child's raw score so that their score can be compared to the score of a child with typical development.~~
- ~~C. The standard deviation of 1.5 will be applied to all raw scores. Any score that is more than 1.5 standard deviations below that of a child with typical development will be referred for further evaluation for EIDT services.~~
- ~~D. Assessors who administer the Battelle Developmental Inventory screen must meet the qualifications of a DD assessor, listed in Section 220.200 and undergo training specific to administering the tool.~~

230.000**PERSONAL CARE SERVICES ARCHOICES**

To qualify for the ARChoices Program, a person must be age twenty-one (21) through sixty-four (64) and have been determined to have a physical disability through the Social Security Administration or the Department of Human Services (DHS) Medical Review Team (MRT) and require an intermediate level of care in a nursing facility or be sixty-five (65) years of age or older and require an intermediate level of care in a nursing facility. Persons determined to meet the skilled level of care, as determined by the Division of County Operations DCO are not eligible for the ARChoices Program.

230.100 Referral Process**41-1-246**

Independent aAssessment (IA) referrals are initiated by Personal Care (PC) service providers identifying a beneficiary who may require PC services. After January 1, 2019, individuals who are enrolled in a PASSE do not require a personal care assessment to continue services. Requests for functional assessment shall be transmitted to DHS or its designee, and will require supporting documentation. Supporting documentation that must be provided include:

A. A provider completed form that has been provided by DHS; and

B. A referral form if it is an initial referral.

DHS or its designee will review the request and make a determination to:

A. Finalize a referral and send it to the vendor for a PC independent assessment, or

B. Provide notification to the requesting entity that more information is needed, and that the PC provider may resubmit the request with the additional information, or

C. Provide notification to the requesting entity that the request is denied, for example, if a functional assessment has been performed within the previous ten (10) months and there is no change of circumstances to justify reassessment.

Reassessments must be conducted in person or by telemedicine and occur annually but may occur more frequently if a change of circumstances necessitates such. the Division of County

Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. -The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

230.200 Assessor Qualifications

41-1-246

In addition to the qualifications listed in Section 202.000, PCARChoices assessors must be a Registered Nurse licensed in the State of Arkansas.

230.300 Tiering

41-1-246

A. Tier Definitions:

- Tier 0 means you did not score high enough in any of the activities of daily living (ADLs) such as eating, bathing, or toileting to meet the state's eligibility criteria for personal care services. A Tier 0 means that you did not need any "hands-on assistance" in being able to bathe yourself, feed yourself and dress yourself as examples. Tier 0 and Tier 1 mean indicate the individual's assessed needs, if any, do not support the need for either ARChoices waiver services or nursing facility services.
- Tier 1 means you scored high enough in at least one of the ADLs such as eating, bathing, toileting, to be eligible for the state's Personal Care services. A Tier 1 means that you need "hands-on assistance" to be able to bathe yourself, dress yourself, or feed yourself, as examples. Tier 2 means indicates the individual's assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.

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

B. Tiering Logic:

	Tier 0	Tier 1
Functional Status (ADLs)	Score < 3 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Score of >= 3 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning

DAAS Approved Tier Logic				
STATE APPROVED				
	Tier 0	Tier 1	Tier 2	Tier 3
Skilled Nursing	<u>Treatments/Monitoring</u> Score < 2	<u>Treatments/Monitoring</u> Score < 2	<u>Treatments/Monitoring</u> Score < 2	<u>Treatments/Monitoring</u> Score >= 2
	AND	AND	AND	
Functional	<u>Physical Assistance</u> Score < 2 in all of the following ADLs:	<u>Physical Assistance</u> Score of >= 2 in at	<u>Must meet scores in at least ONE ADL listed:</u>	

	<u>Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning</u>	<u>least ONE of the following ADLs:</u> <u>Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning</u>	<u>1. Eating Physical Assistance</u> <u>Score = 3</u> <u>2. Mobility Physical Assistance</u> <u>Score = 3</u> <u>3. Toileting Physical Assistance</u> <u>Score = 3</u> <u>4. Transfers Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Must meet scores in at least TWO ADLs listed:</u> <u>1. Eating Physical Assistance</u> <u>Score = 2</u> <u>2. Toileting Physical Assistance</u> <u>Score = 2</u> <u>3. Transfers Physical Assistance</u> <u>Score = 2</u> <u>OR</u> <u>Mobility Physical Assistance</u> <u>Score = 2</u>	
			<u>OR</u>	
<u>Safety Status (Memory & Behavior)</u>			<u>Neurological/Central Nervous System</u> <u>Score ≥ 2</u> <u>AND</u> <u>Types of supports in home</u> <u>Score ≥ 3</u> <u>OR</u> <u>Types of supports in community</u> <u>Score ≥ 2</u> <u>AND</u> <u>[Score in at least ONE of the following:</u>	

			<u>Injurious to Self</u> <u>Score ≥ 8</u> <u>Aggressive Toward Others, Physical</u> <u>Score ≥ 8</u> <u>Aggressive Toward Others, Verbal/Gestural</u> <u>Score ≥ 8</u> <u>Socially Unacceptable Behavior</u> <u>Score ≥ 8</u> <u>Wandering/Elopement</u> <u>Score ≥ 8</u> <u>Susceptibility to Victimization</u> <u>Score ≥ 8</u> <u>Eating Cuing/Supervision</u> <u>Score ≥ 1</u> <u>OR</u> <u>Life Threatening Condition</u> <u>Score = 1</u>	
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Tiering Stratification Logic

Applies to Tier 2 results ONLY

<u>DAAS Tier Stratification Logic – STATE APPROVED</u> <u>Applies to Tier 2 Results ONLY</u>			
<u>Intensive</u>	<u>Intermediate</u>	<u>Preventative</u>	

Functional Status (ADLs)	Scores must be present in <u>ALL THREE</u> categories below: <u>Category 1: Mobility</u> <u>Mobility Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Transfers Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Positioning Physical Assistance</u> <u>Score = 3</u> <u>AND</u> <u>Category 2: Eating</u> <u>Eating Physical Assistance</u> <u>Score = 3</u> <u>AND</u> <u>Category 3: Toileting</u> <u>Toileting Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Toileting/ Contenance Support</u> <u>Challenge = Cannot change incontinence pads.</u> <u>Cannot do own peri care</u> <u>Score = 1</u> <u>OR</u> <u>Toileting/Contenance Support</u> <u>Challenge = Cannot empty ostomy/ catheter bag</u> <u>Score = 1</u>	Scores must be present in at least <u>TWO</u> of the categories below: <u>Category 1: Mobility</u> <u>Mobility Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Transfers Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Positioning Physical Assistance</u> <u>Score = 3</u> <u>AND/OR</u> <u>Category 2: Eating</u> <u>Eating Physical Assistance</u> <u>Score = 3</u> <u>AND/OR</u> <u>Category 3: Toileting</u> <u>Toileting Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Toileting/Contenance Support</u> <u>Challenge = Cannot change incontinence pads.</u> <u>Cannot do own peri care</u> <u>Score = 1</u> <u>OR</u> <u>Toileting/Contenance Support</u> <u>Challenge = Cannot empty ostomy/catheter bag</u> <u>Score = 1</u>	<u>Does not meet conditions of Intermediate or Intensive.</u> <u>By default, is Tier 2 Preventative.</u>
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230.400 Possible Outcomes

44-1-246

~~Upon successful completion of an assessment, the tier determination will determine eligibility of service levels. Possible outcomes include:~~

~~A. Tier 0 Determination~~

- ~~1. Not currently eligible for Personal Care services.~~
- ~~2. May be reassessed when a change in circumstances necessitates a re-assessment.~~

~~B. Tier 1 Determination~~

- ~~1. Currently eligible for up to 256 units (64 hours) per month of Personal Care services.~~
- ~~2. The PC assessment is submitted to DHS or its designee who reviews it, along with any information submitted by the provider to authorize the set amount of service time per month.~~

~~The PC assessment is not used to assign clients to a PASSE.~~ These indications notwithstanding, the final determination of Level of Care and waiver eligibility is made by DCO.

240.000 LIVING CHOICES

Living Choices Assisted Living is a home and community-based services waiver program that is administered jointly by the Division of Medical Services (DMS, the state Medicaid agency) and the Division of Aging, Adult, and Behavioral Health Services (DAABHS), under the waiver authority of Section 1915(c) of the Social Security Act. -Home and community-based services waiver programs cover services designed to allow specific populations of individuals to live in their own homes or in certain types of congregate settings. -The Living Choices Assisted Living waiver program serves persons sixty-five (65) years of age and older and persons twenty-one through sixty-four (21-64) years of age who are determined, by the Social Security Administration or the Arkansas DHS Medical Review Team (MRT), to be individuals with physical disabilities and who are eligible for nursing home admission at the intermediate level of care.

240.100 Referral Process

4-1-26

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. -The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

240.200 Assessor Qualifications

4-1-26

In addition to the qualifications listed in Section 202.000, Living Choices assessors must be a Registered Nurse licensed in the State of Arkansas.

240.300 Tiering

4-1-26

A. Tier definitions:

1. Tier 0 and Tier 1 indicate ~~mean~~ 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 indicates ~~means~~ 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 indicates ~~means~~ the individual needs skilled care available through a licensed nursing facility and therefore is not eligible for the Living Choices waiver program.

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

B. Tiering logic:

DAAS Approved Tier Logic				
STATE APPROVED				
	Tier 0	Tier 1	Tier 2	Tier 3

Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ≥ 2
	AND	AND	AND	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Physical Assistance Score of ≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 OR Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 OR Mobility Physical Assistance Score = 2	
			OR	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score ≥ 2 AND Types of supports in home Score ≥ 3 OR Types of supports in community Score ≥ 2	

			<u>AND</u> <u>[Score in at least ONE of the following:</u> <u>Injurious to Self</u> <u>Score ≥ 8</u> <u>Aggressive Toward Others, Physical</u> <u>Score ≥ 8</u> <u>Aggressive Toward Others,</u> <u>Verbal/Gestural</u> <u>-Score ≥ 8</u> <u>Socially Unacceptable Behavior Score ≥ 8</u> <u>Wandering/Elopement</u> <u>Score ≥ 8</u> <u>Susceptibility to Victimization</u> <u>Score ≥ 8</u> <u>Eating</u> <u>Cuing/Supervision</u> <u>Score ≥ 1]</u>	
			<u>OR</u>	
<u>Life Threatening Condition</u>			<u>Life Threatening Condition Score = 1</u>	

Tiering Stratification Logic

Applies to Tier 2 results ONLY

<u>DAAS Tier Stratification Logic – STATE APPROVED</u> <u>Applies to Tier 2 Results ONLY</u>			
	<u>Intensive</u>	<u>Intermediate</u>	<u>Preventative</u>
<u>Functional Status (ADLs)</u>	<u>Scores must be present in ALL THREE categories below:</u> <u>Category 1: Mobility</u> <u>Mobility Physical Assistance</u> <u>Score = 3</u> <u>OR</u>	<u>Scores must be present in at least TWO of the categories below:</u> <u>Category 1: Mobility</u> <u>Mobility Physical Assistance</u> <u>Score = 3</u> <u>OR</u>	<u>Does not meet conditions of Intermediate or Intensive.</u> <u>By default, is Tier 2 Preventative.</u>

<u>Transfers Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Positioning Physical Assistance</u> <u>Score = 3</u> <u>AND</u> <u>Category 2: Eating</u> <u>Eating Physical Assistance</u> <u>Score = 3</u> <u>AND</u> <u>Category 3: Toileting</u> <u>Toileting Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Toileting/ Contenance Support Challenge =</u> <u>Cannot change incontinence pads.</u> <u>Cannot do own peri care</u> <u>Score = 1</u> <u>OR</u> <u>Toileting/Contenance Support Challenge =</u> <u>Cannot empty ostomy/ catheter bag</u> <u>Score = 1</u>	<u>Transfers Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Positioning Physical Assistance</u> <u>Score = 3</u> <u>AND/OR</u> <u>Category 2: Eating</u> <u>Eating Physical Assistance</u> <u>Score = 3</u> <u>AND/OR</u> <u>Category 3: Toileting</u> <u>Toileting Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Toileting/Contenance Support Challenge = Cannot change</u> <u>incontinence pads.</u> <u>Cannot do own peri care</u> <u>Score = 1</u> <u>OR</u> <u>Toileting/Contenance Support Challenge = Cannot empty</u> <u>ostomy/catheter bag</u> <u>Score = 1</u>	
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240.400 Possible Outcomes**4-1-26**

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

250.000 PACE

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model that enables individuals who are fifty-five (55) years of age or older and certified by the state to need nursing facility care, to live as independently as possible. -Through PACE, fragmented health care financing and delivery system comes together to serve the unique needs of the enrolled individual with chronic care needs. -The population served by PACE is historically very frail. -The PACE organization must provide all needed services to the PACE participant.

250.100 Referral Process**4-1-26**

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. -The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

250.200 Assessor Qualifications**4-1-26**

In addition to the qualifications listed in Section 202.000, PACE assessors must be a Registered Nurse licensed in the State of Arkansas.

250.300 Tiering**4-1-26****A. Tier definitions:**

1. Tier 0 ~~mean~~ and Tier 1 ~~mean~~ indicate the individual's assessed needs, if any, do not support the need for either PACE services or nursing facility services.
2. Tier 2 indicates ~~means~~ the individual's assessed needs are consistent with services available through either the PACE program or a licensed nursing facility.
3. Tier 3 indicates ~~means~~ the individual needs skilled care available through a licensed nursing facility and therefore is not eligible for the PACE program.

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

B. Tiering logic:

DAAS Approved Tier Logic STATE APPROVED				
	Tier 0	Tier 1	Tier 2	Tier 3
Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score $\geq$ 2
	AND	AND	AND	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Physical Assistance Score of $\geq$ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 OR	

			Must meet scores in at least TWO ADLs listed: 1. <u>Eating Physical Assistance</u> Score = 2 2. <u>Toileting Physical Assistance</u> Score = 2 3. <u>Transfers Physical Assistance</u> Score = 2 OR <u>Mobility Physical Assistance</u> Score = 2	
			OR	
<u>Safety Status (Memory & Behavior)</u>			<u>Neurological/Central Nervous System</u> Score ≥ 2 AND <u>Types of supports in home</u> Score ≥ 3 OR <u>Types of supports in community</u> Score ≥ 2 AND <u>[Score in at least ONE of the following:</u> <u>Injurious to Self</u> Score ≥ 8 <u>Aggressive Toward Others, Physical</u> Score ≥ 8 <u>Aggressive Toward Others, Verbal/Gestural</u> Score ≥ 8 <u>Socially Unacceptable Behavior</u> Score ≥ 8 <u>Wandering/Elopement</u> Score ≥ 8	

			<u>Susceptibility to Victimization</u> <u>Score ≥ 8</u> <u>Eating Cuing/Supervision</u> <u>Score ≥ 1</u> <u>OR</u> <u>Life Threatening Condition</u> <u>Score = 1</u>	
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Tiering Stratification LogicApplies to Tier 2 results ONLY

<u>DAAS Tier Stratification Logic – STATE APPROVED</u>			
<u>Applies to Tier 2 Results ONLY</u>			
	<u>Intensive</u>	<u>Intermediate</u>	<u>Preventative</u>
<u>Functional Status (ADLs)</u>	Scores must be present in ALL THREE categories below: Category 1: Mobility <u>Mobility Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Transfers Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Positioning Physical Assistance</u> <u>Score = 3</u> <u>AND</u> Category 2: Eating <u>Eating Physical Assistance</u> <u>Score = 3</u> <u>AND</u> Category 3: Toileting <u>Toileting Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Toileting/ Contenance Support Challenge = Cannot change incontinence pads.</u>	Scores must be present in at least TWO of the categories below: Category 1: Mobility <u>Mobility Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Transfers Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Positioning Physical Assistance</u> <u>Score = 3</u> <u>AND/OR</u> Category 2: Eating <u>Eating Physical Assistance</u> <u>Score = 3</u> <u>AND/OR</u> Category 3: Toileting <u>Toileting Physical Assistance</u> <u>Score = 3</u> <u>OR</u> <u>Toileting/Contenance Support Challenge = Cannot change incontinence pads.</u>	Does not meet conditions of Intermediate or Intensive. <u>By default, is Tier 2 Preventative.</u>

	<u>Cannot do own peri care</u> <u>Score = 1</u> <u>OR</u> <u>Toileting/Continence</u> <u>Support Challenge =</u> <u>Cannot empty ostomy/</u> <u>catheter bag</u> <u>Score = 1</u>	<u>Cannot do own peri care</u> <u>Score = 1</u> <u>OR</u> <u>Toileting/Continence</u> <u>Support</u> <u>Challenge = Cannot empty</u> <u>ostomy/catheter bag</u> <u>Score = 1</u>	
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250.400 Possible Outcomes**4-1-26**

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

SECTION II – STATE PLAN PERSONAL CARE

CONTENTS

TOC required

200.000 GENERAL INFORMATION

200.100 Participation Requirements for State Plan Personal Care Providers 4-1-26

- A. State Plan Personal Care providers are designated high-risk providers based on the lack of licensure or certification from the Department of Human Services and the potential for fraud, waste, and abuse. As such, and as a condition of enrollment in the Arkansas Medicaid program, Arkansas Medicaid requires State Plan Personal Care providers to have:
 - 1. On-site visits conducted by Arkansas Medicaid in accordance with 42 CFR 455.432, which includes pre-enrollment and post enrollment site visits as well as unannounced on-site inspections of any provider location.
 - 2. Federal fingerprint-based checks in accordance with 42 CFR 455.434 and 42 CFR 455.50(c). All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq.
- B. Each employee must successfully pass the following:
 - 1. A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann. § 20-38-103;
 - 2. An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;
 - 3. An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;
 - 4. An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and
 - 5. At least a five (5) panel drug screen upon hiring and prior to any contact with clients, and as required thereafter by Ark. Code Ann. §20-77-128(b).
- C. A provider must meet the following participation requirements to qualify as a State Plan Personal Care provider under Arkansas Medicaid:
 - 1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual; and
 - 2. Obtain a license as a private care agency, or be a certified Home Health Agency Class A or B; Assisted Living Facility (ALF) I; or Residential Care Facility (RCF).

200.200 Participation Requirements for Personal Care Providers that are School Districts or Education Service Cooperatives 4-1-26

- A. A school district or education service cooperative must meet the following participation requirements to qualify as a State Plan Personal Care provider under Arkansas Medicaid.
 - 1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual; and
 - 2. Be certified as a Local Educational Agency (LEA) by the Arkansas Department of Education.

3. School personnel providing billable Personal Care services must be trained and certified by the Division of Elementary and Secondary Education (DESE).

200.300 Personal Care Services at School

4-1-26

- A. Beneficiaries under the age of twenty-one (21) may receive personal care services when attending school. For these purposes:
 1. A "school" is an entity accredited by the Arkansas Department of Education to provide elementary or secondary education services;
 2. A school setting is not limited to just the school-building or campus as long as the setting is related to the beneficiary's receipt of educational services from the school (i.e. attending a field trip to a museum);
 3. The beneficiary's home is not considered a "school" place of service when a parent elects to home school.
- B. Medicaid Program requirements are the same as for services delivered in the beneficiary's home.
- C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the beneficiary receives services.
- D. Beneficiaries receiving personal care in schools may receive a number of services in accordance with an Individualized Education Program (IEP).
 1. The IEP may not supersede or substitute for the personal care treatment plan.
 2. The Personal Care Program requires a distinct and separate assessment and treatment plan.

200.400 Out-of-State Limited Services Personal Care Providers

4-1-26

Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and they have a claim or claims to file with Arkansas Medicaid. To enroll, providers must download an Arkansas Medicaid application and contract from the DMS website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. [View or print the provider enrollment and contract package \(Application Packet\)](#). A provider number will be assigned upon approval of the provider application and Medicaid contract. [View Medicaid Provider Enrollment Unit contact information](#).

205.000 PERSONAL CARE AIDE PARTICIPATION REQUIREMENTS

205.100 Personal Care Aide Participation Requirements

4-1-26

205.200 Personal Care Aide

4-1-26

An individual must meet the following requirements to serve as a personal care aide for a personal care services provider:

- A. Have one of the following active certifications in good standing:
 1. Certified Nursing Assistant (CNA);
 2. Home Health Aide; or
 3. Certified Personal Care Aide;

- B. Enroll as an Arkansas Medicaid rendering provider unless employed as school personnel and certified by the Division of Elementary and Secondary Education (DESE).
- C. School personnel providing billable school-based Personal Care services must be trained and certified by the Division of Elementary and Secondary Education (DESE).

210.000 DOCUMENTATION REQUIREMENTS

210.100 Documentation Requirements for all Medicaid Providers

4-1-26

See section 140.000 of this Medicaid manual for the documentation that is required for all Arkansas Medicaid providers.

210.200 State Plan Personal Care Provider Documentation Requirements

4-1-26

- A. State Plan Personal Care providers must maintain in each beneficiary's service record:
 - 1. The beneficiary's:
 - a. Applicable medical records;
 - b. Age and Date of Birth;
 - c. Medicaid ID number;
 - d. The initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP) (see section 212.200);
 - e. All treatment prescriptions (see section 212.300);
 - f. All DMS-618 functional assessments;
 - g. All treatment plans;
 - h. Frequency of In-home Supervisory visits; and
 - i. Discharge notes and summary, if applicable.
 - 2. Treatment plan service log documentation, which must be completed at the time-of-service delivery and at a minimum include:
 - a. Beneficiary name;
 - b. Beneficiary's Medicaid ID number and date of birth;
 - c. The date and beginning and ending time for each personal care service performed each day;
 - i. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.
 - ii. It is not necessary to itemize the time spent on each activity of daily living (ADL) or instrumental activity of daily living (IADL) task for a given beneficiary, provided these tasks were performed by the same personal care aide on the same visit on the same day and at the same location;
 - iii. If the personal care aide discontinues or interrupts the beneficiary's service-plan-required activities at one location to begin service-plan-required activities at another location, the aide must record the beginning and ending times of service at each location.
 - iv. If a personal care aide does not perform a scheduled treatment plan task, the personal care aide must document and justify why the task was not performed as scheduled;
 - d. The location where the service was performed;
 - e. Any service performance difficulties;
 - f. Notes on the beneficiary's condition or other data or criteria required by the

- treatment plan;
- g. When an emergency or special circumstances requires a personal care aide to perform a task not included on the personal care treatment plan, documentation describing:
 - i. The nature of the emergency or special situation;
 - ii. The action or task required to resolve the emergency or special situation;
 - iii. The date, start time, end time, location, nature and scope of the unscheduled task performed;
 - iv. When supervisor approval for the unscheduled task was obtained; and
 - v. If supervisor approval was not obtained prior to performing the unscheduled task, justification for why pre-approval was not possible
 - h. Name(s), credential(s), and signature(s) of the personal care aide who performed the service; and
3. Weekly or more frequent progress notes outlining the condition of the beneficiary;
 4. If service delivery involves delivering services to multiple beneficiaries, the following additional service log documentation requirements apply:
 - a. When service delivery involves two (2) beneficiaries concurrently (i.e. cleaning a bathroom shared by two beneficiaries), then the personal care aid must also document in each beneficiary's service delivery log the name of the other individual who received the concurrent personal care service;
 - b. When service delivery is in a congregate setting (i.e. involves more than two (2) beneficiaries), then the personal care aide must:
 - i. Record the date and time the congregate service began and ended; and
 - ii. The name of each individual who received congregate services;
 - c. The provider must equally split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took twenty (20) minutes, the personal care aide would document ten (10) minutes to each beneficiary for the service).
- B. Every personal care provider must maintain the required employment, certification, and licensure records for all individuals employed or contracted to provide personal care services on behalf of the provider. If an individual performs personal care services on behalf of a personal care provider pursuant to a contract, then a copy of the contractual agreement must be maintained.

210.300 Electronic Signatures

4-1-26

Arkansas Medicaid will accept electronic signatures in compliance with Arkansas Code Ann, § 25-31-103 et seq.

215.000 PROGRAM ELIGIBILITY

215.100 Scope

4-1-26

Arkansas Medicaid will reimburse enrolled providers for covered personal care services when such services are provided to a treatment plan to beneficiaries who meet the eligibility requirements of this Medicaid manual. Medicaid reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

215.200 Beneficiary Eligibility Requirements

4-1-26

215.300 Evaluation Referral

4-1-26

- A. Personal Care services require an initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP).
- B. An initial evaluation referral for personal care services is required to be on a DMS-618 ER "State Plan Personal Care Services Initial Evaluation Referral." [View or print the form DMS-618 ER.](#)
- C. A DMS-618 ER evaluation referral is only required to perform a beneficiary initial evaluation for state plan personal care services.
- D. No DMS-618 ER is required for a provider to perform the annual functional needs assessment necessary to demonstrate a beneficiary's continued eligibility for state plan personal services, unless there is a significant break in services. A significant break in service is defined as not receiving state plan personal care within the prior one hundred twenty (120) days.

215.400 Functional Needs Assessment**4-1-26**

- A. Personal care services must be medically necessary as demonstrated by the results of an annual functional needs assessment.
 - 1. A diagnosis alone is not sufficient to demonstrate medical necessity.
 - 2. A beneficiary is no longer eligible for personal care services if the annual functional needs assessment demonstrating medical necessity in accordance with this section 212.200 is not renewed within twelve (12) months.
- B. A functional needs assessment for personal care services must be completed using the approved DHS functional assessment form:
 - 1. A beneficiary twenty (20) years of age **and under** must use the "Youth Personal Care Functional Assessment & Treatment Plan" ([View or print the Youth Personal Care Functional Assessment & Treatment Plan](#)); and
 - 2. A beneficiary twenty-one (21) years of age or older must use the "Adult Personal Care Functional Assessment & Treatment Plan" ([View or print the Adult Personal Care Functional Assessment & Treatment Plan](#)).
- C. All Personal Care Functional Assessment & Treatment Plan functional needs assessments must be completed, signed, and dated by a licensed Registered Nurse.
- D. All aspects of the Assessment for personal care services, including the administration, must be communicated and conducted in the beneficiary's primary or preferred language.
- E. A new Personal Care Functional Assessment & Treatment Plan is not required when a beneficiary:
 - 1. Transitions from one personal care provider to another personal care provider **before the expiration of the current Functional Assessment & Treatment Plan; or**
 - 2. Changes primary care providers.

215.500 Treatment Prescription**4-1-26**

- A. Personal care services require a treatment prescription signed by the beneficiary's primary care provider (PCP). The frequency, intensity, and duration of the prescribed personal care services must be medically necessary based on the results of the assessment and realistic for the age of the beneficiary.
- B. A treatment prescription for personal care services is valid for one (1) year unless a short period is specified on the treatment prescription.

- C. A treatment prescription for personal care services must be on form DMS-618 TP "State Plan Personal Care Services Treatment Prescription." [View or print form DMS-618 TP](#).
- D. An existing treatment prescription would remain valid through its date of expiration and a new DMS-618 TP treatment prescription is not required when a beneficiary:
 - 1. Changes PCPs; or
 - 2. Transitions from one personal care provider to another personal care provider.

220.000 PROGRAM SERVICES

220.100 Non-covered Services

4-1-26

- A. Personal care services can only supplement, and are prohibited from being used to supplant, otherwise available beneficiary resources.
- B. Personal care cannot be provided to individuals:
 - 1. Admitted to an inpatient hospital,
 - 2. Admitted to a nursing facility,
 - 3. Enrolled in the Living Choices Waiver
 - 4. Admitted to intermediate care facility for individuals with intellectual disabilities (ICF/IID); or
 - 5. Admitted to an institution for mental diseases (IMD).
- C. Arkansas Medicaid will not reimburse for personal care services performed by a member of the beneficiary's family. The following individuals are considered a member of the beneficiary's family:
 - 1. A spouse.
 - 2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent.
 - 3. Legal guardian of the person of the beneficiary; and
 - 4. Attorney-in-fact granted authority to direct the beneficiary's care.
- D. Arkansas Medicaid will not reimburse for personal care services delivered via telehealth. Telehealth means the use of electronic documentation and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a beneficiary.

220.200 Covered Services

4-1-26

- A. Arkansas Medicaid will only reimburse for the personal care services listed in Section **220.300** delivered in a manner in compliance with the treatment plan and this Medicaid manual, manual update transmittals, and official program correspondence.
- B. A provider of personal care services must contract with or employ the personal care aides that perform personal care services on its behalf.
 - 1. The provider must identify the personal care aide performing the personal care services as the performing provider on the claim when billing Arkansas Medicaid for the service.
 - 2. Each personal care aide listed as the performing provider on a personal care provider claim must be enrolled with Arkansas Medicaid, as per section **140.000** of this Medicaid manual.

220.300 Personal Care Services

4-1-26

- A. Personal care services are medically necessary services that assist a beneficiary with assessed physical dependency needs in the performance of their routine activities of daily living **or** instrumental activities of daily living. **42 C.F.R. § 441.505**
- B. A personal care provider may be reimbursed for performing the following medically necessary personal care services in accordance with the beneficiary's treatment plan:
1. Bathing;
 2. Dressing;
 3. Feeding/eating;
 4. Grooming;
 5. Toileting;
 6. Transferring;
 7. Walking;
 8. Cleaning;
 9. Laundry;
 10. Preparing meals;
 11. Shopping; and
 12. Transportation to and from employment (or seeking employment) that meets the requirements of section **220.400** of this Medicaid manual (no mileage costs associated with the transportation would be covered).
- C. Medical necessity for personal care services is established by:
1. The results of Personal Care Functional Assessment & Treatment Plan completed in accordance with this Medicaid manual; and
 2. A treatment prescription on a DMS-618 TP "State Plan Personal Care Services Treatment Prescription." [View or print form DMS-618 TP](#).
- D. All personal care services must be performed by a certified personal care aide. See section **205.200** of this Medicaid manual.
- E. The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered. **A qualified supervisor must be a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.**
1. The qualified supervisor must complete the following at least monthly:
 - a. Review the beneficiary's service delivery logs and documentation;
 - b. Document the time and date of their service documentation review;
 - c. Actively train or assist assigned personal care aide with personal care service delivery when necessary;
 - d. Document any training or assistance provided to an assigned personal care aide.

2. A supervising registered nurse must conduct an on-site evaluation of a day's service delivery to a beneficiary as required in the treatment plan, but no less often than annually. On each on-site evaluation, the supervising registered nurse must
 - a. Observe and document;
 - i. The condition of the beneficiary;
 - ii. The type and quality of the personal care aide's service provision;
 - iii. The interaction and relationship between the beneficiary and the personal care aide; and
 - iv. Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.
 - b. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
 3. An individual who provides personal care services to a beneficiary may not supervise another personal care aide providing personal care services to that same beneficiary.
- F. A provider must obtain the following before initiating a permanent change to personal care service delivery:
1. A registered nurse must complete an updated Personal Care Functional Assessment & Treatment Plan; and
 2. Obtain a new DMS-618 TP treatment prescription
- G. Personal care services are reimbursable on a per unit basis. See section 230.000 of this Medicaid manual regarding submitting a request for a prior authorization.

220.400 Employment-Related Personal Care Outside the Home**4-1-26**

Outside of the home personal care services may be included in a beneficiary's treatment plan when it allows a beneficiary to obtain or retain employment and each of the following requirements are met:

- A. The beneficiary is sixteen (16) years of age or older;
- B. The beneficiary must be "disabled" as defined by Social Security/SSI [20 CFR 404.1505];
- C. The beneficiary must be working (or be actively seeking employment where they would be working):
 1. At least forty (40) hours per month; and
 2. In an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability); and
- D. The beneficiary is earning at least minimum wage (or be actively seeking employment that pays at least minimum wage);
- E. Employment-related personal care associated with transportation is covered as follows:
 1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking;
 2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; in the service plan and all pertinent service documentation;
 3. Medicaid does not cover mileage associated with any personal care service;

4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is included in the 64-hour per month personal care benefit limit for beneficiaries aged twenty-one (21) and older.

220.500 Personal Care Services at School

4-1-26

- A. Beneficiaries under the age of twenty-one (21) may receive personal care services when attending school. For these purposes:
 1. A "school" is an entity accredited by the Arkansas Department of Education to provide elementary or secondary education services;
 2. A school setting is not limited to just the school-building or campus as long as the setting is related to the beneficiary's receipt of educational services from the school (i.e. attending a field trip to a museum);
 3. The beneficiary's home is not considered a "school" place of service when a parent elects to home school.
- B. All other aspects of personal care service delivery at school are the same as for personal care services delivered at the beneficiary's home.

220.600 Concurrent Treatment Service Delivery by Different Providers

4-1-26

Personal care services must be delivered by a single provider, unless a beneficiary is receiving personal care services outside the home as permitted in sections 223.000 and 224.000 of this Medicaid manual, in which case a second provider may deliver those allowable outside the home personal care services included in the beneficiary's treatment plan.

220.700 Transitioning Personal Care Providers

4-1-26

- A. This section does not apply to school-based personal care providers, RCFs, or ALF I's.
- B. A beneficiary has freedom of choice in selecting a personal care provider. However, the requirements of this section must be followed to ensure the continuity and smooth transition of personal care services when a beneficiary selects a new personal care provider.
- C. Personal Care providers must comply with each of the following when a beneficiary elects to transition from one provider to another:
 1. The beneficiary or, if applicable, the beneficiary's parent or legal guardian, must complete a personal care provider transition request form. [View or print a Personal Care Provider Transition Request form.](#)
 2. The newly selected personal care provider must:
 - a. Notify the current provider of the beneficiary's decision to switch personal care providers; and
 - b. Deliver the current provider a copy of the completed Personal Care Provider Transition Request form.

The new provider should maintain verifiable proof of the date and method of its required notification and transition request form delivery.

3. The current personal care service provider will continue to provide services to the beneficiary in accordance with this Medicaid manual until the last day of the second month after the month the new provider completed the notification and delivery requirements in subpart (2.) directly above (i.e. if notified on May 11th, then current provider would continue providing personal care services until June 30th so new provider can begin services July 1st).

- a. The current provider is responsible for forwarding the beneficiary's complete service record to the newly selected personal care provider before the current provider's last day of service, as described in subpart (3.) directly above.
 - b. The beneficiary's complete service record includes, at minimum: The beneficiary's signed 618-ER; the beneficiary's active current Assessment and Treatment Plan; the beneficiary's active, signed 618-TP.
- D. Switching from one personal care provider to another personal care provider does not automatically require a new:
 - 1. Treatment prescription; **and**
 - 2. Functional needs Assessment and Treatment Plan.

230.000 PRIOR AUTHORIZATION

- A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries.
- B. Prior authorization does not guarantee payment for the service.
 - 1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.
 - 2. The provider must follow the billing procedures in this manual.
- C. A Personal Care Functional Assessment & Treatment Plan is the assessment instrument used by registered nurses of personal care providers to collect information used in determining the beneficiary's physical dependency needs for hands-on services and in calculating the number of personal care hours that can be requested for the beneficiary. This Personal Care Functional Assessment & Treatment Plan must be accompanied by an approved Treatment Prescription from the beneficiary's Primary Care Provider (PCP).

230.100 Prior Authorization Responsibility

4-1-26

- A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization (PA) of personal care services for beneficiaries.
- B. DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's completed Functional Assessment & Treatment Plan and the PCP's Treatment Prescription submitted for personal care services. Based on the information within, they prior authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.
- C. DHS professional staff or contractor(s) designated by DHS have a right to review the beneficiary's medical information.

230.200 Personal Care PA Request Procedure

4-1-26

- A. Providers must use the form designated by DHS to request PA.
 - 1. [View or print the form designated by DHS \(English\)](#) (PA request on last page).
 - 2. [View or print the form designated by DHS \(Spanish\)](#) (PA request on last page).
- B. Providers should submit prior authorization forms to the contractor(s) designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff.

- C. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals will be retroactive to the beginning date of service if the request is received within the 30-day time frame.
- D. There will be no prior authorization, including any retroactive prior authorization, if the beneficiary is assessed to not require medically necessary services.

230.300 Provider Prior Authorization Notification Procedure

4-1-26

Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

- A. For approved cases, an approval letter will be mailed to the requesting provider, detailing the procedure codes approved, total number of service time increments, beginning and ending dates and the authorization number.
- B. For denied or partially denied cases, a denial letter with reason for denial will be mailed to the beneficiary and the requesting provider. The letter shall specify why the prior authorization request was denied or partially denied and shall give the beneficiary notice of the right to file a request for a fair hearing and where to file the request. Reconsideration of the denial may be requested within thirty (30) calendar days of the denial date. **Requests for reconsideration must be made in writing and include additional documentation.**

230.400 Duration of Prior Authorization

4-1-26

Personal Care PAs are generally assigned for twelve (12) months from the date of the last Treatment Prescription signed by the beneficiary's Primary Care Provider, or for the life of the Treatment Plan, whichever is shorter, unless the beneficiary has a change in condition.

230.500 Administrative Reconsideration and Appeals

4-1-26

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

230.600 Reserved

4-1-26

240.000 EXTENSION OF BENEFITS**240.100 Extension of Benefits for Personal Care Services**

4-1-26

- A. If a beneficiary requires more hours of personal care than what has been prior authorized on their Treatment Plan, the personal care provider can submit a request for an extension of benefits for medically necessary personal care services.
- B. For beneficiaries twenty (21) years of age and older, the maximum monthly limit for state plan personal care is two hundred fifty-six (256) units per month. If an adult beneficiary requires more extensive care, the beneficiary should apply for HCBS Waiver services. See: <https://humanservices.arkansas.gov/newsroom/hcbs>
- C. For beneficiaries twenty (20) years of age and younger, the maximum monthly limit for state plan personal care noted in part B can be exceeded if determined medically necessary. Medicaid Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)

mandates coverage of all services that are medically necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions (42 U.S.C. § 1396d(r)).

250.000 REIMBURSEMENT

250.100 Reimbursement Methods

4-1-26

- A. Concurrent billing is not allowed unless specifically permitted herein. It is considered concurrent billing when multiple practitioners bill Medicaid for services provided to the same beneficiary during the same time increment.
- B. Rest, toileting, or other break times between service delivery is not billable.
- C. Time spent on documentation alone is not billable as a treatment service.
- D. Providers may bill the total units of service for a single date of service but may not bill for units of service that span over more than one date of service. Each calendar date must be billed separately. For example, a provider may provide personal care services to an eligible beneficiary on Monday and then again on Tuesday. The provider may, then, bill for the total amount of time spent on Monday and a separate claim-line, or separate claim, for the total amount of time spent on Tuesday, but may not bill for the total amount of time spent both days on a single claim-line.

250.200 Unit Billing

4-1-26

- A. Fifteen (15) minutes of authorized, documented and logged personal care equals one unit of personal care aide service.
- B. Providers may not bill for less than fifteen (15) minutes of service; however personal care aides' time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day, and the sum—in minutes—divided by 15 to calculate the number of units of service provided during that day.
- C. The estimated daily maximum service time in the beneficiary's service plan is the upper limit for daily billing.
- D. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary.
- E. There is no "carryover" of time from one day to another or from one beneficiary to another.
- F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

250.300 Calculating Units

4-1-26

- A. Personal Care providers must bill Medicaid by 15-minute units.
- B. Total the daily personal care service-time for a single beneficiary in minutes, using the beginning and ending service times from the service logs.
- C. Set your calculator to compute to three decimal places.
- D. Divide the total time (expressed in minutes) by fifteen and
- E. Bill for the lesser of:

1. The rounded, whole-number quotient of the division or
2. The maximum time estimate in the service plan.

250.400 Rounding

4-1-26

When a quotient contains decimals, look at the numbers after the decimal point.

- A. If the number after the decimal point is 500 (e.g., 3.500) or less (e.g., 3.495) round downward to the whole number displayed before the decimal point (3, in this example)
- B. If the number after the decimal is 501 (e.g., 3.501) or greater (e.g., 3.576) round upward to the whole number one greater than the whole number displayed before the decimal point (4 in this example, because it is a whole number one greater than 3).

250.500 Fee Schedules

4-1-26

Arkansas Medicaid provides [fee schedules on the DMS website](#). The fees represent the fee-for-service reimbursement methodology.

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

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

250.600 Electronic Visit Verification (EVV)

4-1-26

- A. In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) has implemented electronic visit verification (EVV) for in-home personal care services paid by Medicaid. Refer to [Provider Manual Section I, General Policy](#), subsection 145.000 for complete EVV requirements regarding personal care services.
- B. An EVV system is a telephone, computer, or other technology-based system under which visits conducted as part of personal care services.
- C. All personal care services are electronically verified with respect to:
 1. The type of service(s) performed;
 2. The individual receiving the service(s);
 3. The date of the service(s);
 4. The location of service delivery;
 5. The individual providing the service(s); and
 6. The time the service(s) begins and ends.
- D. The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

TOC required**201.000 Arkansas Independent Assessment (ARIA) System Overview****4-1-26**

The Arkansas Independent Assessment (ARIA) system is comprised of several parts that are administered through separate steps for each eligible Medicaid individual served through one of the state's waiver programs. The purpose of the ARIA system is to perform a functional-needs assessment to assist in the development of an individual's Person-Centered Service Plan (PCSP), and for certain populations to establish the per member per month payment to a managed care entity. As such, it assesses an individual's capabilities and limitations in performing activities of daily living, including bathing, toileting, and dressing. It is not a medical diagnosis, although the medical history of an individual is an important component of the assessment as a functional deficiency may be caused by an underlying medical condition. In the case of an individual in need of behavioral health services, or waiver services, the independent assessment does not determine whether an individual is Medicaid eligible. That determination is made prior to and separately from the assessment of an individual.

Federal statutes and regulations require states to use an independent assessment for determining eligibility for certain services offered through Home and Community-Based Services (HCBS) waivers. It also is important to Medicaid beneficiaries and their families that any type of assessment is based on tested and validated instruments that are objective and fair to everyone. In 2017, Arkansas selected the ARIA system. It has been phased in over time for different population groups. When implemented for a population, the ARIA system replaces and voids any previous IA systems.

The ARIA system is administered by a vendor under contract with the Arkansas Department of Human Services (DHS). The basic foundation of the ARIA system is MnCHOICES, a comprehensive functional assessment tool originally developed by state and local officials in Minnesota for use in assessing the long-term services and supports (LTSS) needs of elderly individuals. Many individuals with developmental disabilities (DD)/intellectual disabilities (ID) and individuals with severe behavioral health needs also have LTSS needs. Therefore, the basic MnCHOICES tool has common elements across the different population groups. DHS and its vendor further customized MnCHOICES to reflect the Arkansas populations.

The assessment is administered by professional assessors who have successfully completed the vendor's training curriculum. The assessor training is an important component of ensuring the consistency and validity of the tool. The assessment tool is a series of more than 300 questions that might be asked during an in-person interview. The interview may include family members and friends as well as the Medicaid beneficiary. How a question is answered may trigger another question. Responses are weighted based on the service needs being assessed. The MnChoices assessment is computerized and uses computer program language based on logic (an algorithm) to generate a tier assignment for each individual. An algorithm is simply a sequence of instructions that will produce the exact same result to ensure consistency and eliminate interviewer bias. Reassessments may be conducted in person or through the use of telehealth.

The results of the assessment are provided to the individual and program staff at DHS. The results packet includes the individual's tier result, scores, and answers to all questions asked during the assessment. [Click here to see an example results packet](#). Individuals can review those results and may contact the appropriate division for more information on their individual results, including any explanations for how their scores were determined. Depending upon which program the individual participates in, the results also may be given to service providers. The results will assign an individual into a tier which subsequently is used to develop the individual's PCSP. The tiers and tiering logic are defined by DHS and are specific to the population served. DHS and the vendor provide internal quality review of the assessment results as part of the overall process. The tier definitions for each population group/waiver group are available in the

respective section of this Manual. In the case of an individual whose services are delivered through the Provider-led Arkansas Shared Savings Entity (PASSE); the tier is used in the determination of the actuarially sound global payment made to the PASSE. Each PASSE is responsible for its network of providers and payments to providers are based on the negotiated payment arrangements.

For beneficiaries who receive HCBS services, the assessment results are used to develop the PCSP with the individual Medicaid beneficiary. The DHS ARIA vendor does not participate in the development of the PCSP, nor in the provision of services under the approved plan.

There are four key features of every HCBS waiver:

- A. It is an alternative to care in an institutional setting (hospital, nursing home, intermediate care facility for individuals with developmental disabilities), therefore the individual must require a level of services and supports that would otherwise require that the individual be admitted to an institutional setting;
- B. The state must assure that the individual's health and safety can be met in a non-institutional setting;
- C. The cost of services and supports is cost effective in comparison to the cost of care in an institutional setting; and
- D. The PCSP should reflect the preferences of the individual and must be signed by the individual or the individual's designee.

210.100 Referral Process

4-1-26

Independent Assessment (IA) referrals are initiated by the Division of Aging, Adult, and Behavioral Services (DAABHS) and Behavioral Health (BH) Service providers identifying an individual who may require services in addition to behavioral health counseling services and medication management. Requests for functional assessment shall be transmitted to the Department of Human Services (DHS) or its designee. Supporting documentation related to treatment services necessary to address functional deficits may be provided.

DHS or its designee will review the request and make a determination to either:

- A. Finalize a referral and send it to the vendor for a BH independent assessment
- B. Provide notification to the requesting BH service provider that more information is needed
- C. Provide notification to the requesting entity

Reassessments will occur annually unless a change in circumstances requires a new assessment. A reassessment will be completed by staff employed by the independent assessment contractor utilizing the current approved assessment instrument (ARIA), which was approved prior to April 1, 2021, to assess functional need. An interview will be conducted in person for initial assessments, with the option of using telemedicine to complete Behavioral Health reassessments. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

210.300 Tiering

4-1-26

- A. Tier Definitions:
 - 1. Tier 1 indicates the score reflected that the individual can continue Counseling and Medication Management services but is not eligible for the additional array of services available in Tier 2 and Tier 3.

2. Tier 2 indicates the score reflected difficulties with certain functional behaviors allowing eligibility for a full array of services to help the individual function in home and community settings and move towards recovery.
3. Tier 3 indicates the score reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the individual move towards reintegrating back into the community, function in home and community settings, and move toward recovery.

B. Tier Logic

1. Beneficiaries aged 18 and over

	Tier 1 – Counseling and Medication Management Services	Tier 2 – Counseling, Medication Management, and Support Services	Tier 3 – Counseling, Medication Management, Support, and Residential Services
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score of 4 <u>AND</u> Intervention Score of 1 or 2 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA	Mental Health Diagnosis Score of 4 <u>AND</u> Intervention Score of 3 or 4 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 4 or 5 in any ONE of the following Psychosocial Subdomains: Difficulties Regulating Emotions Susceptibility to Victimization Withdrawal Agitation	

		Impulsivity Intrusiveness	
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> Intervention Score of 1, 2, 3 or 4 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5 in the following Psychosocial Subdomain: Psychotic Behaviors	
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> Intervention Score of 4 <u>AND</u> Frequency Score of 4 or 5 in the following Psychosocial Subdomain: Manic Behaviors	
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> PHQ-9 Score of 3 or 4 (Moderately Severe or Severe Depression) <u>OR</u> Geriatric Depression Score of 3 (≥ 10)	
		<u>OR</u>	
		Mental Health Diagnosis Score of 4 <u>AND</u> Substance Abuse or Alcohol Use Score of 3	

When you see “**AND**”, this indicates you must have a score in this area **AND** a score in another area. When you see “**OR**”, this indicates you must have a score in this area **OR** a score in another area.

2. Beneficiaries Under Age 18

	Tier 1 – Counseling and Medication Management Services	Tier 2 – Counseling, Medication Management, and Support Services	Tier 3 – Counseling, Medication Management, Support, and Residential Services
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score ≥ 2 <u>AND</u> Injurious to Self: Intervention Score of 1, 2 or 3 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score ≥ 2 <u>AND</u> Injurious to Self: Intervention Score of 4 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Aggressive Toward Others, Physical: Intervention Score of 1, 2 or 3 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score ≥ 2 <u>AND</u> Aggressive Toward Others, Physical: Intervention Score of 4 <u>AND</u> Frequency Score of 2, 3, 4 or 5
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Aggressive Toward Others, Verbal/Gestural Wandering/Elopement	Mental Health Diagnosis Score ≥ 2 <u>AND</u> Psychotic Behaviors: Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 3, 4 or 5
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intervention Score of 2, 3 or 4	

		<u>AND</u> Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Socially Unacceptable Behavior Property Destruction	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Agitation Anxiety Difficulties Regulating Emotions Impulsivity Injury to Others, Unintentional Manic Behaviors Susceptibility to Victimization Withdrawal	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> PICA: Intervention Score of 4	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intrusiveness: Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 4 or 5	
		<u>OR</u>	

		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Psychotic Behaviors: Intervention Score of 1 or 2 <u>AND</u> Frequency Score of 1 or 2	
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Psychosocial Subdomain Score ≥ 5 and ≤ 7 <u>AND</u> Pediatric Symptom Checklist Score > 15	

210.400 Possible Outcomes

4-1-26

- A. For a beneficiary receiving a Tier 1 determination:
1. Eligible for Counseling and Medication Management services and may continue Tier 1 services with a certified behavioral health service provider or Independently Licensed Practitioner (ILP).
 2. Not eligible for Tier 2 or Tier 3 services.
 3. Not eligible for assignment to a Provider-led Arkansas Shared Savings Entity (PASSE) or to continue participation with a PASSE.
- B. For a beneficiary receiving a Tier 2 or Tier 3 determination:
1. Eligible for services contained in Tier 1 and higher.
 2. Eligible for assignment to a PASSE or to continue participation with a PASSE.
 - a. The PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.
 - b. The PASSE will be responsible for providing care coordination assisting the beneficiary in accessing all needed services and providing those services.

220.300 Tiering

4-1-26

- A. Tier Definitions:
1. Tier 2 indicates that the score reflected difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings.
 2. Tier 3 indicates that the score reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings.
- B. Tiering Logic:

1. DDS tier logic is organized by categories of need, as follows:
 - a. Safety: Your ability to remain safe and out of harm's way
 - b. Behavior: Behaviors that could place you or others in harm's way
 - c. Self-Care: Your ability to take care of yourself, such as bathing yourself, getting dressed, preparing your meals, shopping, or going to the bathroom

Tier 2: Institutional Level of Care	Tier 3: Institutional Level of Care and may need 24 hours a day/7 days a week paid supports and services to maintain current placement
<u>Safety Level High</u> A. Self-Preservation Score ≥ 4 <u>AND</u> B. Caregiving Capacity/Risk Score ≥ 6 <u>AND</u> C. Caregiving/Natural Supports Score ≥ 6 <u>AND</u> D. Mental Status Evaluation Score (in the home) = 3 or 4 <u>AND</u> E. Mental Status Evaluation Score (in the community) = 2	A. Self-Preservation Score ≥ 16 <u>AND</u> B. Caregiving Capacity/Risk Score = 11 <u>AND</u> C. Caregiving/Natural Supports Score of = 7 <u>AND</u> D. Mental Status Evaluation Score (in the home) Score = 5 <u>AND</u> E. Mental Status Evaluation Score (in the community) Score = 3
<u>Safety Level Medium</u> A. Self-Preservation Score ≥ 4 <u>AND</u> B. Caregiving Capacity/Risk Score ≥ 6 <u>AND</u> C. Caregiving/Natural Supports Score ≥ 6 <u>AND</u> D. Mental Status Evaluation Score (in the home) = 2 <u>AND</u> E. Mental Status Evaluation Score (in the community) = 2	
<u>Safety Level Low</u> A. Self-Preservation Score ≥ 4 <u>AND</u> B. Caregiving Capacity/Risk Score ≥ 6 <u>AND</u> C. Caregiving/Natural Supports Score ≥ 6 <u>AND</u>	

D. Mental Status Evaluation Score (in the home) = 1 <u>AND</u> E. Mental Status Evaluation Score (in the community) Score = 1	
<u>Behavior Level High</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of ≥ 5 - ≤ 7 <u>in at least ONE of the following Subdomains:</u> Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement; <u>AND</u> C. Caregiving Capacity/Risk Score of ≥ 6 <u>AND</u> D. Caregiving/Natural Supports Score of ≥ 5 <u>OR</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of ≥ 5 - ≤ 7 <u>in at least THREE of the following Subdomains:</u> Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal	<u>Behavior Level High</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 <u>in at least TWO of the following Subdomains:</u> Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement <u>OR</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of ≥ 8 - ≤ 9 <u>in at least THREE of the following Subdomains:</u> Aggressive Toward Others Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Verbal/Gestural; Withdrawal

C. <u>AND</u> at least one of the following scores: Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 5	
<u>Behavior Level Low</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of $\geq 3 - \leq 4$ <u>in at least ONE of the following Subdomains:</u> Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement C. <u>AND</u> at least one of the following scores: Caregiving Capacity/Risk Score of ≤ 8 Caregiving/Natural Supports Score of ≤ 3 <u>OR</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of $\geq 5 - \leq 7$ <u>in at least one of the following Subdomains:</u> Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. <u>AND</u> at least one of the following scores: Caregiving Capacity/Risk Score of ≤ 8	<u>Behavior Level Low</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of $\geq 8 - \leq 9$ <u>in at least ONE of the following Subdomains:</u> Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement] <u>OR</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Psychosocial Subdomain Score of $\geq 8 - \leq 9$ <u>in at least TWO of the following Subdomains:</u> Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal

Caregiving/Natural Supports Score of ≤ 3	
<u>Self-Care Level High</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. <u>Scores within stated range in at least THREE of any of the following:</u> 1. <i>ADLs:</i> Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers 2. <i>Functional Communication:</i> Score of 2 or 3 in Functional Communication 3. <i>IADLs:</i> Score of 3 in any of the following IADLs (Meal Preparation, Housekeeping, Finances, Shopping) 4. <i>Safety:</i> Self-Preservation Score of ≥ 4 <u>AND a score in at least one of the following areas:</u> Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 4 Treatment/Monitoring Score of at least 2	<u>Self-Care Level High</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. Treatments/Monitoring Score of at least 2 C. <u>AND at least one of the following scores:</u> Caregiving Capacity/Risk Score ≥ 10 Caregiving/Natural Supports Score of $= 7$
<u>Self-Care Level Medium</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. <u>Scores within stated range in at least THREE of any of the following:</u> 1. <i>ADLs:</i> Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting	

Score of 1-10 in Mobility Score of 1-10 in Transfers 2. <i>Functional Communication:</i> Score of 1 in Functional Communication 3. <i>IADLs</i> Score of 3 in any of the following IADLs: (Meal Preparation, Housekeeping, Finances, Shopping) 4. <i>Safety:</i> Self-Preservation Score of ≥ 2 <u>AND</u> a score in at least one of the following areas: Caregiving Capacity/Risk Score of ≥ 9 Caregiving/Natural Supports Score of ≥ 4	
<u>Self-Care Level Low</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. <u>Scores within stated range in at least THREE of any of the following combinations:</u> Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers] <u>OR</u> Neurodevelopmental Score of 2 <u>AND</u> Score of ≥ 1 in any of the following: IADLs (Meal Preparation, Housekeeping, Finances, Shopping)	<u>Self-Care Level Low</u> A. Neurodevelopmental Score of 2 <u>AND</u> B. <u>Scores within stated range in at least THREE of any of the following combinations:</u> Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers C. <u>AND</u> at least one of the following scores: Caregiving Capacity/Risk Score of ≥ 10 Caregiving/Natural Supports Score of 7

When you see “**AND**”, this indicates you must have a score in this area **AND** a score in another area. When you see “**OR**”, this indicates you must have a score in this area **OR** a score in another area.

To qualify for the ARChoices Program, a person must be age twenty-one (21) through sixty-four (64) and have been determined to have a physical disability through the Social Security Administration or the Department of Human Services (DHS) Medical Review Team (MRT) and require an intermediate level of care in a nursing facility or be sixty-five (65) years of age or older and require an intermediate level of care in a nursing facility. Persons determined to meet the skilled level of care, as determined by the Division of County Operations DCO are not eligible for the ARChoices Program.

230.100 Referral Process

4-1-26

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

230.200 Assessor Qualifications

4-1-26

In addition to the qualifications listed in Section 202.000, ARChoices assessors must be a Registered Nurse licensed in the State of Arkansas.

230.300 Tiering

4-1-26

A. Tier Definitions:

1. Tier 0 and Tier 1 indicate the individual's assessed needs, if any, do not support the need for either ARChoices waiver services or nursing facility services.
2. Tier 2 indicates the individual's assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.

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

B. Tiering Logic:

DAAS Approved Tier Logic				
STATE APPROVED				
	Tier 0	Tier 1	Tier 2	Tier 3
Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ≥ 2
	AND	AND	AND	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence	Physical Assistance Score of ≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3	

	Support, Positioning	Use/Continence Support, Positioning	3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 <u>OR</u> Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 <u>OR</u> Mobility Physical Assistance Score = 2	
			<u>OR</u>	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score ≥ 2 <u>AND</u> Types of supports in home Score ≥ 3 <u>OR</u> Types of supports in community Score ≥ 2 <u>AND</u> [Score in at least ONE of the following: Injurious to Self Score ≥ 8 Aggressive Toward Others, Physical Score ≥ 8	

			Aggressive Toward Others, Verbal/Gestural Score ≥ 8 Socially Unacceptable Behavior Score ≥ 8 Wandering/ Elopement Score ≥ 8 Susceptibility to Victimization Score ≥ 8 Eating Cuing/Supervision Score ≥ 1] <u>OR</u> Life Threatening Condition Score = 1	
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Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED Applies to Tier 2 Results <u>ONLY</u>			
	<u>Intensive</u>	<u>Intermediate</u>	<u>Preventative</u>

Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 <u>OR</u> Transfers Physical Assistance Score = 3 <u>OR</u> Positioning Physical Assistance Score = 3 <u>AND</u> Category 2: Eating Eating Physical Assistance Score = 3 <u>AND</u> Category 3: Toileting Toileting Physical Assistance Score = 3 <u>OR</u> Toileting/ Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 <u>OR</u> Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 <u>OR</u> Transfers Physical Assistance Score = 3 <u>OR</u> Positioning Physical Assistance Score = 3 <u>AND/OR</u> Category 2: Eating Eating Physical Assistance Score = 3 <u>AND/OR</u> Category 3: Toileting Toileting Physical Assistance Score = 3 <u>OR</u> Toileting/Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 <u>OR</u> Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.
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230.400 Possible Outcomes

4-1-26

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

240.000 LIVING CHOICES

Living Choices Assisted Living is a home and community-based services waiver program that is administered jointly by the Division of Medical Services (DMS, the state Medicaid agency) and the Division of Aging, Adult, and Behavioral Health Services (DAABHS), under the waiver authority of Section 1915(c) of the Social Security Act. Home and community-based services waiver programs cover services designed to allow specific populations of individuals to live in their own homes or in certain types of congregate settings. The Living Choices Assisted Living waiver program serves persons sixty-five (65) years of age and older and persons twenty-one through sixty-four (21-64) years of age who are determined, by the Social Security Administration or the Arkansas DHS Medical Review Team (MRT), to be individuals with

physical disabilities and who are eligible for nursing home admission at the intermediate level of care.

240.100 Referral Process

4-1-26

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

240.200 Assessor Qualifications

4-1-26

In addition to the qualifications listed in Section 202.000, Living Choices assessors must be a Registered Nurse licensed in the State of Arkansas.

240.300 Tiering

4-1-26

A. Tier definitions:

1. Tier 0 and Tier 1 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 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 indicates the individual needs skilled care available through a licensed nursing facility and therefore is not eligible for the Living Choices waiver program.

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

B. Tiering logic:

DAAS Approved Tier Logic				
STATE APPROVED				
	Tier 0	Tier 1	Tier 2	Tier 3
Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ≥ 2
	<u>AND</u>	<u>AND</u>	<u>AND</u>	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Physical Assistance Score of ≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring,	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3	

		Toilet Use/Continence Support, Positioning 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 <u>OR</u> Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 <u>OR</u> Mobility Physical Assistance Score = 2	
		<u>OR</u>	
Safety Status (Memory & Behavior)		Neurological/Central Nervous System Score ≥ 2 <u>AND</u> Types of supports in home Score ≥ 3 <u>OR</u> Types of supports in community Score ≥ 2 <u>AND</u> [Score in at least ONE of the following: Injurious to Self Score ≥ 8 Aggressive Toward Others, Physical Score ≥ 8 Aggressive Toward Others, Verbal/Gestural Score ≥ 8	

			Socially Unacceptable Behavior Score ≥ 8 Wandering/Elopement Score ≥ 8 Susceptibility to Victimization Score ≥ 8 Eating Cuing/Supervision Score ≥ 1	
			OR	
Life Threatening Condition			Life Threatening Condition Score = 1	

Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED Applies to Tier 2 Results <u>ONLY</u>			
	Intensive	Intermediate	Preventative
Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 OR Transfers Physical Assistance Score = 3 OR Positioning Physical Assistance Score = 3 AND Category 2: Eating Eating Physical Assistance Score = 3 AND Category 3: Toileting Toileting Physical	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 OR Transfers Physical Assistance Score = 3 OR Positioning Physical Assistance Score = 3 AND/OR Category 2: Eating Eating Physical Assistance Score = 3 AND/OR Category 3: Toileting Toileting Physical	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.

Assistance Score = 3 OR Toileting/ Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 OR Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	Assistance Score = 3 OR Toileting/Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 OR Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	
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240.400 Possible Outcomes**4-1-26**

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

250.000 PACE

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model that enables individuals who are fifty-five (55) years of age or older and certified by the state to need nursing facility care, to live as independently as possible. Through PACE, fragmented health care financing and delivery system comes together to serve the unique needs of the enrolled individual with chronic care needs. The population served by PACE is historically very frail. The PACE organization must provide all needed services to the PACE participant.

250.100 Referral Process**4-1-26**

Independent Assessment (IA) referrals are initiated by the Division of County Operations (DCO) when the individual completes an application for services at the DHS office in the county of their residence. The referral is transmitted to the IA vendor.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where a participant has experienced a significant change in circumstances, an evaluation will be performed and based on the review of the evaluation, a reassessment may be requested.

250.200 Assessor Qualifications**4-1-26**

In addition to the qualifications listed in Section 202.000, PACE assessors must be a Registered Nurse licensed in the State of Arkansas.

250.300 Tiering**4-1-26****A. Tier definitions:**

1. Tier 0 and Tier 1 indicate the individual's assessed needs, if any, do not support the need for either PACE services or nursing facility services.
2. Tier 2 indicates the individual's assessed needs are consistent with services available through either the PACE program or a licensed nursing facility.

3. Tier 3 indicates the individual needs skilled care available through a licensed nursing facility and therefore is not eligible for the PACE program.

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

B. Tiering logic:

DAAS Approved Tier Logic STATE APPROVED				
	Tier 0	Tier 1	Tier 2	Tier 3
Skilled Nursing	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score < 2	Treatments/ Monitoring Score ≥ 2
	<u>AND</u>	<u>AND</u>	<u>AND</u>	
Functional Status (ADLs)	Physical Assistance Score < 2 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Physical Assistance Score of ≥ 2 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Must meet scores in at least ONE ADL listed: 1. Eating Physical Assistance Score = 3 2. Mobility Physical Assistance Score = 3 3. Toileting Physical Assistance Score = 3 4. Transfers Physical Assistance Score = 3 <u>OR</u> Must meet scores in at least TWO ADLs listed: 1. Eating Physical Assistance Score = 2 2. Toileting Physical Assistance Score = 2 3. Transfers Physical Assistance Score = 2 <u>OR</u>	

			Mobility Physical Assistance Score = 2	
			<u>OR</u>	
Safety Status (Memory & Behavior)			Neurological/Central Nervous System Score ≥ 2 <u>AND</u> Types of supports in home Score ≥ 3 <u>OR</u> Types of supports in community Score ≥ 2 <u>AND</u> [Score in at least ONE of the following: Injurious to Self Score ≥ 8 Aggressive Toward Others, Physical Score ≥ 8 Aggressive Toward Others, Verbal/Gestural Score ≥ 8 Socially Unacceptable Behavior Score ≥ 8 Wandering/Elopement Score ≥ 8 Susceptibility to Victimization Score ≥ 8 Eating Cuing/Supervision Score ≥ 1] <u>OR</u> Life Threatening Condition Score = 1	

Tiering Stratification Logic

Applies to Tier 2 results ONLY

DAAS Tier Stratification Logic – STATE APPROVED			
Applies to Tier 2 Results <u>ONLY</u>			
	<u>Intensive</u>	<u>Intermediate</u>	<u>Preventative</u>
Functional Status (ADLs)	Scores must be present in ALL THREE categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 <u>OR</u> Transfers Physical Assistance Score = 3 <u>OR</u> Positioning Physical Assistance Score = 3 <u>AND</u> Category 2: Eating Eating Physical Assistance Score = 3 <u>AND</u> Category 3: Toileting Toileting Physical Assistance Score = 3 <u>OR</u> Toileting/ Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 <u>OR</u> Toileting/Continence Support Challenge = Cannot empty ostomy/ catheter bag Score = 1	Scores must be present in at least TWO of the categories below: Category 1: Mobility Mobility Physical Assistance Score = 3 <u>OR</u> Transfers Physical Assistance Score = 3 <u>OR</u> Positioning Physical Assistance Score = 3 <u>AND/OR</u> Category 2: Eating Eating Physical Assistance Score = 3 <u>AND/OR</u> Category 3: Toileting Toileting Physical Assistance Score = 3 <u>OR</u> Toileting/Continence Support Challenge = Cannot change incontinence pads. Cannot do own peri care Score = 1 <u>OR</u> Toileting/Continence Support Challenge = Cannot empty ostomy/catheter bag Score = 1	Does not meet conditions of Intermediate or Intensive. By default, is Tier 2 Preventative.

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

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200.000 PERSONAL CARE GENERAL INFORMATION**200.100 Arkansas Medicaid Participation Requirements for Personal Care Providers 4-1-19**

Numerous agencies, organizations and other entities may qualify for enrollment in the Arkansas Medicaid Personal Care Program. Participation requirements vary among these different types of providers. Sections 200.110 through 200.119 outline the participation requirements specific to each type of personal care provider. Section 201.000 describes the procedures required to enroll in the Medicaid Program. Sections 201.010 through 201.030 set forth the licensing, certification and other requirements specific to each type of personal care provider.

All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

200.110 Class A Home Health Agencies 3-1-05

The Division of Health Facility Services, Arkansas Department of Health, must license a Class A Home Health agency before the agency may apply to enroll as a personal care provider.

200.120 Class B Home Health Agencies 8-1-04

- A. A Class B Home Health agency applying for enrollment as a personal care provider must be licensed as a Class B Home Health agency by the Arkansas Department of Health.
- B. The Class B Home Health license must state that the provider is licensed to perform personal care services only.

200.130 Private Care Agencies 4-1-18

- A. A private care agency applying to enroll as a personal care provider must be licensed by the Arkansas Department of Health.
- B. Private care agencies must be enrolled in the Arkansas Medicaid ARChoices Program.

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

200.140 Assisted Living Facilities

1-1-19

A. Only one type of assisted living facility, a Level 1 Assisted Living Facility (ALF), may enroll as a personal care provider.

B. The Division of Provider Services and Quality Assurance (DPSQA) certifies, licenses and regulates certain institutions, including ALFs.

C. Each ALF has a separate license, regardless of which type it is and regardless of its location or proprietorship.

D. Each ALF that provides personal care for Medicaid beneficiaries and that desires Medicaid reimbursement for those services must enroll separately in the Arkansas Medicaid Personal Care Program, effective for dates of service on and after March 1, 2005.

1. Some providers operate multiple ALF facilities, sometimes on the same property or in the same complex and sometimes in multiple locations.

a. Effective for dates of service before March 1, 2005, Medicaid covers personal care services provided by enrolled RCFs for residents of Level I ALFs under the same proprietorship as the enrolled RCF.

b. Level I ALFs that are not under the same proprietorship as a Medicaid-enrolled RCF may not contract for Medicaid-covered personal care with an enrolled RCF owned by another entity.

c. Except under the conditions described in part 4 above, personal care in any assisted living facility may be provided only by the facility itself, if it is enrolled in the Arkansas Medicaid Personal Care Program, or by

(1). A private care agency that is enrolled as a Personal Care provider or

(2). A Class A or Class B home health agency that is enrolled as a Personal Care provider.

2. Several provider files may share the same Federal Employer Identification Number (FEIN). For example: A corporate entity that has one FEIN owns an RCF and a Level I ALF and enrolls them as Personal Care Program providers.

a. Each facility is assigned a unique Arkansas Medicaid provider number.

b. Each facility's Arkansas Medicaid Personal Care provider number is linked to its unique license number.

c. Each facility's Arkansas Medicaid Personal Care provider number is linked to the corporate entity's single FEIN.

E. Sections 200.141 and 200.142 outline Arkansas Medicaid Personal Care Program participation requirements for RCFs, and Level I ALFs.

F. Level II ALFs may participate in the Living Choices Assisted Living Program.

1. Living Choices is a home and community-based program established for certain nursing home-eligible individuals who, without a program like Living Choices, would not be able to live in a dwelling of their own or would be able to do so only with great difficulty and with significant risk to their health and safety.

2. Providers may obtain Living Choices Program participation requirements by downloading the Living Choices Assisted Living Provider Manual from the Arkansas Medicaid website, <https://medicaid.mmis.arkansas.gov>.

3. Living Choices services are not covered for beneficiaries receiving services through the Personal Care Program, and Personal Care Program services are not covered for beneficiaries in the Living Choices Program.

200.141 Residential Care Facilities

1-1-19

A residential care facility applying for enrollment as a personal care provider must be licensed as a residential care facility by the Division of Provider Services and Quality Assurance (DPSQA).

200.142 Level I Assisted Living Facilities

1-1-19

A Level I ALF applying for enrollment as a personal care provider must be licensed as a Level I ALF by the Division of Provider Services and Quality Assurance (DPSQA).

200.160 School Districts and Education Service Cooperatives

8-1-04

A school district or education service cooperative must be certified as a Local Educational Agency (LEA) by the Arkansas Department of Education. The Arkansas Department of Education will provide verification of LEA certification to the Provider Enrollment Unit of the Division of Medical Services (DMS).

201.000 Reserved

11-1-09

201.100 Provider Enrollment Procedures

7-22-10

Personal care providers must meet the Provider Participation and enrollment requirements contained within Section 201.000 of this manual as well as the following criteria to be eligible for the Arkansas Medicaid Program.

Sections 201.110 through 201.140 list the documentation required for each type of applicant for enrollment as a provider in the Personal Care program.

201.110 Class A and Class B Home Health Agencies

1-1-19

Class A and Class B Home Health Agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current Class A or Class B license. In addition, certification by DPSQA is required for Medicaid provider enrollment.

201.120 Private Care Agencies

1-1-19

- A. Private care agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current license from the Arkansas Department of Health. In addition, certification by DPSQA is required for Medicaid provider enrollment.
- B. Private care agencies must ensure that there is on file with the Provider Enrollment Unit proof of liability insurance coverage of not less than one million dollars (\$1,000,000.00), covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.
- C. Annually, private care agency providers must ensure that there is on file with the Provider Enrollment Unit proof that the agency's required liability insurance remains in force and has remained in force at a level of coverage no less than the required minimum since the provider's previous report.

201.130 Assisted Living Facilities**201.131 Residential Care Facilities****1-1-19**

A residential care facility applying for enrollment as a personal care provider must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of its current license from the Division of Provider Services and Quality Assurance (DPSQA). In addition, certification by DPSQA is required for Medicaid provider enrollment.

201.132 Level I Assisted Living Facilities**1-1-19**

A Level I Assisted Living Facility (ALF) applying to enroll as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the Division of Provider Services and Quality Assurance (DPSQA). In addition, certification by DPSQA is required for Medicaid provider enrollment.

202.000 Routine Services Providers and Limited Services Providers Not Licensed in Arkansas**202.100 Routine Services Providers****3-1-05**

Routine services providers in the Arkansas Medicaid Personal Care Program are enrolled Medicaid providers who, in accordance with the regulations of the Arkansas Medicaid Program, may provide medically necessary services to eligible and qualified individuals who choose to receive their services.

202.110 Personal Care Providers in Arkansas**3-1-05**

Enrolled Personal Care providers in Arkansas qualify as routine service providers. However, some personal care providers are limited to providing services only in certain places of service. See Section 213.000, part F.

202.210 Out-of-State Limited Services Personal Care Providers**1-1-19**

A. Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid-eligible beneficiary and they have a claim or claims to file with Arkansas Medicaid.

1. To enroll, providers must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet). View Medicaid Provider Enrollment Unit contact information.**
2. Out of state providers must also be certified by DPSQA.
3. Enrollment as a limited services provider automatically expires after a year unless the provider provides and bills for subsequent services for Arkansas Medicaid beneficiaries during the year. See part B below.

B. Out-of-state limited services providers remain enrolled for one year.

1. If an out-of-state limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

203.000 Independent Choices**1-1-13**

Independent Choices began as a Cash and Counseling Demonstration and Evaluation Project. Independent Choices seeks to increase the opportunity for consumer direction and control for Medicaid beneficiaries receiving or needing personal care by offering a cash allowance and counseling services in place of traditionally provided personal care. Independent Choices and how it related to the Personal Care State Plan program is referenced in this manual and the Independent Choices provider manual.

204.000 Record Maintenance and Availability**11-1-09**

- A. Personal Care providers are required to keep documentation and records as described in Section 140.000, in Section 221.000 and in officially promulgated, approved and published rules that may be incorporated into this manual.

205.000 Electronic Signatures**10-8-10**

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

210.000 PROGRAM OVERVIEW**211.000 Program Authority****10-13-03**

- A. Title XIX of the Social Security Act authorizes personal care services as an optional State Plan benefit.
- B. The Arkansas Medicaid Program has elected to offer personal care services benefits in conformity with the rules set out in this manual.

212.000 Program Purpose**1-1-18**

- A. The purpose of Personal Care Program services is to supplement, not to supplant, other resources available to the beneficiary.
- B. Personal care services are medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS and individually designed to assist beneficiaries with their physical dependency needs as described in Section 213.200 and Sections 216.100 through 216.140.

213.000 Scope of the Program**1-1-19**

- A. Personal care services are primarily based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Hands-on assistance in at least one of these areas, based on the ARIA assessment results, is required. This type of assistance is provided by a personal care aide based on a beneficiary's physical dependency needs (as opposed to purely housekeeping services). An individualized plan of care is developed based on the ARIA assessment results and information in the form designated by DHS that is submitted by the provider, and is based on a beneficiary's assessed dependency in at least one of the above-listed activities of daily living. While not

a part of the eligibility criteria, the need for assistance with other tasks and IADLs (Instrumental Activities of Daily Living) are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized. Routines or IADLs include meal preparation, incidental housekeeping, laundry, medication assistance, etc. These tasks are also defined and described in this section of this provider manual and are defined in the Arkansas State Board of Nursing Position Statement 97-2.

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

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

1. Home health aides may provide personal care services in the home under the home health benefit.
2. Skilled services that only a health professional may perform are not considered personal care services.

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

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State, e.g., ARChoices, IndependentChoices;
2. Furnished in the beneficiary's home, and at the State's option, in another location.
3. Provided by an individual claimed to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family".

E. Personal care for Medicaid-eligible individuals requires prior authorization. See Sections 240.000 through 246.000.

F. Only Class A Home Health agencies, Class B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, and education service cooperatives may provide personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the beneficiary's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

213.100 Individuals Eligible for Personal Care

213.110 Categorically Needy Medicaid Eligibility

10-13-03

A. Only Categorically Needy Medicaid beneficiaries are eligible for personal care services. Beneficiaries in Medically Needy categories are not eligible for personal care services.

B. See Section I of this manual for the Beneficiary Aid Categories, including the category codes and abbreviated category descriptions. The suffix "MN" indicates a "Medically Needy" aid category.

1. An Eligibility Verification Transaction Response identifies an Aid Category Code and an Aid Category Description for each eligibility segment it lists.
2. The headings, "AID CATEGORY CODE" and "AID CAT DESCRIPTION," appear beneath each eligibility segment.

3. The Aid Category description of a Medically Needy category ends with "EC" (Exceptional Category) or "SD" (Spend Down), as it appears on the Eligibility Verification Transaction Response.

213.120 Non-Inpatient, Non-Institutionalized Status**1-1-19**

- A. Personal care services are services furnished to an individual who is not an inpatient or a resident of:
1. A hospital;
 2. A nursing facility;
 3. A Level II assisted living facility;
 4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or
 5. An institution for mental diseases (IMD).
- B. Individuals who are inpatients or residents of the foregoing institutions or facilities are ineligible for Personal Care Program services.
1. Under applicable federal statutory and regulatory provisions, the institutional status of an individual controls the individual's exclusion from service eligibility.
 2. The location of the personal care service delivery site is not a determinant of the institutionalized individual's ineligibility for services.

213.200 Physical Dependency Need Criteria for Service Eligibility**1-1-19**

- A. The terms "routine," "activities of daily living," and "service" have particular definitions that apply to the Personal Care Program. See Sections 216.000 through 216.140 for definition of these and other terms employed in this manual.
- B. Personal care services, described in Sections 216.000 through 216.330, must be medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS.
- C. Personal care services are individually designed to assist with a beneficiary's assessed physical dependency needs related to the following routine activities of daily living and instrumental activities of daily living:
1. Bathing
 2. Bladder and bowel requirements
 3. Dressing
 4. Eating
 5. Incidental housekeeping
 6. Laundry
 7. Personal hygiene
 8. Shopping for personal maintenance items
 9. Taking medications*
 10. Mobility and Ambulation

* Assistance with medications is a personal care service only to the extent that it is permitted by the Arkansas Nurse Practice Act, implementing regulations permit a personal care aide to perform the service, and Arkansas State Board of Nursing Position Statement 97-2.

D. A number of conditions may cause "physical dependency needs."

1. Particular disabilities or conditions may or may not be pertinent to specific needs for individual assistance.
2. In assessing an individual's need for personal care, the question to pursue is whether the individual is unable to perform tasks covered by this program without assistance from someone else.
3. The need for individual assistance indicates whether to consider personal care.

213.300 Beneficiary's Consent and Freedom of Choice

10-13-03

- A. A Medicaid beneficiary has freedom of choice in selecting a personal care provider.
- B. Provision of personal care services is contingent upon the written consent of the beneficiary or the beneficiary's representative.

213.310 IndependentChoices Program, Title XIX State Plan Program

1-1-19

IndependentChoices is operated by the Division of Provider Services and Quality Assurance (DPSQA) and operates under the authority of the Title XIX State Plan with the Division of Medical Services responsible for administrative and financial authority.

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly (age 65 and older) to direct their personal care. The beneficiary chooses a cash allowance in lieu of agency personal care services. IndependentChoices provides qualifying beneficiaries with counseling and training to assist them with information to fulfill their role as an employer. The beneficiary and the employee will hire, train, supervise and, if necessary, terminate the services of their employee. In addition to hiring an employee, the beneficiary may use part of their budget to purchase goods and services that lessen their physical dependency need. In addition to counseling support services, beneficiaries may receive Financial Management Services (FMS) from a DMS contracted provider. The FMS provider will assist the participant by processing timesheets, withholding and reporting State and Federal taxes, issuing a W-2 to all employees who meet the tax threshold and refunding taxes to the participant and the employee when the threshold was not met. The FMS provider also coordinates the accuracy and coordination of the forms used to establish the Medicaid beneficiary as an employer and to employ a worker. The FMS provider representing the Medicaid beneficiary will obtain permissions and execute an IRS Form 2678 to act as the beneficiary's agent.

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

213.500 Personal Care Service Locations

1-1-19

- A. Arkansas Medicaid covers personal care in a beneficiary's home and, at the state's option, in another location, for beneficiaries of all ages.
 1. A beneficiary's home is the beneficiary's residence, subject to the exclusions in part B, below.
 2. Service locations outside the beneficiary's home must be included in the service plan. (If shopping or assistance with shopping is included in the service plan, it is understood that the actual activity occurs at a store. The place of service—for billing purposes—remains the beneficiary's home.)
 3. The beneficiary's assessment and service plan must justify the medical necessity for personal care in a location other than the beneficiary's residence. For example: A beneficiary's service plan includes assistance with dressing. This particular

beneficiary regularly (by PCP referral or a physician's order) goes to a clinic or other site for a therapy, such as aqua therapy, that involves changing clothes. If, at the therapy site, assistance with dressing and/or changing is not included with the therapy service, the personal care service plan may include an aide's assistance. However, in such a situation, only the time the aide spends performing the service is covered.

B. Medicaid does not cover personal care services in the following locations:

1. A hospital,
2. A nursing facility,
3. A Level II assisted living facility,
4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or
5. An institution for mental diseases (IMD).

C. All individuals residing in locations listed above in part B are ineligible for Medicaid-covered personal care.

D. Individuals who are inpatients or residents of the facilities and institutions listed in part B are not eligible for Medicaid-covered personal care services in any location.

213.520 Personal Care in Public Schools—Beneficiaries under Age 21

7-1-09

A. Personal care in public schools is available to eligible beneficiaries under the age of 21.

1. School may be on or off site based on accessibility for the beneficiary.
2. When a beneficiary's education is the responsibility of the school district in which that individual resides, "public school" as a place of service for Medicaid-covered services is any location, on-site or away from the site of an actual school building or campus.
 - a. When a beneficiary is attending school at a DDS community provider facility because the school district has contracted with the facility to provide educational services, the place of service for Medicaid-Program purposes is "public school."
 - b. When the home is the educational setting for a beneficiary who is enrolled in the public school system, "public school" is considered the place of service.
 - c. The beneficiary's home is not considered a "public school" place of service when a parent elects to home school a child.

B. Medicaid Program requirements are the same as for services delivered in the beneficiary's home.

C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the beneficiary receives services.

D. Beneficiaries receiving personal care in public schools may receive a number of services in accordance with an Individualized Education Program (IEP).

1. The IEP may not supersede or substitute for the personal care service plan.
2. The Personal Care Program requires a distinct and separate assessment and service plan.

E. Refer to Section 262.103 for billing instructions regarding personal care in public schools.

213.530 Personal Care in Residential Care Facilities (RCFs)

3-1-08

- A. Residential Care Facilities (RCFs) enrolled as Personal Care providers may furnish Medicaid-covered personal care services, on their own RCF-licensed premises, to their own beneficiaries (i.e. personal care-qualified Medicaid beneficiaries whose residence is the RCF).
- B. RCF Personal Care providers may not provide Medicaid-covered Personal Care services at any other locations or for any other Medicaid beneficiaries.
- C. RCF Personal Care providers are subject to the same requirements as all other Personal Care providers unless this manual, other official documents or jurisdictional court or consent decrees explicitly state otherwise as, for instance, in parts A and B above.

213.540 Employment-related Personal Care Outside the Home

1-1-19

No condition of this section alters or adversely affects the status of individuals who are furnished personal care in sheltered workshops or similarly authorized habilitative environments. There may be a few beneficiaries working in sheltered workshops solely or primarily because they have access to personal care in that setting. This expansion of personal care outside the home may enable some of those individuals to move or attempt to move into an integrated work setting.

- A. Personal care may be provided outside the home when the requirements in subparts A1 through A5 are met and the services are necessary to assist an individual with a disability to obtain or retain employment.

1. The beneficiary must have an authorized, individualized personal care service plan that includes the covered personal care services necessary to and appropriate for an employed individual or for an individual seeking employment.
2. The beneficiary must be aged 16 or older.
3. The beneficiary's disability must meet the Social Security/SSI disability definition.
 - a. A beneficiary's disability may be confirmed by verifying his or her eligibility for SSI, Social Security disability benefits or a Medicaid disability aid category, such as Working Disabled or DDS Alternative Community Services waiver.
 - b. If uncertain whether a beneficiary qualifies under this disability provision, contact the Department of Human Services local office in the county in which the beneficiary resides.
4. One of the following two conditions must be met.
 - a. The beneficiary must work at least 40 hours per month in an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability).
 - b. Alternatively, the beneficiary must be actively seeking employment that requires a minimum of 40 hours of work per month in an integrated setting.
5. The beneficiary must earn at least minimum wage or be actively seeking employment that pays at least minimum wage.

- B. Personal care aides may assist beneficiaries with personal care needs in a beneficiary's workplace and at employment-related locations, such as human resource offices, employment agencies or job interview sites.

- C. Employment-related personal care associated with transportation is covered as follows.

1. Aides may assist beneficiaries with transportation to and from work or job-seeking and during transportation to and from work or for job-seeking.
2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; see Section 215.300, part F) in the service plan and all pertinent service documentation.

3. Medicaid does not cover mileage associated with any personal care service.
4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is included in the 64-hour per month personal care benefit limit for beneficiaries aged 21 and older.

D. All personal care for beneficiaries requires prior authorization.

E. Providers furnishing both employment-related personal care outside the home and non-employment-related personal care at home or elsewhere for the same beneficiary must comply with the applicable rules at Sections 215.350, 215.351 and 262.100.

213.600 In-State and Out-of-State Limited Services Secondary Personal Care Providers

1-1-19

On rare occasions, a personal care beneficiary might have urgent cause to travel to a locality outside his or her personal care provider's service area. If DHS professional staff or contractor(s) designated by DHS authorizes personal care during the beneficiary's stay in that locality, the beneficiary may choose a personal care provider agency in the service area to which he or she is traveling.

A. In-State and Out-of-State Limited Services Secondary Personal Care Provider

If the selected provider is an in-state provider, the selected provider's services may be covered if all the following requirements are met:

1. The beneficiary's personal care provider (the "primary" provider) must request in writing that the selected provider (the "secondary" provider) assume the beneficiary's service for the specified duration of the beneficiary's stay.
2. The primary provider must forward to the secondary provider a copy of the beneficiary's current service plan and service documentation, including logs, for a minimum service period of sixty days prior to the request.
3. If the secondary provider requests additional information or documentation, the primary provider must forward the requested materials immediately.
4. The secondary provider must execute a written agreement to assume the beneficiary's care on behalf of the primary provider.
5. The secondary provider must submit its service documentation to the primary provider within ten working days of the beneficiary's departure from the temporary locality.

B. Out-of-State Limited Services Secondary Personal Care Provider

If the provider is an out-of-state provider, the provider must also download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application and contract to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).**

The selected provider must also submit to contractor designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff a written request for prior authorization accompanied with copies of the provider's license, Medicare certification, beneficiary's identifying information and the beneficiary's service plan.

C. All documentation exchanged between the primary and secondary providers must satisfy all Medicaid requirements.

213.610 Personal Care/Hospice Policy Clarification

1-1-19

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

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

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

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

REPEAL

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

214.200 Service Plan Review and Renewal

7-1-20

A. A personal care service plan is effective for up to one (1) year from the date of the beneficiary's last independent assessment.

B. Personal care services may not continue past the one-year anniversary of the last independent assessment until DHS professional staff or contractor(s) designated by DHS authorizes a revised service plan, or renews, or extends the authorization of an existing service plan.

214.300 Authorization of ARChoices Person-Centered Service Plan and Personal Care Individual Service Plan

1-1-21

The DHS RN is responsible for developing an ARChoices Person-Centered Service Plan (PCSP) that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DHS RN authorizing the services listed.

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

The ARChoices PCSP is effective for one (1) year from the date of the beneficiary's most recent assessment, reassessment, or evaluation. The authorization for personal care services, when included on the ARChoices PCSP, will be for one (1) year from the date of the beneficiary's most recent assessment, reassessment, or evaluation unless revised by the DHS RN or the personal care individualized service plan needs to be revised, whichever occurs first.

NOTE: For ARChoices beneficiaries who receive personal care through traditional agency services or have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a DHS RN, will serve as the authorization for personal care services for one year from the date of the beneficiary's most recent assessment, reassessment, or evaluation as described above.

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

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

214.310 Development of ARChoices Person-Centered Service Plan 1-1-19

If personal care services are not currently being provided when the DHS RN develops the ARChoices Person-Centered Service Plan (PCSP), the DHS RN will determine if personal care services are needed. If so, the service, amount, frequency, duration and the beneficiary's provider of choice will be included on the ARChoices PCSP. A copy of the ARChoices PCSP and a Start of Care form (AAS-9510) will be forwarded to the personal care provider, as is current practice for waiver services. The Start of Care form must be returned to the DHS RN within 10 working days from mailing or action may be taken by the DHS RN to secure another personal care provider or modify the ARChoices PCSP. (The ARChoices PCSP is dated the date it is mailed.) Before taking action to secure another provider or modifying the PCSP, the applicant and/or family members will be contacted to discuss possible alternatives.

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

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

NOTE: It is the IndependentChoices employer or personal care provider's responsibility to place information regarding their presence in the home in a prominent location so that the DHS RN will be aware that they are serving the beneficiary. Preferably, the provider will place the information on the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will

place the information in a location satisfactory to the applicant, as long as it is readily available and easily accessible by the DHS RN.

The personal care individualized service plan developed by the personal care provider must meet all requirements as detailed in the personal care provider manual. This includes, but is not limited to, the amount of personal care services, personal care tasks, frequency and duration. The ARChoices PCSP and the required justification for each service remains the responsibility of the DHS RN. Therefore, final decisions regarding services included on the ARChoices PCSP rest with the DHS RN.

NOTE: For ARChoices waiver beneficiaries participating in the IndependentChoices program, services are effective on the date of the DHS RN's signature on the ARChoices waiver PCSP.

214.330 Medicaid Audit Requirements for the ARChoices Person-Centered Service Plan

1-1-19

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

215.000 Personal Care Assessment and Individualized Service Plan

215.100 IndependentChoices Assessment and Service Plan Formats

1-1-19

A.

For IndependentChoices beneficiaries who are also active waiver beneficiaries in the ARChoices Program, the assessment tool used for waiver Personal Care determination and the waiver Person-Centered Service Plan (PCSP) will suffice to support authorization for personal care services, if signed by the DHS RN. Eligibility for personal care services is based on the same criteria as state plan personal care services. Services are effective on the date of the waiver PCSP. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver PCSP must include, at least, the information designated by DHS that is utilized to support the medical necessity, eligibility and amount of personal care services provided through IndependentChoices or agency personal care services. This information is required in documentation for each beneficiary. As with all required documentation, this information must be available in the participant's chart or electronic record and available for audit and Quality Management Strategy reviews.

215.200 Personal Care Provider's Prior Authorization Request

7-1-20

A. As part of each prior authorization request, each provider shall submit a complete and accurate form designated by DHS. The provider is not required to submit a proposed Individualized Service Plan to DHS.

B. The completed form designated by DHS shall include all information applicable to the individual beneficiary, including:

1. Beneficiary and provider information;
2. Certification that the beneficiary's service plan will not duplicate any other in-home services of which the provider is aware;
3. The total number of hours per month the provider seeks to offer the beneficiary;
4. Detailed information on all personal assistance available to the beneficiary through other sources, including informal caregivers (e.g., family, friends), community

organizations (e.g., Meals on Wheels), Medicare (e.g., Medicare home health aide services), or the beneficiary's Medicare Advantage health plan;

5. The frequency of in-person supervisory visits to be made by an agency supervisor based on the specific needs of the beneficiary and the recommendations of an agency-designated registered nurse; and,

6. The signed approval of the beneficiary or the beneficiary's legal representative.

C. When a beneficiary has two or more personal care providers, the providers should cooperate in the required nursing evaluation and the preparation and submission of the prior authorization request and completed form designated by DHS on behalf of the beneficiary.

D. When an individual will receive some or all of his or her services in a congregate setting, the assessment must reflect the RN's determination that the individual is an appropriate candidate for services delivered in that setting. See Section 216.201 and Sections 220.110 through 220.112.

E. Before furnishing any personal care services to an individual, the provider must prepare a complete and accurate Individualized Service Plan with proposed hours/minutes and frequency of needed tasks consistent with the aggregate number of hours authorized under the Task and Hour Standards (as described in Section 240.100). The service plan must be prepared, certified, and signed by a supervisor or registered nurse. The service plan and all subsequent revisions must be kept by the personal care provider as Documentation under Section 221.000.

215.210 Alternative Resources for Assistance

4-1-19

A. The following requirements regarding alternative resources for assistance do not apply, or apply only insofar as they are legal, practical and practicable, when the identifiable resources are prohibited from assisting the beneficiary by law, by a facility's or organization's rules or bylaws. For example, a relative of the beneficiary is an alternative resource in the beneficiary's home or the relative's home but not in the public school.

B. The form designated by DHS that is submitted by the provider to DHS or the contractor designated by DHS must include written evidence that the beneficiary or the beneficiary's representative and the provider have considered alternative resources available to assist or partially assist the beneficiary with physical dependency needs identified in the assessment:

1. The provider must determine whether voluntary third-party resources are available and if so, the extent of the third party's willingness to devote time to the benefit of the beneficiary. The provider must:

a. Consider other members of the beneficiary's household as well as nearby relatives and friends;

b. Indicate the usual times of their availability to assist the beneficiary and the frequency and duration of their assistance; and

c. Explain the circumstances of any individual household member's inability to provide any assistance or to provide less than complete assistance with the beneficiary's physical dependency needs.

2. The provider must also consider such alternative community resources as public and private community agencies and organizations, whether secular or religious, paid or volunteer.

a. Consider entities that provide not only in-home services, but also such services as adult day care or caregiver respite;

b. List the approximate number of hours per week the beneficiary receives (or will receive) services from each such community resource;

- C. The provider must make reasonable efforts to determine the nature, scope, frequency and duration of other services the individual receives, particularly in home services.
- D. The provider's case record documentation must include the certification that the beneficiary's individualized service plan does not duplicate any other in-home services of which the provider is aware.

215.300 Individualized Service Plan**1-1-19**

- A beneficiary must receive services in accordance with an individualized service plan.
- A. The plan must be acceptable to the beneficiary or the beneficiary's representative.
- B. A registered nurse and other appropriate personnel of the personal care provider agency, in concert with the beneficiary or the beneficiary's representative, must design the individualized service plan to correlate with the physical dependency needs identified in the assessment.
- C. The individualized service plan must be limited to assistance with the beneficiary's individual physical dependency needs.
- D. The service plan must clearly identify which of the beneficiary's physical dependency needs will be met by each task performed by a personal care aide.
 - 1. This requirement does not necessarily mandate writing a unique statement for each task or task component. Indexing the assessment may expedite documentation by permitting one to reference the relevant section of the assessment for the appropriate detail. For example:
 - a. "Task 4 (corresponds to) Physical Dependency 2"
 - b. "Task 6 (corresponds to) Physical Dependency 3"
 - 2. In addition to establishing its correspondence to the assessment (e.g., designing individualized services for a beneficiary's physical dependency needs); the service plan must describe for each routine or activity listed:
 - a. The individual tasks the aide is to perform for the beneficiary;
 - b. The individual tasks with which the aide is to assist the beneficiary and
 - c. The frequency and duration of service of each routine and activity, including:
 - (1) The number of days per week each routine or activity will be accomplished and
 - (2) The maximum and minimum estimated aggregate minutes the aide should spend on all authorized tasks each service day.
- E. The service plan must include written instructions for the personal care aide specifying how and when to execute or assist with the beneficiary's routines or activities including:
 - 1. The number of days per week to accomplish each routine or activity (as well as which days when relevant) and
 - 2. The time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.
- F. The service plan must include written instructions describing whether and to what extent the aide's function in individual task components of each routine or activity is:
 - 1. To assist the beneficiary to perform the task;
 - 2. To perform the task for the beneficiary or
 - 3. To observe the beneficiary perform the task;

G. The service plan must require the beneficiary to perform all tasks within the beneficiary's capability. Medicaid does not cover assistance with any task a beneficiary can perform unless DHS professional staff or contractor(s) designated by DHS have authorized the assistance. For example:

1. A beneficiary can manage his own laundry but he cannot extract wet items from the washer while leaning over the machine.
 - a. The assessment notes that he needs assistance with the task of removing wet items from the washing machine.
 - b. The service plan describes the assistance designed for his individual physical dependency need with his laundry.
 - c. The registered nurse instructs the aide to perform the task(s) constituting the service.
2. Loading the washer, emptying the dryer, folding and ironing clothing and linens are not covered tasks for this particular beneficiary.
3. Removing laundry from the washer and loading it in the dryer are covered tasks for this beneficiary if those tasks are described in his service plan and authorized by DHS professional staff or contractor(s) designated by DHS.

H. The form designated by DHS that is submitted by the provider must support the service plan and the provider's RN's instructions to the aide(s) regarding the delivery of services. The plan must reflect whether the individual is receiving services in more than one setting. If a beneficiary is receiving services in more than one setting, it must be clear in which setting a beneficiary receives a particular service or assistance. See part G of Section 215.200, Section 216.201 and Sections 220.110 through 220.112.

See Section 215.330 for information about service plan revision requirements.

215.310 Identifying Individual Physical Dependency Needs

4-4-19

- A. A personal care provider must identify and describe (assess) a beneficiary's need for assistance (*physical dependency need*) with individual task components of routines and activities of daily living in the form designated by DHS.
- B. The provider must describe the type, amount, frequency and duration of assistance required for each task thus identified (*individualized service plan*) in the form designated by DHS.
- C. A personal care aide furnishes assistance (*service*) with the individual task components of routines and activities of daily living, in accordance with the individualized service plan authorized by DHS professional staff or contractor(s) designated by DHS.
- D. The following examples illustrate how to facilitate service plan development and service documentation by assessing the beneficiary at the level of individual task performance:
- E. A beneficiary is unable to pick up slender items, such as spoons and toothbrushes, and sometimes loses his grip on those objects.
 1. This condition causes similar physical dependency needs in different routines:

Sample Assessment Entry

Eating:	The beneficiary needs someone to place eating utensils in his grasp and to retrieve them when he drops them.
Oral hygiene:	The beneficiary needs someone to place his toothbrush in his grasp and to retrieve it when he drops it.

2. The service plan will contain instructions to the aide similar to this Sample Service Plan Entry.

Sample Service Plan Entry

Eating:	Place the (object) in (beneficiary's name)'s grasp.
Oral hygiene:	Retrieve the (object) when (beneficiary's name) drops it and replace the (object) in his grasp.

- F. Medicaid Program staff reviewing a personal care provider's records must be able to readily observe that the service plan logically follows the assessment, which is possible only if the provider assesses the beneficiary at the individual task performance level.

1. Additionally, the aide's daily service documentation and the registered nurse's case notes must address the requirements and objectives of the service plan.
2. There must be a clear and logical relationship of each component of this documentation to each other component and to the service continuum.

215.320 Identifying Frequency of In-Person Supervisory Visits

7-1-20

- A. A registered nurse designated by the personal care provider must identify and recommend the frequency for in-person visits to be made by the supervisor of the personal care aide, based on the specific needs of the beneficiary.
- B. The frequency of in-person visits shall be at least every 365 days and shall be determined jointly by the personal care provider and the beneficiary or the beneficiary's legal representative, based on the recommendations of the registered nurse.
- C. The individualized service plan must identify the agreed frequency, the risk factors that are specific to that beneficiary, and a justification for the agreed frequency. The risk factors identified by the service plan must include without limitation any relevant medical diagnoses; the beneficiary's mental status; the presence of family or other residents in the beneficiary's home, and the frequency of their presence; and the beneficiary's physical dependency needs, including the activities of daily living (ADL) with which the beneficiary needs assistance.
- D. If the frequency identified in the service plan is less than the frequency recommended by the registered nurse, the service plan shall identify the medical justification for the reduced frequency.
- E. If the beneficiary has a significant change of condition affecting a risk factor, the registered nurse shall review the frequency of in-person visits and recommend changes as appropriate.

215.330 Service Plan Revisions

7-1-20

NOTE: Subsections (A) (3) and (B) are not applicable to IndependentChoices program.

- A. A personal care provider must amend a beneficiary's individualized service plan to document any permanent service plan changes before the provider amends service delivery.
1. For purposes of this requirement, a **permanent** service plan change is one expected to last thirty (30) days or more.
 2. Service plan revisions must be made if a beneficiary's condition changes to the extent that the personal care provider must modify, add or delete tasks.

3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.
 - a. Changes in the amount, frequency or duration of a service must be documented in the medical record.
 - b. The reasons for the service variances must be written daily in the service documentation.

4. A service plan revision must be authorized by DHS professional staff or contractor(s) designated by DHS only if the provider requests to increase or decrease the total monthly hours. DHS professional staff or the DHS contractor will review the request and determine, based on application of the Task and Hour Standards described in Section 240.100, the amount of adjustment to make in prior authorized minutes. DHS professional staff or the DHS contractor will revise the number of minutes in Interchange.

B. Providers may not reduce a beneficiary's services without prior authorization by DHS professional staff or contractor(s) designated by DHS.

C. The personal care provider must document medical reasons for service plan revisions.

D. The new beginning date of service is the date authorized by DHS professional staff or contractor(s) designated by DHS.

E. Service plan revisions and updates since the previous assessment must remain with the service plan. Updates since the previous assessment must include documentation of when and why the change occurred.

215.350 Service Plan Requirements for a Single Provider at a Single Beneficiary at Multiple Service Locations **10-1-07**

A. Only one service plan for personal care services is necessary when a single provider is delivering services to a beneficiary in more than one authorized location.

B. The service plan must identify which tasks the aide performs at each location.

1. When the aide performs the same or similar tasks at each location, the service plan must separately identify the tasks at each location in accordance with the criteria in Sections 215.300 and 215.310.
2. The aide's service documentation must reflect the service location distinctions.

215.351 Service Plan Requirements for Multiple Providers **7-1-20**

When a beneficiary receives services from more than one personal care provider, each provider must comply with the following requirements.

A. Each provider must create an individualized service plan and collaborate with the beneficiary's other personal care provider(s) to create a comprehensive service plan.

1. Each comprehensive service plan must clearly state which provider provides which services, where and on which day(s) they do so, which time(s) of day they furnish services and the maximum and minimum amount of time per day and per week that the provider will take to perform those services.
2. Each comprehensive service plan must be authorized, signed and dated by the provider.

B. Each time a personal care provider intends to revise or renew a comprehensive service plan, that provider must notify the beneficiary's other personal care provider(s) to agree on the revision or renewal.

C. If the providers cannot agree on a comprehensive service plan, plan revision or plan renewal, the providers shall submit the various alternatives to DHS professional staff or contractor(s) designated by DHS, who shall determine the terms of the final comprehensive service plan.

D. Any Medicaid provider having knowledge that another Medicaid provider has failed to comply with a service plan, including a comprehensive service plan, shall notify the DMS Director of such failure within ten (10) business days of the occurrence, or sooner if the beneficiary's life or health is threatened.

215.360 Changes of Condition

7-1-20

A. The individualized service plan must identify individualized, beneficiary-specific standards, based on the identified risk factors, for when a caregiver or supervisor must document and report any significant change in the beneficiary's condition. A significant change is one that exhibits a major decline or improvement in the physical or mental health status of the beneficiary.

B. If a caregiver or supervisor observes a significant change of condition, the caregiver or supervisor must document and report the change of condition as required by the change-reporting standards contained in the beneficiary's individualized service plan. Documentation must include the time and date the change was identified by the caregiver and a full description of the change.

C. Within twenty-four (24) hours of a significant change of condition being reported, a registered nurse must evaluate and document an assessment of the beneficiary, including without limitation the change of condition.

D. A change of condition under this section may result in a change to the service plan or to the frequency of supervisory visits, but it does not automatically result in a new Independent Assessment by the DHS Independent Assessment Contractor. Independent Assessments or Reassessments are governed by the provisions of the Arkansas Independent Assessment Medicaid Provider Manual.

REPEAL

216.000 Coverage

7-1-20

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

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State
2. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family"
3. Prior authorized by DHS professional staff or contractor(s) designated by DHS
4. Provided by an individual who is
 - a. Qualified to provide the services;
 - b. Supervised by an individual meeting the qualification set forth in Section 220.100; and,
 - c. Not a member of the beneficiary's family; OR
 - d. Qualified to provide the service according to approved policy in the Independent Choices Program.
5. Furnished in the beneficiary's home or, at the State's option, in another location

B. Medicaid restricts coverage of personal care to services directly helping a beneficiary with certain specified routines and activities, regardless of the beneficiary's ability or inability to execute other non-covered routines and activities. Personal care services may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in this section.

C. Travel Time of Personal Care Aide Accompanying Beneficiary:

1. Personal care only covers personal care aide travel time when all of the following apply:
 - a. The personal care aide accompanies the beneficiary in the same vehicle as the beneficiary travels to and returns from a community location for medical appointment or community activity;
 - b. The travel time billed is solely for necessary time in transit from the beneficiary's home to the community location and the return travel from the community location to the beneficiary's home;
 - c. The beneficiary's participation in the local community activity is for the benefit of the beneficiary and to meet the beneficiary's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the personal care aide, a family member, the driver, or other passengers);
 - d. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;
 - e. The beneficiary's Individualized Service Plan includes Personal Care service hours, or one or both of the following activities: daily living (ADLs): toileting and mobility/ambulating;
 - f. While in transit to and from the community location, the beneficiary requires, or is likely to require, assessed medical assistance or personal assistance with the ADL task of toileting or the ADL task of mobility/ambulating; and
 - g. The travel time is reasonable given driving distances, traffic conditions, and weather, with time and locations documented.
2. Travel time is not reimbursable if any other adult person accompanying (or driving) the beneficiary is a family member and is reasonably able to assist the beneficiary in transit if needed.
3. Travel time accompanying a beneficiary will count against the total number of Personal Care hours per month authorized in the participant's Individualized Service Plan and prior authorization.
4. Requesting Hours for Travel Time of Attendant Accompanying Participant:

Beneficiaries vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of a personal care aide accompanying a beneficiary is incident to but itself not the ADL task of toileting or the ADL task of mobility/ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Personal Care hours, if any, associated solely with travel time of a personal care aide accompanying a beneficiary to a medical visit or community activity.

For an ARChoices beneficiary, the number of hours allowed for travel time of a personal care aide will be determined by the DHS nurse in the beneficiary's Person-Centered Service Plan.

For other beneficiaries, the provider may include in the prior authorization request justification for travel time, based on the beneficiary's community activities, need for

a personal care aide to accompany them, and the distances and roundtrip travel times typically involved. Based on this information and consistent with the above requirements, the contractor designated by DHS to process prior authorization requests, or if there is no contractor designated by DHS, DHS professional staff, may increase the number of Personal Care hours per month covered in the Individualized Service Plan and prior authorization to reasonably accommodate the travel time of a personal care aide accompanying the beneficiary.

216.100 Definitions of Terms

216.110 Routines and Activities of Daily Living

7-22-10

In the Arkansas Medicaid Personal Care Program, essential chores are referred to as "routines." Beneficiaries must eat, dress, void the bladder and bowels, bathe and perform other personal hygiene chores.

216.120 Instrumental Activities of Daily Living

7-22-10

In the Arkansas Medicaid Personal Care Program, certain chores are referred to as "instrumental activities of daily living" or "activities." For example, beneficiaries need to wash their clothes and linens (laundry), clean their immediate living area (incidental housekeeping) and purchase the items necessary to maintain themselves (shopping).

216.130 Tasks

7-22-10

A. "Tasks" are components of routines and instrumental activities of daily living. For example:

1. Meal preparation is a routine that involves a number of tasks: removing food from the refrigerator or pantry; opening food containers and packaging; processing meats or vegetables; mixing ingredients; setting oven temperatures and adjusting stovetop settings; setting pan, broiler, washing and putting away cooking and eating utensils, etc.
2. Laundry is an activity of daily living. Some tasks associated with the laundry activity are: sorting items to be washed, measuring detergent and additives, adjusting machine settings, extracting wet items from the washer and dry items from a dryer, hanging wet items on a line to dry, etc.

B. "Individual task component" and "task component" have the same meaning as "task." The words "routine," "activity" and "task," retain their meaning regardless of whether the person performing them is the beneficiary, the aide or any other person.

216.140 Service

1-1-19

A. A "personal care service" is a covered task or a related group of covered tasks.

B. A "personal care aide service" is a personal care service.

1. "Personal care services" and "personal care aide services" are interchangeable expressions that mean "covered tasks."
2. Only a certified personal care aide, or an individual who meets or exceeds the qualifications of a personal care aide, as defined in Section 222.100, who is also in the employ of a Medicaid-enrolled personal care provider, may provide covered personal care services or personal care aide services as defined in this manual.

C. As a condition of coverage and reimbursement, all personal care services must be:

1. Reasonable and medically necessary, supported by the individual's latest nursing evaluation, and consistent with the individual's service plan;

2. Expressly authorized in the individual's approved personal care services prior authorization;
3. Not available from another source (including, but not limited to, family members, a member of the beneficiary's household, or other unpaid caregivers; another Medicaid State Plan covered service; the Medicare program; the beneficiary's Medicare Advantage plan or Medicare prescription drug plan; or the beneficiary's private long-term care, disability, or supplemental insurance coverage);
4. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services, including without limitation the aggregate weekly or monthly limits calculated by DHS for the beneficiary in accordance with the Arkansas Medicaid Task and Hours Standards;
5. Provided by qualified, Medicaid-enrolled, DPSQA-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and
6. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

D. Personal care services exclude all of the following:

1. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including, but not limited to, aseptic or sterile procedures, application of dressings, medications administration, injections, observation and assessment of health conditions, insertion, removal, or irrigation of catheters, tube or other enteral feedings, tracheostomy care, oxygen administration, ventilator care, drawing blood, and setup and maintenance of any medical equipment;
2. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, estheticians, except for necessary assistance with personal hygiene and basic grooming;
3. Services provided for a person other than the beneficiary, including but limited to a provider, family member, household resident, or neighbor;
4. Companion, socialization, entertainment, or recreational services or activities of any kind (including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);
5. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and
6. Mental health counseling or services.

216.200 Tasks Associated with Covered Routines

10-1-12

Effective for dates of service on and after March 1, 2008, all regulations regarding personal care aides' logging beginning and ending times (i.e., time of day) of individual services, and all references to any such regulations, do not apply to RCF and ALF Personal Care providers.

216.201 Simultaneous Services and Congregate Settings

10-13-03

Simultaneous services to two beneficiaries or to more than two beneficiaries in a congregate setting may be covered provided the service plan and the scope, duration and frequency of each individual's services are directly related to the needs of the individual as reflected in the RN's assessment of the individual's physical dependency needs. Part H of Section 215.300, Sections 216.211 and Sections 220.110 through 220.112 provide additional information and include instructions for determining the relative amount of coverage available per beneficiary for tasks performed for multiple beneficiaries.

216.210 Eating

See Section 216.212, Consuming Meats, below

216.211 Meal Preparation**10-13-03**

A. Meal preparation is a covered personal care service if the aide's logged service time meets certain conditions:

1. The aide must make reasonable efforts to prepare servings of a size or an amount commensurate with the beneficiary's nutritional needs and normal appetite. For the purpose of these rules a provider will be presumed to have made a reasonable effort unless the quantity of food prepared exceeds by more than 100% the beneficiary's need for a meal or meals. An example follows:

a. An aide prepares soup for a beneficiary.

b. The beneficiary typically consumes 8 oz. of soup per meal.

c. If the aide prepares 16 oz. or less per meal, the provider will be presumed to have made reasonable efforts to limit the service to the beneficiary's needs.

d. However, if the aide prepares 3 quarts of soup per meal, the time required is presumed unreasonable and the provider is not entitled to reimbursement. Refer to part E of this section for rules regarding simultaneous services for two or more beneficiaries.

2. Medicaid does not cover an aide's time at meal preparation tasks or assisting at meal preparation tasks for individuals who are not personal care beneficiaries or whose personal care service plan does not include meal preparation tasks or assistance with meal preparation tasks.

a. The aide must document the meal preparation task in the beneficiary's personal care service record.

b. Refer to part E of this section for rules regarding simultaneous services for two or more beneficiaries.

B. This routine includes the tasks involved in:

1. Preparing and serving a meal and

2. Cleaning articles and utensils used in the preparation of the meal.

C. To be eligible to receive personal care assistance with meal preparation, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to perform meal preparation tasks or to clean up the utensils and preparation area.

D. The aide's service in the beneficiary's meal preparation routine is hands-on assistance with meal preparation tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

E. Simultaneous services to two beneficiaries or to more than two beneficiaries in a congregate setting may be covered if the rules below and the regulations stated at Section 216.201 and Sections 220.110 through 220.112 are followed.

1. Medicaid will cover the actual time attributable to the individual beneficiary when services, such as meal preparation, are delivered simultaneously.

2. Refer to Section 220.111 for the methodologies required to determine the amount of time attributable to the individual beneficiary.

F. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following example:

1. A beneficiary is able to remove items from the refrigerator and pantry and to perform most tasks related to meal preparation.
2. The assessment states, "Beneficiary's arthritic condition prevents him from opening bottles and jars with small tops and from gripping eating utensils."
3. A related entry in the service plan would be similar to:
Meal preparation:
 - a. The aide will open bottles and jars with lids too small for the beneficiary to negotiate.
 - b. The aide will operate cooking and serving utensils the beneficiary cannot grip or pick up.
- G. The complete meal preparation routine might include additional instructions. These examples are simply to illustrate that instructions at the task level facilitate correlation of physical dependency needs with individualized services.

216.212 Consuming Meals**1-1-19**

- A. The service related to this routine includes the tasks involved in giving the beneficiary hands-on assistance to consume a meal and fluids. It does not include meal preparation.
- B. To receive personal care assistance with this routine, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to execute tasks such as cutting food in bite-size pieces or negotiating food from plate to mouth.
- C. The related service is hands-on assistance with the beneficiary's physical dependency needs to accomplish eating. The aide may only assist with or perform functional tasks the beneficiary cannot physically perform or accomplish with the beneficiary's physical dependency needs described in the assessment.
- D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following examples:
 1. An assessment states, "Beneficiary's arthritis prevents him from gripping slender objects such as eating utensils with either hand." The related task in the service plan is for the aide to "cut items into bite-size pieces and deliver them from plate to mouth for the beneficiary."
 2. The same assessment also states, "Effects of a recent stroke cause the beneficiary to choke or to risk choking unless food is pureed."
 - a. The related task in the service plan is for the aide to "puree food items for the beneficiary."
 - b. A separate statement, "The aide will deliver spoonfuls from plate to mouth for the beneficiary," addresses the arthritic condition.
- E. Observing a beneficiary eat is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the beneficiary's eating places the beneficiary at risk of injury or harm.

216.240 Personal Hygiene**1-1-19**

- A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's personal hygiene. "Personal hygiene" means grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene.
 1. An aide's time spent reminding a beneficiary to perform personal hygiene tasks is not a covered service unless the beneficiary's service plan includes hands-on assistance with personal hygiene.

2. An aide's time spent observing a beneficiary perform personal hygiene tasks is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the activity places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency preventing or substantially impairing their ability to perform hair and skin care and grooming, oral hygiene, shaving and nail care.

C. The aide's service in regard to this routine is hands-on assistance with personal hygiene tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.250 Bladder and Bowel Requirements

10-13-03

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's elimination routines.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To safely enter and exit the bathroom, or

2. To properly complete elimination routines without assistance.

C. The aide's service in this routine is hands-on assistance with bladder and bowel voiding tasks the beneficiary cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.260 Medication

1-1-19

A. Personal care aide services regarding medication routines are covered only to the extent that they are permitted by the Arkansas Nurse Practice Act and implementing rules and regulations.

B. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's medications.

C. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability to safely and correctly dispense and ingest orally administered prescription medications.

D. The aide's service in regard to the beneficiary's medication routines is hands-on assistance with tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment, as described in the Arkansas State Board of Nursing Position Statement 97.2.

E. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.270 Mobility and Ambulation

1-1-19

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's mobility and ambulation. "Mobility and ambulation" mean functional mobility

(moving from seated to standing, getting in and out of bed) and mastering the use of adaptive equipment.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To turn themselves in bed,
2. To move from bed to chair (including wheelchair or motorized chair),
3. To walk (alone or with a device) or
4. To operate a push wheelchair or a motorized chair.

C. The aide's service in this routine is hands-on assistance with ambulation and mobility tasks the beneficiary cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.300 Tasks Associated with Covered Activities of Daily Living

10-13-03

A. The tasks constituting this group of services are those involved in hands-on assistance with the beneficiary's incidental housekeeping, laundry and shopping. Tasks associated with activities of daily living are not covered if the aide is also performing the tasks for other individuals of the same household, home or facility.

1. Who are not Personal Care Program beneficiaries, or
2. Who are Personal Care Program beneficiaries whose service plans do not require the required tasks.

B. To be eligible for services associated with activities of daily living:

1. A beneficiary must exhibit one or more physical dependency need(s) related to his or her impaired ambulation, mobility or functional capability within the service delivery location;
2. The personal care assessment must describe the impairments that prevent or impede the beneficiary's ability to move freely and safely about the living area and to perform necessary tasks and
3. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.310 Incidental Housekeeping

1-1-19

A. "Incidental housekeeping" means cleaning of the floor, furniture, and areas that are directly used by the beneficiary.

B. The aide's service in regard to incidental housekeeping is hands-on assistance with covered tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

C. The assessment must describe the impairments that prevent or impede the beneficiary's ability to move freely and safely about their living area and clean the floor and furniture in the area they occupy.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

216.320 Laundry

10-13-03

A. "Laundry" means laundering only items incidental to the care of the beneficiary. Laundry is not a covered service if it includes laundry services for the convenience of non-Medicaid eligible individuals residing in the same service delivery location. For example,

1. A spouse requires assistance with laundry. The remaining cohabiting spouse is not a Medicaid beneficiary.

a. The cohabiting spouse is usually considered an alternative resource.

b. It is presumed that the cohabiting spouse will perform routine laundry services for the household.

2. If, however, the Medicaid-eligible spouse is incontinent of bowel or bladder:

a. Laundry may be a covered service to the extent that it is a service designed to address the beneficiary's immediate needs, e.g., cleaning soiled bedding or clothing.

b. If the laundry service is designed to address the beneficiary's immediate needs, the aide may top up an incomplete washer load by including items used by the remaining cohabiting spouse and the service will still be covered.

B. The aide's service in regard to laundry is hands-on assistance with covered laundry tasks the beneficiary cannot physically perform, according to the beneficiary's physical dependency needs detailed in the assessment.

C. The assessment must also describe the impairment(s) that prevent or impede the beneficiary's ability to move freely and safely about his or her living area and to perform some or all of the laundry tasks involved in maintaining his or her own clothing and bed and bath linens.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

REPEAL

216.330 Shopping

4-4-19

"Shopping" means services to address the beneficiary's physical dependency need by assisting the beneficiary with shopping or by shopping for the beneficiary.

A. Assisting a beneficiary with shopping is a covered service only when the beneficiary is purchasing items that are necessary for the beneficiary's health and maintenance in the home (such as food, clothing, and other essential items) and that are used primarily by the beneficiary or, are used primarily by the beneficiary and other Personal Care Program beneficiaries who reside in the same service delivery location, and whose service plans include assistance with shopping.

1. The aide's service in regard to shopping is hands-on assistance with covered shopping tasks the beneficiary cannot physically perform, according to the beneficiary's physical dependency needs detailed in the assessment.

2. The assessment must describe the impairment(s) that prevent or impede the beneficiary's ability to move freely and safely in stores and perform some or all of the shopping tasks necessary to maintain his or her health and comfort.

3. The service plan must correlate each required task with the beneficiary's corresponding physical dependency need. See Sections 215.300 and 215.310.

B. If the service plan requires the aide to shop for the beneficiary:

1. The beneficiary, or the beneficiary's representative, has freedom of choice to describe the items to be purchased (within the constraints stated herein) for the beneficiary's maintenance in the home.

2. The beneficiary has freedom of choice to designate the individual stores at which to purchase the items.

- a. If the designated stores are within the beneficiary's normal retail service area the service plan need not identify the specific stores.
- b. If the designated stores are outside the normal retail service area for residents of the beneficiary's locale, the service plan must include the stores' names and locations.
- C. If there are other members of the beneficiary's household, the service plan must not include shopping, or assistance with shopping, unless the assessment fully documents all reasons each household member can neither:
 - 1. Assist with or do the beneficiary's shopping, nor
 - 2. Arrange for someone else to assist with or to do the beneficiary's shopping.
- D. Medicaid provides no additional coverage for an aide's mileage incurred performing shopping tasks.

216.400 Personal Care Aide Service and Documentation Responsibility

1-1-19

NOTE: This section is not applicable to the Independent Choices program.

It is the responsibility of the personal care aide to accomplish the following:

- A. Perform authorized tasks as instructed by the supervising RN or QIDP.
- B. Maintain a service log.
 - 1. The service log must be completed at the time services are delivered. In the service log, it is not necessary to itemize the time spent on each individual ADL or IADL task for a given beneficiary, provided those tasks were performed by the same personal care aide on the same visit, on the same day and at the same location.
 - 2. If the service log is not completed concurrently with service delivery, coverage may be denied.
 - 3. Refer to Sections 220.110 through 220.112 for service log requirements.
- C. Provide necessary documentation showing the date, time, location, nature and scope of authorized services delivered.
- D. Provide necessary documentation showing the date, time, location, nature and scope of emergency services delivered.
 - 1. If an emergency requires the personal care aide to perform a personal care service task not included on the personal care service plan, the personal care aide must receive when possible, prior approval from the supervising registered nurse or QIDP to perform the task.
 - 2. When prior approval is not possible, the personal care aide may perform the emergency service task, but she or he must receive post service approval from the supervising registered nurse or QIDP.
 - 3. Document the circumstances in detail, describing:
 - a. The nature of the emergency,
 - b. The action or task required to resolve the emergency and
 - c. The justification for the unscheduled service.
- E. If a personal care aide does not perform a particular task scheduled on the service plan, the personal care aide must document why she or he did not perform the task that day.

217.000 Benefit Limits

1-1-19

- A. Medicaid imposes a 64-hour benefit limit, per month, per beneficiary, on personal care aide services for beneficiaries aged 21 and older.
- B. The 64-hour limitation applies to the monthly aggregated hours of personal care aide services.
- C. This 64-hour limit on personal care services for beneficiaries aged 21 and older is a firm cap for which there will be no extensions or exceptions.
- D. The hour limit does not apply to beneficiaries under age 21.

220.000 Service Administration**10-1-12**

Effective for dates of service on and after March 1, 2008, RCF and ALF Personal Care providers are exempt from all requirements of Sections 220.000 through 221.000—whether by explicit statement or reference—to record or log the time of day (clock time) when a service begins or ends.

220.100 Service Supervision**7-1-20**

- A. The provider must assure that the delivery of personal care services by personal care aides is supervised.
 - 1. A supervisor must be a licensed nurse or have completed two (2) years of full-time study at an accredited institution of higher learning. An individual who has a high school diploma or general equivalency diploma may substitute one (1) year of full-time employment in a supervisory capacity in a healthcare facility or community-based agency for one (1) year at an institution of higher education.
 - 2. Alternatively, a Licensed Intellectual Disabilities Professional (LIDP) may fulfill the supervisory requirement for personal care services to beneficiaries residing in alternative living arrangements or alternative family homes, licensed and certified by DPSQA as personal care providers.
 - 3. An individual who personally provides personal care services to a beneficiary may not supervise another personal care aide providing personal care services to that same beneficiary.
- B. The supervisor has the following responsibilities:
 - 1. The supervisor must instruct the personal care aide in
 - a. Which routines, activities and tasks to perform in executing a beneficiary's service plan;
 - b. The minimum frequency of each routine or activity; and
 - c. The maximum number of hours per month of personal care service delivery, as authorized in the service plan.
 - 2. At least once a month, the supervisor must
 - a. Review the aide's records;
 - b. Document the record review; and
 - c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
 - 3. At least annually, the supervisor must visit the beneficiary at the service delivery location to conduct on-site evaluation.
 - a. Medicaid requires that at least one of these supervisory visits annually must be when the aide is not present.
 - b. If the frequency of in-home supervisory visits for a beneficiary is greater than

one annually, at least one visit must be while the aide is present and furnishing services.

4. When the aide is present during the visit the supervising RN or QIDP must

a. Observe and document;

(1). The condition of the beneficiary;

(2). The type and quality of the personal care aide's service provision;

(3). The interaction and relationship between the beneficiary and the aide; and

(4). Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.

b. Consult with the agency-designated registered nurse regarding modifications to the service plan, if necessary, based on the observations and findings from the visit and document the consultation in the beneficiary's records; and,

c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

5. When the aide is not present during the visit, the supervisor must

a. Observe and document the condition of the beneficiary;

b. Observe and document, from available evidence, the type and quality of the personal care aide's service provision;

c. Observe, document, and report any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits;

d. Query the beneficiary or the beneficiary's representative and document

(1). The type and quality of the aide's service provision;

(2). The aide's conduct; and

(3). The nature of the working relationship of the beneficiary and the aide.

e. Consult with the agency-designated registered nurse regarding modifications to the service plan, if necessary, based on observations and findings from the visit and document the consultation in the beneficiary's records; and

f. Further instruct the aide, if necessary, and document the nature of and the reasons for further instructions.

C. The provider must review the service plan and the aide's records as necessary. The review will ensure that the daily aggregate time estimate in the service plan accurately reflects the actual average time the aide spends delivering personal care aide services to a beneficiary.

220.110 Service Log

1-1-13

NOTE: This section is not applicable to the Independent Choices program.

Instructions in this section apply to all beneficiaries' service logs, with one exception. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers maintain their service logs by means of the format and instructions of form DMS-873, "Arkansas Department of Human Services Division of Medical Services Instructions for completing the Service Log & Aide Notes For Personal Care Services in a Residential Care Facility". Effective for dates of service on and after March 1, 2008, form DMS-873 is found in Section V of this manual and DMS requires that RCF Personal Care providers use it exclusively for its designated purposes. See Section 220.111 for special documentation requirements regarding multiple beneficiaries who are attended by one aide. Those instructions at Section 220.111 do not apply to RCF Personal Care providers, effective for dates of service on and after March 1, 2008. See Section 220.112 for special documentation requirements regarding multiple aides attending one beneficiary. Those instructions at Section 220.112 do not apply to RCF Personal Care providers, effective for dates

of service on and after March 1, 2008. The examples in these sections and in Section 220.110 are related to food preparation, but personal care beneficiaries may receive other services in congregate settings if their individual assessments support their receiving assistance in that fashion.

A. Medicaid covers only service time that is supported by an aide's service log.

B. Service time in excess of the maximum service time estimates in the authorized service plan is covered only when the provider complies with the rules in Sections 215.330 and 220.110 through 220.112.

C. The time estimate in the service plan is not service documentation. It is an estimate of the anticipated minimum and maximum daily duration of medically necessary personal care aide service for an individual beneficiary.

D. For each service date, for each beneficiary, the personal care aide must record the following:

1. The time of day the aide begins the beneficiary's services.
2. The time of day the aide ends a beneficiary's services. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.
3. Notes regarding the beneficiary's condition as instructed by the service supervisor.
4. Task performance difficulties.
5. The justification for any emergency unscheduled tasks and documentation of the prior approval or post approval of the unscheduled tasks.
6. The justification for not performing any scheduled service plan required tasks.
7. Any other observations the aide believes are of note or that should be reported to the supervisor.

E. If the aide discontinues performing service plan required tasks at any time before completing all of the required tasks for the day, the aide will record:

1. The beginning time of the non-service plan required activities.
2. The ending time of the non-service plan required activities.
3. The beginning time of the aide's resumption of service plan required activities and
4. The beginning and ending times of any subsequent breaks in service plan required aide activities.
5. If the aide discontinues or interrupts the beneficiary's service plan required activities at one location to begin service plan required activities at another location, the aide must record the beginning and ending times of service at each location.

220.111 Service Log for Multiple Beneficiaries

1-1-19

Effective for dates of service on and after March 1, 2008, the rules in this section do not apply to RCF and ALF Personal Care providers.

An aide delivering services to two or more beneficiaries at the same service location, during the same period (discontinuing or interrupting a beneficiary's service plan required tasks to begin or resume service plan required tasks for another beneficiary, or performing an authorized service simultaneously for two or more beneficiaries. For example, cleaning a living space used by more than one beneficiary or preparing a meal that will be eaten by more than one beneficiary), must comply with the applicable instructions in parts A or B below:

- A. If providing services for only two beneficiaries, the aide must record in each beneficiary's service log
1. The name of each individual for whom they are simultaneously performing personal care service;
 2. The beginning and ending times of service for each beneficiary and the beginning and ending times of each interruption and of each resumption of service; and
 3. Which services or services were performed simultaneously for more than one beneficiary.
- B. If services are performed in a congregate setting (more than two beneficiaries) the service log must state
1. The actual time of day (clock time) that the congregate services begin and end;
 2. The number of individuals, and the name of each individual, both Medicaid-eligible and non-Medicaid-eligible, who received the documented congregate services during that period; and
 3. Which services or services were performed simultaneously for more than one beneficiary.
- C. For services performed simultaneously for more than one beneficiary, the provider must split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took 20 minutes, the aide would document only half of that time – 10 minutes – for each beneficiary for the task).
- D. If the beneficiaries have different providers and different aides, both providers may not bill for cleaning a shared living space (e.g., bathroom) or performing another task that benefits both beneficiaries (e.g., repairing a sink or bed). The providers must determine which of their aides will be responsible for performing the task. The provider whose aide did not perform the task may not bill for it.
- E. A provider who knowingly bills twice for the same service or for a service that has been billed by another provider is committing a fraudulent act and may be referred by DHS to the Medicaid Fraud Control Unit.

REPEAL

220.112 Service Log for Multiple Aides with One Beneficiary

10-1-12

Effective for dates of service on and after March 1, 2008, the rules in this section do not apply to RCF and ALF Personal Care providers.

When two or more aides attend a single beneficiary, each aide must record the beginning and ending times of each service plan required routine or activity of daily living that she or he performs for the beneficiary, regardless of whether another aide is performing a service plan required routine or activity of daily living at the same time.

220.113 Service Logging by Electronic Media

3-1-05

- A. Personal care aides may log the times that they begin and end services, as well as the services themselves, by electronic media, such as telephony.
- B. Electronic signatures, as permitted under Arkansas law and as defined in Section IV of this manual, are allowed in the Personal Care Program.
- C. All Arkansas Medicaid documentation requirements must be met, regardless of documentation media.

221.000 Documentation

7-1-20

NOTE: ~~This section is not applicable to the IndependentChoices program.~~

The personal care provider must keep and make available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Human Services and its authorized agents or officials; records including:

- A. ~~If applicable, certification by the Home Health State Survey Agency as a participant in the Title XVIII Program. Agencies that provided Medicaid personal care services before July 1, 1986 are exempt from this requirement.~~
- B. ~~When applicable, copies of pertinent residential care facility license(s) issued by the Office of Long Term Care.~~
- C. ~~Medicaid contract.~~
- D. ~~Effective for dates of service on and after March 1, 2008, RCF Personal Care providers will be required, when requested by DHS, to provide payroll records to validate service plans and service logs.~~
- E. ~~Documents signed by the supervisor or, Qualified Intellectual Disabilities Professional (QIDP), or agency-designated registered nurse including without limitation:~~
 1. ~~The initial and all subsequent assessments.~~
 2. ~~Instructions to the personal care aide regarding:~~
 - a. ~~The tasks the aide is to perform;~~
 - b. ~~The frequency or schedule; and~~
 - c. ~~The maximum number of hours and minutes per month of aide service authorized by DHS professional staff or contractor(s) designated by DHS.~~
 3. ~~Notes arising from supervisor's visits to the service delivery location, regarding:~~
 - a. ~~The condition of the beneficiary;~~
 - b. ~~Evaluation of the aide's service performance;~~
 - c. ~~The beneficiary's evaluation of the aide's service performance; and,~~
 - d. ~~Difficulties the aide encounters performing any tasks.~~
 4. ~~The service plan and service plan revisions:~~
 - a. ~~The justifications for service plan revisions;~~
 - b. ~~Justification for emergency, unscheduled tasks;~~
 - c. ~~Documentation of prior or post approval of unscheduled tasks; and~~
 - d. ~~Recommendation or justification for the frequency needed for in-person supervisory visits.~~
- F. ~~Any additional or special documentation required to satisfy or to resolve questions arising during, from or out of an investigation or audit. "Additional or special documentation," refers to notes, correspondence, written or transcribed consultations with or by other healthcare professionals (i.e., material in the beneficiary's or provider's records relevant to the beneficiary's personal care services, but not necessarily specifically mentioned in the foregoing requirements). "Additional or special documentation," is not a generic designation for inadvertent omissions from program policy. It does not imply and one should not infer from it that, the State may arbitrarily demand media, material, records or documentation irrelevant or unrelated to Medicaid Program policy as stated in this manual and in official program correspondence.~~
- G. ~~The personal care aide's training records, including:~~
 1. ~~Examination results;~~

2. Skills test results; and
3. Personal care aide certification;

H. The personal care aide's daily service notes for each beneficiary, reflecting:

1. The date of service;
2. The routines performed on that date of service, noted to affirm completion of each task;
3. The time of day the aide began performing the first service-plan-required task for the beneficiary;
4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function;
5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks; and,
6. The time of day the aide completed the last service-plan-required task for the day for that beneficiary.

I. Notes, orders and records reflecting the activities of the physician, the agency-designated registered nurse, the supervisor or QIDP, the aide and the beneficiary or the beneficiary's representative; as those activities affect delivering personal care services.

222.000 Personal Care Aide Qualifications and Certification

222.100 Personal Care Aide Selection, Training and Continuing Education

1-1-13

NOTE: This section is not applicable to the Independent Homes program.

A. The beneficiary must receive Medicaid Personal Care services from a certified personal care aide who is not a member of the beneficiary's family. The Medicaid agency defines, "a member of the beneficiary's family" as:

1. A spouse;
2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent;
3. Legal guardian of the person;
4. Attorney-in-fact granted authority to direct the beneficiary's care.

B. Personal care aides must be selected on the basis of such factors as:

1. A sympathetic attitude toward the care of the sick;
2. An ability to read, write and carry out directions and
3. Maturity and ability to deal effectively with the demands of the job.

C. The personal care provider is responsible for ensuring that personal care aides in its employ are:

1. Certified as personal care aides;
2. Participate in all required in-service training and
3. Maintain at least "satisfactory" competency evaluations from their supervisors in all personal care tasks they perform.

D. DMS will deem valid the Certified Personal Care Aide status of an individual with

1. Personal Care Aide Certification conferred before April 1, 1998, and

2. Documentation of ongoing compliance with Personal Care Program policies in effect before April 1, 1998, regarding continuing education and competency requirements.
3. The deemed status will be effective for dates of service on and after April 1, 1998, conditional upon the certified aide's continuing compliance with program policies.

E. A qualified training program (see Section 222.110) may waive the training component of personal care aide certification requirements for individuals who can document previous experience as personal care aides, nurse's aides or similar occupations requiring the same skills needed by personal care aides.

1. The qualified training program must verify the individual's previous experience.
2. The individual must pass the personal care aide examinations and skills tests.

F. Certified Nursing Assistants with current valid credentials are deemed qualified personal care aides.

G. Certified Home Health Aides with current valid credentials are deemed qualified personal care aides.

222.110 Conduct of Training

7-1-20

NOTE: This section is not applicable to the IndependentChoices program.

A. A personal care aide training program may be offered by any organization meeting the standards in this section for:

1. Instructor qualifications;
2. Content and duration of personal care aide training and;
3. Documentation of personal care aide training and certification.

B. Personal Care provider agencies conducting personal care aide training must maintain their training program documentation.

C. Personal Care providers hiring or contracting with individuals or organizations to conduct personal care aide training must maintain the individual's or organization's training program documentation. The provider is responsible for maintaining the training program documentation file.

D. Required training program documentation includes:

1. The number of hours each of classroom instruction and supervised practical training;
2. Names and qualifications of instructors and copies of licenses of supervising registered nurses;
3. Street addresses and physical locations of training sites, including facility names when applicable;
4. Maintaining samples of the forms used to document the beneficiary's consent to the training in their home, if the training includes supervised practical training in the home;
5. The course outline;
6. Lesson plans;
7. The instructor's methods of supervising trainees during practical training;
8. The training program's methods and standards for, determining whether a trainee can read and write well enough to perform satisfactorily the duties of a personal care aide;

9. The training program's method of evaluating written tests, oral exams (if any) and skills tests, including the relative weights of each in the minimum standard for successful completion of the course;

10. The training program's minimum standard for successful completion of the course; and

11. Evidence and documentation of successful completions (Certificates supported by internal records);

E. Personal Care providers are responsible for the upkeep of all required training program documentation;

F. A qualified personal care aide training and certification program must include instruction in each of the subject areas listed in Section 222.120;

G. Classroom and supervised practical training must total at least 40 hours;

1. Minimum classroom training time is twenty four (24) hours;

2. Minimum time for supervised practical training is sixteen (16) hours;

a. "Supervised practical training" means training in a laboratory or other setting in which:

(1). The trainee demonstrates knowledge by performing tasks on an individual while

(2). The trainee is under supervision as defined in Section 220.100;

b. Trainees must complete at least sixteen (16) hours of classroom training before beginning any supervised practical training;

3. Supervised practical training may occur at location other than the site of the classroom training;

a. However, trainees must complete at least twenty four (24) hours of classroom training before undertaking any supervised practical training at an actual service delivery site;

b. The training program must have the written consent of the beneficiary or the beneficiary's representative if aide trainees furnish any of the beneficiary's services at the beneficiary's service delivery location;

(1). A copy of the beneficiary's consent must be maintained in the file of each aide trainee receiving supervised practical training at the beneficiary's service delivery location;

(2). The beneficiary's daily service documentation must include the names of the supervisor or QIDP and the personal care aide trainees;

4. The training of personal care aides and the supervision of personal care aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse whose current credentials are on file with the provider;

a. The qualified registered nurse must possess a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of in-home health care;

b. Other individuals may provide instruction under the supervision of the qualified registered nurse;

c. Supervised practical training with a consenting personal care beneficiary for a subject must be personally supervised by;

(1). The qualified registered nurse; or

(2). By a licensed practical nurse under the general supervision of the qualified registered nurse;

- H. Providers must maintain documentation demonstrating that aide training meets the requirements set forth herein.

222.120 Personal Care Aide Training Subject Areas**7-1-20**

NOTE: This section is not applicable to the Independent Choices program.

- A. Correct conduct toward beneficiaries, including respect for the beneficiary, the beneficiary's privacy and the beneficiary's property.
- B. Understanding and following spoken and written instructions.
- C. Communications skills, especially the skills needed to:
1. Interact with beneficiaries;
 2. Report relevant and required information to supervisors; and,
 3. Report events accurately to public safety personnel and to emergency and medical personnel.
- D. Record keeping, including:
1. The role and importance of record keeping and documentation;
 2. Service documentation requirements and procedures, especially all documentation Medicaid requires of personal care aides, as described in Medicaid Personal Care Program policy statements current at the time of the aide's training;
 3. Reporting and documenting non-medical observations of beneficiary status; and
 4. Reporting and documenting, when pertinent, the beneficiary's observations regarding the beneficiary's status.
- E. Recognizing and reporting to the supervisor a Qualified Intellectual Disabilities Professional (QIDP), when changes in the beneficiary's condition or status require the aide to perform tasks differently than instructed.
- F. State law regarding delegation of nursing tasks to unlicensed personnel as designated by the Arkansas State Board of Nursing.
- G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.
- H. Safe transfer techniques and ambulation.
- I. Normal range of motion and positioning.
- J. Recognizing emergencies and knowledge of emergency procedures.
- K. Basic household safety and fire prevention.
- L. Maintaining a clean, safe and healthy environment.
- M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the beneficiary with:
1. Bed bath;
 2. Sponge, tub or shower bath;
 3. Shampoo; sink, tub or bed;
 4. Nail and skin care;
 5. Oral hygiene;

6. Toileting and elimination;
7. Shaving;
8. Assistance with eating;
9. Assistance with dressing;
10. Efficient, safe and sanitary meal preparation;
11. Dishwashing;
12. Basic housekeeping procedures; and
13. Laundry skills.

N. Early recognition and reporting of changes in client condition.

222.130 Personal Care Aide Certification

1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

- A. A personal care aide trainee must pass an examination based on the curriculum of the personal care aide training course.
 1. Some of the examination may be oral.
 2. Examinations must include written questions requiring written answers, in sufficient number for instructors or other qualified training program personnel to determine that trainees meet or surpass a minimum standard for reading and writing.
- B. The personal care aide candidate must demonstrate the ability to perform all tasks required of personal care aides, by meeting or exceeding minimum standards in a personal care service skills test.
- C. An aide trainee successfully completing training must receive a certificate confirming that the individual is a Certified Personal Care Aide qualified for employment in that capacity.
 1. The certificate must contain the name of the training entity.
 2. The certificate must contain the signature of an individual authorized by the training program to certify the qualifications of personal care aides.

222.140 In-Service Training

1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

Medicaid requires personal care aides to participate in at least twelve (12) hours of in-service training every twelve (12) months after achieving Personal Care Aide certification.

- A. Each in-service training session must be at least 1 hour in length.
 1. When appropriate, in-service training may occur at a personal care service delivery location when the aide is furnishing personal care services.
 2. In-service training at a service delivery site may occur only if the beneficiary or the beneficiary's representative has given prior written consent for training activities to occur concurrently with the beneficiary's care.
- B. The Personal Care Program provider agency and the personal care aide must maintain documentation that they are meeting the in-service training requirement.

240.000 PRIOR AUTHORIZATION

1-1-19

- A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries, including beneficiaries participating in the Independent Choices Program.
- B. Prior authorization does not guarantee payment for the service.
1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.
 2. The provider must follow the billing procedures in this manual.
- C. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the DHS Independent Assessment Contractor to collect information used in determining the beneficiary's physical dependency needs for "hands-on" services with activities of daily living (ADL), and in calculating the number of personal care hours that can be authorized for the beneficiary. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each beneficiary is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment.
1. Tier 0 (zero) indicates the individual's assessed needs, if any, do not support the need for personal care services.
 2. Tiers 1 (one), 2 (two), or 3 (three) indicate the individual's assessed needs do support the need for personal care services.
- D. The Task and Hour Standards will be used by DHS RNs and DHS contractors to calculate the number of personal care hours that can be authorized for the beneficiary.

240.100

Task and Hour Standards (THS)

1-1-19

A. Background of the THS

The Arkansas Medicaid Task and Hour Standards (THS) is the written methodology used by the DHS RNs and DHS contractor RNs to calculate the number of personal care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

The current DAABHS approved THS is located on the web at

<https://medicaid.mmis.arkansas.gov/Download/provider/provdocs/Manuals/ARCHOCES/THS.doc>

The THS includes the following four components, described in a grid format:

1. The beneficiary's Needs Intensity Score (0, 1, 2, or 3) for each task;
2. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;
3. The frequency with which a task is necessary and reasonably performed; and
4. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary personal care services hours, with the minute ranges and frequencies, providing the ability to adjust service plans based on unique factors related to a given beneficiary's needs, preferences, and risks.

The number of personal care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN or by the contractor(s) designated by DHS consistent with the THS grid and based on:

1. Responses by the beneficiary and their representatives to certain relevant questions in the ARIA assessment instrument, and
2. As appropriate, information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representatives or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

B. Needs Intensity Score:

For each task, the DHS RN or the contractor(s) designated by DHS will assign a Needs Intensity Score to the beneficiary based on the beneficiary's and/or representative's responses to questions during the ARIA assessment and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS. The four Needs Intensity Scores are defined as follows:

Impairment Score 0 (Total): The beneficiary has no functional impairment with regard to the task and can perform it without assistance.

Impairment Score 1 (Mild): Minimal/mild functional impairment. The beneficiary is able to conduct activities with minimal difficulty and needs minimal assistance.

Impairment Score 2 (Severe): Extensive/severe functional impairment. The beneficiary has extensive difficulty carrying out activities and needs extensive assistance.

Impairment Score 3 (Total): The beneficiary is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

C. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN or contractor(s) designated by DHS will determine the number of minutes within the range that are appropriate for the beneficiary based on conditions specific to the beneficiary. For example, if a beneficiary has cognitive or behavioral issues, the maximum number of minutes in the range for bathing may be warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a beneficiary who is bald.

If the beneficiary has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN or designated contractor RN must obtain supervisory approval. For supervisory approval, the RN must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed

medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the personal care prior authorization or ARChoices PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the personal care prior authorization or PCSP.

D. The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

E. The amount of assistance with ADLs and IADLs provided by other sources

Personal care services are not available for assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then personal care services are not necessary and no time for that task is included. When another source is available to provide some instances of a needed ADL or IADL task, the frequency and time associated with these other sources are adjusted to correspond with the remaining assessed needs.

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task (e.g., the beneficiary's daughter bathes her mother once a week and prepares all meals on weekends). For example, where a needed meal is supplied by Meals on Wheels, minutes for meal preparation may not be necessary and should be adjusted.

F. Calculation of total hours of personal care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of personal care hours approved for the beneficiary for a month.

241.000 Personal Care Program Prior Authorization (PA) Responsibility

1-1-19

A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization of personal care services for beneficiaries.

B. DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's completed form designated by DHS and submitted documentation for personal

care services. Based on the information in the ARIA assessment and the form designated by DHS, they authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.

- C. DHS professional staff or contractor(s) designated by DHS have a right to review the beneficiary's medical information.

242.000 Personal Care PA Request Procedure

1-1-19

- A. Providers must use the form designated by DHS to request PA. View or print the form designated by DHS (English). View or print the form designated by DHS (Spanish).
- B. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals for beneficiaries who are assessed at Tier 1, 2, or 3 will be retroactive to the beginning date of service if the request is received within the 30-day time frame. There will be no prior authorization, including any retroactive prior authorization, if the beneficiary is assessed at Tier 0.
- C. Providers should submit prior authorization forms to the contractor(s) designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff

243.000 Provider Notification Procedure

1-1-19

Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

- A. For approved cases, an approval letter will be mailed to the requesting provider, detailing the procedure cases approved, total number of service-time increments, beginning and ending dates and the authorization number.
- B. For denied or partially denied cases, a denial letter with reason for denial will be mailed to the beneficiary and the requesting provider. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation. The letter shall specify why the prior authorization request was denied or partially denied and shall give the beneficiary notice of the right to file a request for a fair hearing and where to file the request. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation.

244.000 Duration of PA

7-1-20

Personal Care PAs are generally assigned for twelve (12) months from the date of the last independent assessment or for the life of the service plan, whichever is shorter, unless the beneficiary has a change in condition.

245.000 Administrative Reconsideration and Appeals

6-1-25

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

~~246.000 Reserved~~~~6-1-25~~**250.000 REIMBURSEMENT****250.100 Reimbursement Methods**~~1-1-19~~

- ~~A. Reimbursement for personal care services is the lesser of the billed amount per unit of service or Medicaid's maximum allowable fee (herein also referred to as "rate" or "the rate") per unit.~~
- ~~B. Reimbursement for Arkansas Medicaid Personal Care services is based on a 15-minute unit of service.~~
- ~~C. RCF Personal Care provider reimbursement is in accordance with a multi-hour daily service rate system, employing Medicaid maximum allowable fees (Daily Service Rates) determined by individual beneficiaries' Payment Levels.~~
- ~~D. ALF Personal Care provider reimbursement is in accordance with a multi-hour daily service rate system, employing Medicaid maximum allowable fees (Daily Service Rates) determined by individual beneficiaries' Payment Levels. This excludes the Living Choices Assisted Living waiver beneficiaries.~~

250.200 RCF and ALF Personal Care Reimbursement Methodology~~1-1-19~~

- ~~A. The RCF and ALF Personal Care reimbursement methodology is designed with the intent that reimbursement under the multi-hour Daily Service Rate system closely approximates what reimbursement would have been if the providers were to have billed by units of service furnished.~~
- ~~B. Whenever the unit rate (i.e., the maximum allowable amount per fifteen minutes service) for personal care services changes, Daily Service Rates under the RCF and ALF methodology are correspondingly adjusted in accordance with the initial methodology by which they were established and which is described in detail in the following sections.~~
- ~~C. The Daily Service Rate paid for personal care services is based on a Payment Level determined from the resident's service plan.~~

250.210 Payment Level~~1-1-19~~

~~There are 10 Payment Levels, each based on the average number of 15-minute units of service per month required to fulfill a beneficiary's service plan.~~

- ~~A. Level 1 includes RCF and ALF Personal Care beneficiaries whose service plans comprise 100 units or less per month of medically necessary personal care.~~
- ~~B. Level 10 includes RCF and ALF Personal Care beneficiaries whose service plans comprise 256 or more units per month of medically necessary personal care.~~
- ~~C. Level 2 through Level 9 were established in equal increments between 101 and 255 units per month.~~

250.211 Payment Level Determination~~1-1-19~~

- ~~A. The average of a service plan's monthly units of service is used to determine each beneficiary's Payment Level.~~
- ~~B. Calculate a beneficiary's average number of monthly units of personal care as follows.~~

1. Add the Weekly Minute Totals from the prior authorization approved by DHS using the Task and Hour Standards.
2. Divide the minutes by **15** (*15 minutes equals one unit of service*) to calculate weekly average units of service.
3. Multiply the weekly average units from step 2 by **52** (*Weeks in a year*) and divide the product by **12** (*Months in a year*) to calculate monthly average units of service.
4. Consult the "RCF and ALF Personal Care Service Rate Schedule" on the Arkansas Medicaid Personal Care Fee Schedule to find the applicable Daily Multi-Hour Service Rate for each Payment Level. Procedure code T1020 is the applicable code for RCF and ALF Personal Care providers.

250.212 Rate Development**1-1-19**

A. The Level 1 Daily Service Rate was calculated as follows:

1. Multiplied **100** (*15-minute units*) by **12** (*Months in a year*)
2. Divided units per year calculated in step 1 by **365** (*The average number of days in a year*) to calculate average units per day
3. Multiplied average units (*Unrounded*) per day obtained in step 2 by the current Personal Care maximum allowable fee per unit and rounded the product to the nearest 100th to calculate the Level 1 Daily Service Rate

B. The Level 10 Daily Service Rate was calculated as follows:

1. Multiplied **256** (*Maximum monthly units*) by **12** (*Months per year*)
2. Divided the product calculated in step 1 by **365** (*The average number of days in a year*) to calculate average maximum units per day
3. Multiplied average maximum units per day from step 2 by the current Personal Care maximum allowable fee per unit and rounded the product to the nearest 100th to calculate the Level 10 Daily Service Rate

C. The Daily Service Rates for Level 2 through Level 9 were calculated as follows:

1. The difference between 255 and 101 (154) was divided into eight equal increments that then were designated Payment Levels ("Levels") 2 through 9.
2. The sum of the beginning and ending values within each Payment Level was divided by **2** to calculate the Level's average units per month.
3. The average units per month was multiplied by **12** (*Months per year*) to calculate average annual units.
4. The average annual units calculated in step 3 was divided by **365** (*The average number of days in a year*) to arrive at average units per day.
5. The average units per day calculated in step 4 was multiplied by the current Personal Care maximum allowable fee per unit and the product was rounded to the nearest 100th.

251.100 Individuals with Disabilities Education Act (IDEA) and Beneficiary Free Choice**251.120 IDEA Responsibilities of School Districts and Education Service Cooperatives****8-1-04**

Arkansas public school districts and education service cooperatives (ESCs), when enrolled as Arkansas Medicaid Personal Care providers, are deemed the provider of service.

A. As such, the school districts and ESCs must provide services, under the guidelines of the Arkansas Medicaid Personal Care Provider Manual, to the following groups of children:

1. Medicaid-eligible school-aged children with disabilities, whose Individualized Education Programs (IEPs) call for personal care as a "Related Service" in accordance with the Individuals with Disabilities Education Act (IDEA);
2. Medicaid-eligible preschool children (aged 3 through 4 years) with disabilities, who are enrolled in special education programs, and whose IEPs include personal care.

B. Under the IDEA, the student's parent or guardian may independently select an enrolled Medicaid provider, ("other provider") other than the school district or ESC. This exception requires the existence of each of the following conditions:

1. Neither the school district or ESC nor anyone acting on behalf of the school district or ESC may refer the beneficiary, or the beneficiary's parent or guardian, to the other provider;
2. There is no arrangement by the school district or ESC, or persons or entities in privity with the school district or ESC, for the other provider to furnish the services;
3. The other provider does not, either directly or through another person or entity, have a contract with the school district or ESC or with persons or entities in privity with the school district or ESC, for referrals, consulting or the provision of Medicaid-covered services;
4. The other provider is not under control or supervision of the school district or ESC or persons or entities in privity with the school district or ESC;

C. For purposes of this rule, "privity" is a contractual interest growing out of a contract, mutuality of interest, common ownership or control.

251.121 Fee Schedule

1-1-19

REPEAL

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov/> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

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

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

252.000 Rate Appeal Process

10-13-03

A provider may request reconsideration of a Program decision affecting reimbursement by writing to the Assistant Director, Division of Medical Services (DMS).

A. The Program must receive the request within twenty (20) calendar days of the latest of the following events:

1. The implementation date of the new or revised policy, or
2. The effective date of the new or revised billing or coding instructions, or
3. The date of official provider notification of
 - a. New or revised policy or of
 - b. New or revised billing or coding instructions;

B. The Assistant Director, DMS, will review the request and will arrange a Program/Provider conference if needed or if the provider so requests.

1. The Assistant Director will advise the provider of the Program decision on the matter within twenty (20) calendar days following receipt of the request.
 2. If there is a Program/Provider conference, the Assistant Director will notify the provider within twenty (20) calendar days following the date of that conference.
- C. If the decision of the Assistant Director, DMS, is unsatisfactory to the provider, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the DMS.
1. A member of DHS management staff will chair the Rate Review Panel, which will include a member of the DMS and a representative of the medical professional community.
 2. The written request for review by the Rate Review Panel must be postmarked by the fifteenth (15th) calendar day following the date of notification of the initial decision by the Assistant Director, DMS.
 3. The Rate Review Panel will meet within fifteen (15) calendar days following receipt of the appeal request. The panel will submit its recommendation to the Director of the DMS.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing

7-1-20

- A. Personal Care providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries.
- B. Providers submitting claims electronically through the provider portal use the Professional claim format.
- C. A claim may contain charges for only one (1) beneficiary.
- D. Section III of this manual contains information about available options for electronic claim submission.

261.100 Electronic Visit Verification (EVV)

1-1-24

Refer to Provider Manual Section 1, General Policy, subsection 145.000 for EVV requirements regarding personal care services.

262.000 CMS-1500 Billing Procedures

262.100 Personal Care Billing

3-1-08

- A. Providers must use applicable HCPCS procedure codes and modifiers listed in the following section.
- B. All billing by any media requires the correct national standard place of service code.

262.101 Personal Care for a Beneficiary Aged 21 or Older (Non-RCF)

1-1-19

Procedure Code	Modifier	Service Description
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older, per 15 minutes (requires prior authorization)

262.102 Personal Care for a Beneficiary Under 21 (Non-RCF)

3-1-08

Procedure Code	Modifier	Service Description
T1019		Personal Care for a (non-RCF) Beneficiary Under 21, per 15 minutes (requires prior authorization)

262.103 Personal Care in a Public School**8-1-04**

Procedure Code	Modifier	Service Description
T1019	U4	Personal Care for a Beneficiary Under 21, provided by a school district or education service cooperative, per 15 minutes (requires prior authorization).

262.104 Personal Care in an RCF or ALF**1-1-19**

- A. To bill for RCF or ALF Personal Care, use HCPCS procedure code **T1020** and the modifier corresponding to the beneficiary's Payment Level in effect for the date(s) of service being billed.
- B. The Payment Level that a provider bills must be consistent with the beneficiary's service plan in effect on the day that the provider furnished the personal care services billed.

Payment Level Specifications and Modifiers for Procedure Code T1020

Payment Level	Minimum Service Units	Maximum Service Units	Modifier
Level 1	less than 40	40	U1
Level 2	101	119	U2
Level 3	120	139	U3
Level 4	140	158	U4
Level 5	159	177	U5
Level 6	178	196	U6
Level 7	197	216	U7
Level 8	217	235	U8
Level 9	236	255	U9
Level 10	256	256	UA

262.105 Employment-Related Personal Care Outside the Home**1-1-19**

Procedure Code	Modifier	Service Description
T1019	U5	Employment-related personal care outside the home, beneficiary aged 16 or older, per 15 minutes. All personal care services require prior authorization.

262.106 Billing RCF and ALF Personal Care Services**10-1-12**

- A. ~~RCF and ALF Personal Care providers may not bill for days during which a beneficiary received no personal care services (for instance, he or she was away for a day or more); therefore, do not include in the billed dates of service any days the beneficiary was absent.~~
- B. ~~For each unbroken span of days of service, multiply the days of service by the applicable Daily Service Rate and bill that amount on the corresponding claim detail.~~
- C. ~~Documentation requirements outlined in the Medicaid Personal Care Policy Section 216.400 (Personal Care Aide Service and Documentation Responsibility) must be adhered to when providing Personal Care services at all ALF facilities.~~

262.110 Coding Home and DDS Facility Places of Service

3-1-08

- A. ~~The beneficiary's home is the beneficiary's residence, subject to the exclusions in Section 213.500, part B. For example, if a beneficiary lives in a residential care facility (RCF) or an assisted living facility (ALF), then the RCF or ALF is the beneficiary's home and is so indicated on a claim by place of service code 12.~~
- B. ~~Section 213.520, part A, explains and describes special circumstances under which the place of service is deemed "public school."~~
 - 1. ~~The Arkansas Department of Education (ADE) sometimes deems a student's home a "public school," coded 03.~~
 - 2. ~~Under certain circumstances, the ADE deems a Division of Developmental Disabilities Services community provider facility ("DDS facility") a "public school," also coded 03.~~
- C. ~~When beneficiaries receiving personal care in a DDS facility are not in the charge of their school district, the place of service code is for "Other Place of Service," because there is no national code for a DDS clinic or facility.~~

REPEAL

262.300 Calculating Individual Service Times for Services Delivered in a Congregate Setting

3-1-08

~~Rules in this section and its subsections regard calculation and determination of service time to convert into billing units (Fifteen-minute units). Effective for dates of service on and after March 1, 2008, those rules do not apply to RCF Personal Care providers' billing. Rules in this section and its subsections that are applicable to assessments and service plan development continue to apply to RCFs.~~

~~If services, such as meal preparation in a congregate setting, are delivered simultaneously, only the actual proportionate service time attributable to each individual beneficiary is covered.~~

- A. ~~The provider shall compute the covered time by dividing the actual aide clock hours, attributing a proportionate share to each individual and multiplying each individual's proportionate share by a percentage arrived at from the individual's assessment. For example:~~
 - 1. ~~If an individual is totally dependent and cannot prepare a meal, the provider would be eligible for 100 percent of the beneficiary's proportionate share.~~
 - 2. ~~If a resident is totally capable of preparing a meal, the provider is not eligible for any reimbursement for any of the beneficiary's proportionate share.~~
 - 3. ~~If the beneficiary has an impairment that limits but does not totally prevent meal preparation the provider will be eligible for reimbursement of 50 percent of the individual's proportionate share of the aide's time.~~

- B. The beneficiary's assessment must describe, in narrative form, his or her level of impairment with respect to each physical dependency with which the beneficiary receives assistance in a congregate setting.

262.310 Unit Billing**7-1-04**

- A. Fifteen minutes of authorized, documented and logged personal care equals one unit of personal care aide service.
- B. Providers may not bill for less than fifteen minutes of service; however personal care aides' time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day, and the sum—in minutes—divided by 15 to calculate the number of units of service provided during that day.
- C. The estimated daily maximum service time in the beneficiary's service plan is the upper limit for daily billing.
- D. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary.
- E. There is no "carryover" of time from one day to another or from one beneficiary to another.
- F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

262.311 Calculating Units**07-01-04**

- A. Personal care providers must bill Medicaid in 15-minute units.
- B. Total the daily personal care service time for a single beneficiary in minutes, using the beginning and ending service times from the service logs.
- C. Set your calculator to compute to three decimal places.
- D. Divide the total time (expressed in minutes) by fifteen and
- E. Bill for the lesser of:
1. The rounded, whole-number quotient of the division or
 2. The maximum time estimate in the service plan.

262.312 Rounding**07-01-04**

When a quotient contains decimals, look at the numbers after the decimal point.

- A. If the number after the decimal point is 500 (e.g., 3.500) or less (e.g., 3.495) round downward to the whole number displayed before the decimal point (3, in this example)
- B. If the number after the decimal is 501 (e.g., 3.501) or greater (e.g., 3.576) round upward to the whole number one greater than the whole number displayed before the decimal point (4 in this example, because it is a whole number one greater than 3).

262.400 Billing Instructions—Paper Only**11-1-17**

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

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

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

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

262.410 Completing a CMS-1500 Claim Form for Personal Care

4-1-19

When a provider must bill on a paper claim, the fiscal agent accepts only red-lined, sensor-coded CMS-1500 claim forms. Claim photocopies and claim forms that are not sensor-coded cannot be processed.

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

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

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
	Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness ; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left hand set of vertical, dotted lines.
	The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:
	454 Initial Treatment
	304 Latest Visit or Consultation
	453 Acute Manifestation of a Chronic Condition
	420 Accident
	455 Last X-Ray
	471 Prescription
	090 Report Start (Assumed Care Date)
	091 Report End (Relinquished Care Date)
	444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of the referral source.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not applicable.
19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER	Insert LEA number.
20. OUTSIDE LAB?	Not required.
\$ CHARGES	Not required.

REPEAL

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

REPEAL

Field Name and Number	Instructions for Completion
E. — DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. — \$ CHARGES	The full charge for the services totaled in the detail. This charge must be the usual charge to any beneficiary patient, or other recipient of the provider's services. RCFs' charges should equal no less than the product of the number of units (days) times the beneficiary's Daily Service Rate. If the charge is less, Medicaid will pay the billed charge.
G. — DAYS OR UNITS	The units (in whole numbers) of service provided during the period indicated in Field 24A of the detail.
H. — EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening and referral.
I. — ID QUAL	Not required.
J. — BILLING PROVIDER ID #	Enter the eight Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
— NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. — FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, advise Provider Enrollment so that the year-end 1099 will be correct and reported correctly.
26. — PATIENT'S ACCOUNT NO.	Optional entry for providers' accounting and account retrieval purposes. Enter up to 16 numeric, alphabetic or alpha-numeric characters. This character set appears on the Remittance Advice as "MRN."
27. — ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. — TOTAL CHARGE	Total of Column 24F—the sum of all charges on the claim.
29. — AMOUNT PAID	Enter the total of payments received from other sources on this claim. Do not include amounts previously paid by Medicaid.
30. — RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PROVIDER	The performing provider or an individual authorized by the performing provider or by an institutional, corporate, business or other provider organization, must sign and date the claim, certifying that the services were furnished by the provider, under (when applicable) the direction of the individual provider or other qualified individual, and in strict and verifiable accordance with all applicable rules of the Medicaid program in which the provider participates. A "provider's signature" is the provider's or authorized individual's personally written signature, a rubber stamp of the signature, an automated signature or a typed signature. The name of a group practice, a facility or institution, a corporation, a business or any other organization will prevent the claim from being processed.
32. SERVICE FACILITY LOCATION INFORMATION	If services were not performed at the beneficiary's home or at the provider's facility (e.g., school, etc.) enter the name, street address, city, state and zip code of the facility, workplace etc. where services were performed. If services were furnished at multiple sites (for instance, when job-seeking), indicate "multiple locations" or leave blank.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

REPEAL

State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

HOUSE BILL 1439

By: Representative Ladyman
By: Senator Flippo

For An Act To Be Entitled

AN ACT TO REMOVE THE CERTIFICATION PROCESS OF THE
DEPARTMENT OF HUMAN SERVICES FROM LICENSURE AS A
PRIVATE CARE AGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO REMOVE THE CERTIFICATION PROCESS OF
THE DEPARTMENT OF HUMAN SERVICES FROM
LICENSURE AS A PRIVATE CARE AGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 20-10-2301(b), concerning the purpose and
intent of the licensure of private care agencies, is amended to read as
follows:

(b) It is the purpose of this subchapter to:

(1) Allow a licensed private care agency to provide in-home
personal care services twenty-four (24) hours a day and seven (7) days a week
to eligible recipients;

(2) Provide for the reimbursement of the personal care services
through Medicaid; and

(3) Authorize the Department of Human Services in its
administration of the Arkansas Medicaid Program to set forth Medicaid
provider participation requirements for a private care agency that will
ensure sufficient available personal care service providers in order to meet
the needs of all eligible recipients, including available in-home personal
care services twenty-four (24) hours a day and seven (7) days a week.



1 SECTION 2. Arkansas Code § 20-10-2302 is amended to read as follows:
2 20-10-2302. Definitions.

3 As used in this subchapter, "private care agency" means a provider that
4 ~~is certified by the Division of Provider Services and Quality Assurance as a~~
5 ~~provider of home and community based health services~~ licensed by the
6 Department of Health as a private care agency and that:

7 (1) Furnishes in-home staffing services for personal and
8 attendant care services for which the provider seeks reimbursement through
9 the Arkansas Medicaid Program; and

10 (2) Retains liability insurance of not less than one million
11 dollars (\$1,000,000) to cover its employees and independent contractors while
12 its employees and independent contractors are engaged in providing personal
13 and attendant care services.

14
15 SECTION 3. Arkansas Code § 20-10-2304(c)(3)(B), concerning the rules
16 for private care agencies, is amended to read as follows:

17 (B) A private care agency maintain a primary location in
18 Arkansas ~~and a sufficient number of regional offices~~ to adequately service
19 the administrative needs of the private care agency and the patients of the
20 private care agency; and

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23 **APPROVED: 4/17/25**
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