

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

SUBJECT: Living Choices Rate Increase

DESCRIPTION:

Statement of Necessity

Act 198 of 2023 requires Assisted Living Facilities (ALFs) to complete annual cost-reports and submit them to the Department of Human Services as a condition for participating in the Arkansas Medicaid Program. The reports “[a]ssist the department in ascertaining and monitoring the financial stability and solvency” of the facilities.

Following passage of the Act, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) completed the review of cost reports received through its qualified contractor, Myers & Stauffer. Myers & Stauffer issued a cost report analysis. Based upon the analysis, DHS proposes a rate increase for Living Choices Assisted Living Facility providers.

Summary of Changes

As a result of the cost analysis, DAABHS proposes an amendment to the Centers for Medicare and Medicaid (CMS) for its 1915(c) Home and Community-Based Services Living Choices Assisted Living Waiver. The amendment proposes an increase of the current daily rates of \$81.59 (urban) and \$85.67 (rural) for providers to \$86.73 for both urban and rural, thus removing the distinction between the two types of facilities.

[BLR Staff Note: Due to its length, the Myers & Stauffer cost report analysis has been provided separately.]

PUBLIC COMMENT: A public hearing was held on this rule on April 24, 2024. The public comment period expired on May 13, 2024. The agency indicated that it received no comments.

The proposed effective date is pending legislative review and approval.

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

Per the agency, the total cost to implement this rule is \$1,393,873 for the current fiscal year (\$390,284 in general revenue and \$1,003,588 in federal funds) and \$1,393,873 for the next fiscal year (\$390,284 in general revenue and \$1,003,588 in federal funds). The total estimated cost by fiscal year to state, county, or municipal government to implement this rule is \$390,284 for the current fiscal year and \$390,284 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least \$100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

To increase the daily rates paid Assisted Living Facility providers.

A cost report study with analysis conducted by Myers and Stauffer was completed of 50 Assisted Living Facilities. The report was presented to ALC and the Hospital and Medicaid Study Subcommittee. The public was given the opportunity to provide comment on this study and DHS has responded to comments. This amendment to the Living Choices waiver formally requests approval from CMS to increase the daily rate to \$86.73 and a shift away from urban and rural rates to one single rate for all Assisted Living Facilities across Arkansas.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

To address the results and recommendation of the cost report analysis issued by Myers and Stauffer.

(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;

With the passage of Act 198 during the 2023 general legislative session, which requires all assisted living facilities participating in the Arkansas Medicaid program to submit annual cost reports, DHS contracted Myers and Stauffer LC (Myers and Stauffer) to prepare this analysis of the Living Choices Assisted Living Waiver program, herein referred to as waiver, rates. This effort included analysis of data collected through a cost survey of all assisted living waiver program providers. The cost survey was developed for the 2022 Living Choices Rate Study and updated by the Department for 2023 to fulfill legislatively mandated reporting requirements. All Living Choices Assisted Living Waiver providers were required to submit a cost survey for the 12-month period ending June 30, 2023.

Myers and Stauffer completed a review of all cost survey data. Reports were reviewed to ensure completeness and to investigate data anomalies. Myers and Stauffer also reviewed supporting documentation to ensure the cost surveys tied back to each facilities financial reports. *Table 1* summarizes this information.

High Medicaid Utilization Facilities	> 50%	16
Medium Medicaid Utilization Facilities	≥ 30%, ≤ 50%	16
Low Medicaid Utilization Facilities	< 30%	18
Non-Waiver Providers	No Medicaid	0
Total		50

Table 1: Survey Participation

The costs captured by the survey were separated into cost centers including direct care, indirect care, administrative and general, and rent/utilities/food. Costs were also evaluated to determine if they should be 100% waiver service costs (completely tied to providing waiver services), 100% non-waiver service related (not related to provider waiver services), or allocated between waiver service and non-waiver service related (partially tied to providing waiver services).

- **Direct Care.** Includes wages and benefits for direct caregivers including licensed practical nurses, certified nurse assistants, personal care aides, and universal workers. These costs were considered 100 percent waiver service costs.
- **Indirect Care.** Covers the cost of indirect staffing such as registered nurse (RN) supervisors, dietary supervisor, meal preparation staff and activities staff, as well as non-labor indirect care costs. Most of these costs were treated as 100 percent waiver service costs but a few costs were excluded completely where documentation was not provided to indicate a relevance to the waiver program.
- **Administrative and General (A&G).** Includes the allowable share of administrative expenses such as the salaries for the facility administrator and office staff, as well as any supplies they require. These costs were divided between those considered 100 percent waiver service costs such as the administrator's wages, those that were deemed non-waiver service costs like laundry workers' wages, costs that were allocated by wages such as benefits, and costs that were allocated by square footage such as housekeeping expenses.
- **Rent, Utilities, and Food (RUF).** Cost of the building, maintenance, utilities, and raw food. Most of these costs were considered non-waiver service costs, but a small portion of building and utilities costs were included in two of the rate recommendations to account for space required to conduct administrative functions and to provide resident activities.

Following a period of public comment, no changes were made to the report. Comments generally pertained to the providers requests for increased Medicaid rates in excess of what was supported by the providers actual data. Additionally, requests were made for two policy changes involving eligibility payments and absentee beds days which the agency has committed to review.

[BLR Staff Note: Due to its length, the Myers & Stauffer cost report analysis has been provided separately.]

(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;

See answer to Question 3, above.

(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;

No comments received.

(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

N/A

(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.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

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 responds to cost reporting required by Act 198 of 2023. The Act, sponsored by Representative Jon Eubanks, established cost-reporting for assisted living facilities to the Department of Human Services as a condition of participation in the Arkansas Medicaid Program.



ARKANSAS
DEPARTMENT OF
**HUMAN
SERVICES**

Office of Policy and Rules

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

P: 501.320.6383 F: 501.404.4619

April 12, 2024

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: Living Choices Rate Increase

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
Deputy Chief

Attachments

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

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Aging, Adult & 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?
Living Choices Rate Increase
2. What is the subject of the proposed rule? See Attached.
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 ☒

4. Is this rule being filed for permanent promulgation? Yes ☒ No ☐

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☐

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire? _____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes ☐ No ☒

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes ☐ No ☒

If yes, please provide the state statute and/or rule citation.

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes ☐ No ☒

If yes, please list the rules being repealed.

If no, please explain.

Governor's Exception

8. Is this a new rule? Yes ☐ No ☒

Does this repeal an existing rule? Yes ☐ No ☒

If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes ☒ No ☐

If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

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).

Following Act 198 of 2023, assisted living facilities submitted cost reports to DHS, and this rule is a result of a cost review analysis of those reports.

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

A cost report study with analysis conducted by Myers and Stauffer was completed of 50 Assisted Living Facilities. The report was presented to ALC and the Hospital and Medicaid Study Subcommittee. The public was given the opportunity to provide comment on this study and DHS has responded to comments. This amendment to the Living Choices waiver formally requests approval from CMS to increase the daily rate to \$86.73 and a shift away from urban and rural rates to one single rate for all Assisted Living Facilities across Arkansas.

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).

[ar.gov/dhs-proposed-rules](https://www.ark.gov/dhs-proposed-rules)

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

If yes, please complete the following:

Date: 04/24/2024

Time: 10:00 am

Place: ZOOM: <https://us02web.zoom.us/j/88335196743>; Webinar ID: 883 3519 6743

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. 05/13/2024

15. What is the proposed effective date for this rule? 07/01/2024

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.

[Historically, rate changes for the Living Choices program are controversial based upon public comments received in the past.](#)

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 Director of the Division of Aging, Adult, and Behavioral Services proposes an amendment to the Arkansas 1915(c) Home and Community-Based Services Living Choices Assisted Living Waiver seeking an increase of the daily rate paid assisted living facility providers. The proposal increases the current daily rates of \$81.59 (urban) and \$85.67 (rural) to \$86.73 for both urban and rural providers, removing the distinction between the facility types. The proposal is a result of the review of cost reports submitted to DHS following the implementation of Act 198 of 2023, and subsequent cost report analysis rate review. The proposed effective date of the rule is July 1, 2024. The projected annual cost of this change is \$1,393,873.00 per year (State \$390,284.00; Federal \$1,003,588.00).

To calculate the rate, DHS contracted Myers & Stauffer to review and issue an analysis of the reports. Myers & Stauffer used a rate build-up methodology using the hourly wage data and daily staffing ratios from the 2023 cost survey. This methodology was selected due to the diversity of provider characteristics and cost experiences, and because it reduced the impact of data outliers. The hourly wage data and daily staffing ratios were utilized to calculate a base cost for direct care. Adjustments were applied to this calculation to account for employee benefit costs and inflation. This calculation produced an estimate of the total cost of the direct care labor. Data for contracted positions also was gathered through the cost survey. This cost represents a smaller share of the total direct care staffing costs. The direct care staffing costs are the primary driver of the waiver costs, and therefore, the primary component of the rate calculation. In addition to the staffing ratios and hourly wage rates, other statistics were necessary to complete the direct care staffing calculation. The median staff benefits percentage from the 2023 cost survey data, 18.08 percent, was used as the benefits percentage. Applying this factor to the direct care wages subtotal (not including contracted staff wages) accounts for the expected cost of providing employee benefits. Also, an inflation factor was applied to adjust historical costs.

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 must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than May 13, 2024. 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 Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

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. 4502201653

From: [Legal Ads](#)
To: [Chloe Crater](#)
Subject: Re: FULL RUN AD - Living Choices Rate Increase
Date: Friday, April 12, 2024 1:51:45 PM
Attachments: [image001.png](#)
[image002.png](#)

[EXTERNAL SENDER]

Notice will run Sunday, April 14, April 15 and April 16.

Thank you.

Cate Hubbard, filling in for
Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Chloe Crater" <Chloe.Crater@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>
Sent: Friday, April 12, 2024 9:55:04 AM
Subject: FULL RUN AD - Living Choices Rate Increase

Hi Cate,

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

- Sunday April 14, 2024
- Monday April 15, 2024
- Tuesday April 16, 2024

A public hearing by remote access only will be held through a Zoom webinar. The public comment period will end on May 13, 2024. Also, please reply to this email using "Reply All".

-Thanks,
Chloe



CHLOE CRATER-BETTON

OFFICE OF LEGISLATIVE AND INTERGOVERNMENTAL AFFAIRS – RULES
PROMULGATION

From: [Chloe Crater](#)
To: register@sos.arkansas.gov
Cc: [Mac Golden](#); [Jack Tiner](#); [Lakeya Gipson](#); [Amanda Cox](#)
Subject: DHS/DAABHS- PROPOSED FILING - Living Choices Rate Increase
Date: Friday, April 12, 2024 1:53:00 PM
Attachments: [image001.png](#)
[image002.png](#)
[Rule 274 - SOS INITIAL FILING PACKET.pdf](#)

The Rule will run the following three consecutive Days in the Arkansas Democrat Gazette:

- Sunday April 14, 2024
- Monday April 15, 2024
- Tuesday April 16, 2024

A public hearing by remote access only will be held through a Zoom webinar. The public comment period will end on May 13, 2024.

-Thanks

Chloe



CHLOE CRATER-BETTON

OFFICE OF LEGISLATIVE AND INTERGOVERNMENTAL AFFAIRS – RULES
PROMULGATION

PROGRAM ADMINISTRATOR

P: 501-320-6217

700 MAIN STREET

Little Rock, AR 72201

Chloe.Crater@dhs.arkansas.gov

humanservices.arkansas.gov



This email may contain sensitive or confidential information.

CONFIDENTIALITY NOTICE: The information contained in this email message and any attachment(s) is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to which this email is addressed. If you are not the intended recipient, you are hereby notified that reading, copying or distribution this transmission is **STRICTLY PROHIBITED**. The sender has not waived any applicable privilege by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services

BOARD/COMMISSION Division of Aging, Adult & Behavioral Health 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 Living Choices Rate Increase

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 \$390,284 _____
 Federal Funds \$1,003,588 _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total \$ 1,393,873.00 _____

Next Fiscal Year

General Revenue \$390,284 _____
 Federal Funds \$1,003,588 _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total \$ 1,393,873.00 _____

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

\$ 390,284.00 _____

Next Fiscal Year

\$ 390,284.00 _____

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.

FINANCIAL IMPACT STATEMENT ADDENDUM

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;

To increase the daily rates paid Assisted Living Facility providers.

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To address the results and recommendation of the cost report analysis issued by Myers and Stauffer.

- (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;

See the Cost Report, Arkansas Legislative Council hearing, and public comments found at <https://humanservices.arkansas.gov/rules/ar-living-choices-al-waiver/>.

- (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;

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(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

N/A

(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.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

Statement of Necessity and Rule Summary

Living Choices Rate Increase Effective 07/01/2024

Statement of Necessity

Act 198 of 2023 requires Assisted Living Facilities (ALFs) to complete annual cost-reports and submit them to the Department of Human Services as a condition for participating in the Arkansas Medicaid Program. The reports “[a]ssist the department in ascertaining and monitoring the financial stability and solvency” of the facilities.

Following passage of the Act, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) completed the review of cost reports received through its qualified contractor, Myers & Stauffer. Myers & Stauffer issued a [cost report analysis](#). Based upon the analysis, DHS proposes a rate increase for Living Choices Assisted Living Facility providers.

Summary of Changes

As a result of the cost analysis, DAABHS proposes an amendment to the Centers for Medicare and Medicaid (CMS) for its 1915(c) Home and Community-Based Services Living Choices Assisted Living Waiver. The amendment proposes an increase of the current daily rates of \$81.59 (urban) and \$85.67 (rural) for providers to \$86.73 for both urban and rural, thus removing the distinction between the two types of facilities.

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

1. Request Information

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

B. **Program Title:**

Living Choices Assisted Living Waiver

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

Original Base Waiver Number: AR.0400.

D. **Amendment Number:** AR.0400.R04.06

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

03/01/24 07/01/2024

Approved Effective Date: 03/01/24

Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

~~Arkansas has an approved American Rescue Plan Act (ARP) Spending Plan under Section 9817 that outlines the Workforce Stabilization Incentive Program (Program). The effective dates of the Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program terms. The Workforce Stabilization Incentive Program allows Living Choices provider to pay supplemental/enhanced payments to direct care workers in Assisted Living Facilities.~~

~~Likewise, due to the Appendix K expiration date, the State is seeking to amend the base waiver to include the current per person-per day rate of \$81.59 for urban facilities, with an additional 5% differential for rural facilities which totals \$85.67. The State has amended Appendix J, beginning with waiver year 3 to reflect these rates. Arkansas has broken out the Living Choices Assisted Living Services component into 2 parts: Urban Assisted Living Facilities and Rural Assisted Living Facilities. This amendment proposes to increase the current rate of \$81.59 (urban) and \$85.67 (rural) for Living Choices Assisted Living Facility providers to \$86.73 for both urban and rural, thus removing the distinction between the two types of facilities. This rate change comes as the result of a cost report analysis completed by Myers & Stauffer on behalf of the Department of Human Services, Division of Aging, Adult and Behavioral Health Services.~~

~~Act 198 of the 2023 General Legislative Session requires Assisted Living Facility providers-DHS- to complete an annual cost reports and submit them to DHS-of its Assisted Living Facility providers, and gives DHS the opportunity to make rate changes as a result of the cost report findings.~~

3. Nature of the Amendment

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

MARKUP

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2: Rates, Billing and Claims; I-3: Payment
☒ Appendix J Cost-Neutrality Demonstration	J-1: Composite Overview; J-2: Derivation of Estimates

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- ☐ Modify target group(s)
 - ☐ Modify Medicaid eligibility
 - ☐ Add/delete services
 - ☐ Revise service specifications
 - ☐ Revise provider qualifications
 - ☐ Increase/decrease number of participants
 - ☒ Revise cost neutrality demonstration
 - ☐ Add participant-direction of services
 - ☒ Other
- Specify:

The State is seeking to amend the waiver due to a change in the rate and the current rate structure. The State is moving to a singular daily rate for Assisted Living Services based upon a rate review.

Application for a §1915(c) Home and Community-Based Services Waiver

6. Additional Requirements

Note: Item 6-I must be completed.

- i. Public Input.** Describe how the state secures public input into the development of the waiver:

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

Notices of amendments and renewals of the waiver are posted on the DHS website <https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/> for at least 30 days to allow the general public to submit comments on changes. Notices of amendments and renewals are also published in a statewide newspaper with instructions for submitting comments to DMS.

The public notice for this amendment was published in the Arkansas Democrat-Gazette for three consecutive days from 10/01/2023mm/dd/yyyy to 10/03/2023mm/dd/yyyy. The 30-day public comment period ended 10/30/2023mm/dd/yyyy. Physical copies of the entire proposed waiver renewal were mailed to constituents upon request and were posted on the DHS website on the proposed rules page at <https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/>. The entire proposed waiver amendment was also emailed to an Interested Parties list.

Appendix I: Financial Accountability

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

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

DMS is responsible for the oversight of rate determinations with consultation by DAABHS. There is an established procedure followed by DMS to conduct rate studies, get provider input, and rebase rates when needed. Rates are published for public comment and are made available to all providers before implementation of the new rate via an official notice from DMS. Upon enrollment with Medicaid, new providers are referred to the Arkansas Medicaid website which has published fee schedules. Various methodologies are used for rate determination depending on the waiver service.

~~The Division of Medical Services is required to conduct rate reviews for every Medicaid program in a three-year cycle. Living Choices rates were reviewed in 2021 (year 3 of the cycle). The rates were updated last in 2019. The most recent review indicated that no rate rebasing was needed.~~

The rates may be found at <https://humanservices.arkansas.gov/wp-content/uploads/LCAL-fees.pdf>

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

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

The rate methodology excludes reimbursement of room and board costs.

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

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

Opportunities for Public Comment: Before submitting this waiver renewal to CMS for federal review and approval, DHS engaged in various opportunities for public comment including a webinar. These are in addition to the public comment process for this waiver renewal and the revised provider manual. Further, both the waiver renewal and the revised provider manual undergo prior review by Arkansas legislative committees.

See Main Section 6-I for additional information.

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

Amendment Effective 03/01/2024:

As the COVID-19 pandemic and Public Health Emergency has continued, there has been an increase in applications for the Living Choices waiver increasing the need for direct care staff, further compounded by all providers competing within a severely tightened health care labor market with increased personnel costs. We are extending the end date of the previously approved rate increase from December 31, 2022 to the expiration of the waiver.

The State of Arkansas will not use ARP Funding for this requested rate increase.

Arkansas is extending the current rate of \$67.25 per person per day to \$81.59 per person per day, with an additional 5% differential for rural facilities, which totals \$85.67. This rate is comprised of two components:

• A daily rate of \$49.04 for total practitioner costs, meaning the costs of all direct care labor (care aides, CNAs, nurses). This rate is based on the wages currently paid by DHS to similar staff at the Arkansas Health Center, a state-owned nursing home. This amount represents an increase from the 2019 survey data to account for the competitive labor market and increased wages in the health care sector as a result of the COVID-19 pandemic.

• A daily rate of \$32.55 for remaining administrative and overhead costs. This rate is based on a cost survey and rate review completed by Milliman in 2019. In that rate review, Milliman recommended that the then current rate include administrative/overhead costs as 90.5% of the total practitioner costs, which for the then effective rate equaled \$32.55 per patient per day. The 90.5% was based on the average administrative and overhead costs for surveyed assisted living providers. Therefore, \$32.55 represents the average overhead and administrative cost of surveyed providers. We have received sample cost data from providers within the last three months, and that sample cost data demonstrates that \$32.55 per patient per day is sufficient to cover allowable administrative and overhead costs.

Amendment Effective 07/01/2024:

Pursuant to Arkansas Code Title 20, Chapter 10, Subchapter 24, the Department of Human Services (DHS) Division of Aging, Adult and Behavioral Health Services (DAABHS) has completed the review of cost reports submitted by the Assisted Living Facilities who participate in the Living Choices Assisted Living Facility Wavier program. DHS, through its qualified contractor, Myers and Stauffer, has reviewed each cost report submitted by the Assisted Living Facilities. This statute requires providers to submit annual cost reports and for DHS to consider the cost report results for possible amendment request to the waiver rate.

To calculate a rate for the waiver program Myers and Stauffer used a rate build-up methodology using the hourly wage data and daily staffing ratios from the 2023 cost survey. This methodology was selected due to the diversity of provider characteristics and cost experiences. This methodology reduced the impact of data outliers. The hourly wage data and daily staffing ratios were utilized to calculate a base cost for direct care. Adjustments were applied to this calculation to account for employee benefits costs and inflation. This calculation produced an estimate of the total cost of the direct care labor. Data for contracted positions was also gathered through the cost survey. This cost represents a smaller share of the total direct care staffing costs.

The direct care staffing costs are the primary driver of the waiver costs, and therefore, the primary component of our rate calculation. In addition to the staffing ratios and hourly wage rates, other statistics were necessary to complete the direct care staffing calculation. The median staff benefits percentage from the 2023 cost survey data, 18.08 percent, was used as the benefits percentage. Applying this factor to the direct care wages subtotal (not including contracted staff wages) accounts for the expected cost of providing employee benefits.

An inflation factor is also a common reimbursement element in order to account for expected increases in costs between the data collection period and the rate effective period. An inflation factor was applied to adjust historical costs from the midpoint of the cost data period, December 31, 2022 to the midpoint of the fiscal year 2025 rate period, December 31, 2024. Two inflation factor options were evaluated, the IHS Global Insight, Centers for Medicare & Medicaid Services (CMS) Nursing Home without Capital Market Basket Index (NF Market Basket) and the Consumer Price Index (CPI). The NF Market Basket index is a standard source used to calculate inflation factors for long-term care services. The calculation produced an inflation factor of 6.63 percent. Historically the Department has utilized the Consumer Price Index (CPI), for inflation calculations. This inflation factor was calculated to be 5.67 percent.

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

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

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	17209.53	2173.00	19382.55	40959.00	1687.00	42646.00	23263.45
2	17209.53	2244.00	19453.55	42296.00	1742.00	44038.00	24584.45
3	18588.78	2317.00	20905.78	43677.00	1799.00	45476.00	24570.22
4	21347.23	2393.00	23740.23	45102.00	1858.00	46960.00	23219.77
5	21347.23	2471.00	23818.23	46574.00	1919.00	48493.00	24674.77

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (3 of 9)**

a. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

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

Factor D is derived from current reporting of expenditures from the Medicaid DSS and consideration of previous waiver estimates of utilization and growth rates. Factor D was calculated utilizing data from 01/01/2019 through 12/31/2019.

The unduplicated cap of 1725 was used as the number of users for WY1-WY5 to allow for full-year participation of each available slot. Given the average length of stay of 291 days, the state calculates 1,505 as the maximum number of unduplicated participants who can be served under a point-in-time (PIT) maximum of 1,200. The calculation is:

$$1,200 \text{ (max PIT cap)} \times 365 \text{ days} \div 291 \text{ days (avg. length of stay)} = 1,505$$

This exact amount was used for the estimated number of users in Appendix J-2-d. Units per user was calculated based on actual usage from 02/01/2016-01/31/2019.

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

The Extended Medicaid State Plan Prescription Drug service was calculated utilizing the actual cost of services from 02/01/2016-01/31/2019.

The state's actuary calculated a composite average of the four (4) Living Choices Assisted Living Services tier rate used during the previous renewal cycle, adjusted to reflect the distribution of participants between the four tiers, of \$80.33. The payment rate recommended by the actuary is \$62.89, which is a 20.7% decrease from the

July 1, 2020, the rate decreased to \$67.25; and on January 1, 2021, for the final month of the waiver, the rate should have decreased to the actuary's recommended rate of \$62.89. The state submitted an Appendix K to suspend the final rate decrease and is requesting that under the renewal the rate remain at the current rate of \$67.25.

The dates utilized by the actuary to develop the rate include February 1, 2016 through January 31, 2020.

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

Amendment Effective 03/01/2024:

The State will continue to utilize the approved Appendix K per person per day rate of \$81.59 with an additional 5% differential for rural facilities, which totals \$85.67 for the Living Choices Assisted Living Service until data can be received and verified in accordance with Arkansas law, and if warranted, the State will seek any needed amendments. Arkansas has identified 2 subcomponents for the Living Choices Assisted Living Services waiver component: Urban Assisted Living Facilities and Rural Assisted Living Facilities.

The data that informed the rates included a 2019 rate study and a 2020 & 2021 provider cost survey to determine the indirect service cost. Additionally, the median hourly rate of nursing and certified nursing assistant staff at our state-run nursing home was taken into consideration and applied a 4.1% inflation factor to trend the rate forward. After establishing the urban rate of \$81.59, we applied a 5% rural differential to get to \$85.67. The applied inflation factor was an average of inflation rates reported from the Consumer Price Index for the years 2018-2022.

In December 2023, using data from DAABHS internal databases, the census of existing assisted living facilities was used to determine the percentage of urban and rural facilities in Arkansas. The designation of rural and urban providers can be sourced to the 2020 US Census maps and definitions for Urban and Non-Urban areas.

Amendment Effective 07/01/2024:

Pursuant to Arkansas Code Title 20, Chapter 10, Subchapter 24, the Department of Human Services (DHS) Division of Aging, Adult and Behavioral Health Services (DAABHS) has completed the review of cost reports submitted by the Assisted Living Facilities who participate in the Living Choices Assisted Living Facility Wavier program. DHS, through its qualified contractor, Myers and Stauffer, has reviewed each cost report submitted by the Assisted Living Facilities. This statute requires providers to submit annual cost reports and for DHS to consider the cost report results for possible amendment request to the waiver rate.

To calculate a rate for the waiver program Myers and Stauffer used a rate build-up methodology using the hourly wage data and daily staffing ratios from the 2023 cost survey. This methodology was selected due to the diversity of provider characteristics and cost experiences. This methodology reduced the impact of data outliers. The hourly wage data and daily staffing ratios were utilized to calculate a base cost for direct care. Adjustments were applied to this calculation to account for employee benefits costs and inflation. This calculation produced an estimate of the total cost of the direct care labor. Data for contracted positions was also gathered through the cost survey. This cost represents a smaller share of the total direct care staffing costs.

The direct care staffing costs are the primary driver of the waiver costs, and therefore, the primary component of our rate calculation. In addition to the staffing ratios and hourly wage rates, other statistics were necessary to complete the direct care staffing calculation. The median staff benefits percentage from the 2023 cost survey data, 18.08 percent, was used as the benefits percentage. Applying this factor to the direct care wages subtotal (not including contracted staff wages) accounts for the expected cost of providing employee benefits.

An inflation factor is also a common reimbursement element in order to account for expected increases in costs between the data collection period and the rate effective period. An inflation factor was applied to adjust historical costs from the midpoint of the cost data period, December 31, 2022 to the midpoint of the fiscal year 2025 rate period, December 31, 2024. Two inflation factor options were evaluated, the IHS Global Insight, Centers for Medicare & Medicaid Services (CMS) Nursing Home without Capital Market Basket Index (NF Market Basket) and the Consumer Price Index (CPI). The NF Market Basket index is a standard source used to calculate inflation factors for long-term care services. The calculation produced an inflation factor of 6.63 percent. Historically the Department has utilized the Consumer Price Index (CPI), for inflation calculations. This inflation factor was calculated to be 5.67 percent.

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
Extended Medicaid State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						36589964.61 37,983,837.15
Living Choices Assisted Living Service	1 Day	01505	0291.00	0.0186.73	0.00 3798 3837 .15	
Urban Assisted Living Facilities	1 Day	7830	291.000	81.590	18590526.27 0	
Rural Assisted Living Facilities	1 Day	7220	291.000	85.670	17999438.34 0	
GRAND TOTAL:					36823964.6138217837.15	
Total Estimated Unduplicated Participants:						1725
Factor D (Divide total by number of participants):					21347.232215454.27	
Average Length of Stay on the Waiver:						291

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
Extended Medicaid						

State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						36589964.61 <u>37983837.15</u>
Living Choices Assisted Living Service	1 Day	0.1505	0.00291	0.0186.73	0.00 3798 3837 .15	
Urban Assisted Living Facilities	1 Day	7830	291.000	81.590.01	18590526.27 0	
Rural Assisted Living Facilities	1 Day	7220	291.000	85.670.01	17999438.34 0	
GRAND TOTAL:						36823964.61 <u>38217837.15</u>
Total Estimated Unduplicated Participants:						1725
Factor D (Divide total by number of participants):						2134722155.27 <u>23</u>
Average Length of Stay on the Waiver:						291

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

1. Request Information

- A. The **State** of **Arkansas** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. **Program Title:**
Living Choices Assisted Living Waiver
- C. **Waiver Number:**AR.0400
Original Base Waiver Number: AR.0400.
- D. **Amendment Number:**AR.0400.R04.07
- E. **Proposed Effective Date:** (mm/dd/yy)

07/01/24

Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

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

This amendment proposes to increase the current rate of \$81.59 (urban) and \$85.67 (rural) for Living Choices Assisted Living Facility providers to \$86.73 for both urban and rural, thus removing the distinction between the two types of facilities. This rate change comes as the result of a cost report analysis completed by Myers & Stauffer on behalf of the Department of Human Services, Division of Aging, Adult and Behavioral Health Services.

Act 198 of the 2023 General Legislative Session requires Assisted Living Facility providers to complete annual cost reports and submit them to DHS, and gives DHS the opportunity to make rate changes as a result of the cost report findings.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)		
☐ Waiver			

Component of the Approved Waiver	Subsection(s)
Application	
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2 Rate, Billing & Claims
☒ Appendix J Cost-Neutrality Demonstration	J-1: Composite Overview; J-2: Derivation of Estimates

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- ☐ Modify target group(s)
 - ☐ Modify Medicaid eligibility
 - ☐ Add/delete services
 - ☐ Revise service specifications
 - ☐ Revise provider qualifications
 - ☐ Increase/decrease number of participants
 - ☒ Revise cost neutrality demonstration
 - ☐ Add participant-direction of services
 - ☒ Other
- Specify:

The State is seeking to amend the base waiver to remove the broken-out service components of Urban and Rural Assisted Living Facilities and resume a single component: Assisted Living Facility Services.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Arkansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Living Choices Assisted Living Waiver

C. Type of Request: amendment

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

☐ 3 years ☒ 5 years

Original Base Waiver Number: AR.0400

Waiver Number: AR.0400.R04.07

Draft ID: AR.016.04.08

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21

Approved Effective Date of Waiver being Amended: 07/01/21

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

☒ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

-
- ☐ Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160
- ☒ **Nursing Facility**
Select applicable level of care
- ☒ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:
- Individuals requiring a skilled level of care are not eligible for the Living Choices program. The State's definition of "skilled level of care" is set forth below at b-6-d.
- ☐ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
- ☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:
-

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- ☒ **Not applicable**
- ☐ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

- ☐ §1915(b)(1) (mandated enrollment to managed care)
- ☐ §1915(b)(2) (central broker)
- ☐ §1915(b)(3) (employ cost savings to furnish additional services)
- ☐ §1915(b)(4) (selective contracting/limit number of providers)
- ☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

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

PROPOSED

The Living Choices Assisted Living waiver program allows individuals to live in apartment-style living units in licensed level II assisted living facilities & receive individualized personal, health & social services that enable optimal maintenance of their individuality, privacy, dignity, & independence. The assisted living environment actively encourages & supports these values through effective methods of service delivery & facility or program operation. The environment promotes participants' personal decision-making while protecting their health & safety. The major goal of this program is to delay or prevent institutionalization of these individuals. However, assisted living services are not intended as a substitute for nursing facility or hospital care for individuals needing skilled care, as defined by State administrative rule which is set forth in B-6-d. Room & board services are not covered per federal law.

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

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

Initial applications for Living Choices Assisted Living Waiver are processed to determine financial & functional eligibility for the waiver. The Division of County Operations (DCO) Long-Term Services & Supports (LTSS) unit processes the applications. LTSS eligibility workers are responsible for determining financial eligibility & referring applicant to an independent assessment contractor for an assessment of functional eligibility.

The independent assessment is performed by the Independent Assessment Contactor utilizing the Arkansas Independent Assessment (ARIA) instrument to assess functional need. This assessment of functional need is used as part of the process to determine if the person is medically and financially eligible as well in the development of a participant's PCSP. At least every 12 months, an evaluation utilizing DHS Form 703 will be completed by the DHS PCSP/CC Nurse in conjunction with the participant to determine continued evidence of established medical and functional need or a change in medical condition that may impact continued eligibility. The evaluation may result in a reassessment being requested if it is determined that there is evidence of a material change in the functional or medical need of the participant. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system.

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

The person-centered service plan is informed by the tier level assigned by the ARIA instrument to the participant based on the individuals needs as determined during the ARIA assessment Process, or by the evaluation completed at a minimum of every 12 months by the PCSP/CC nurse using DHS Form 703.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid

eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ☐ **Yes. This waiver provides participant direction opportunities. Appendix E is required.**
- ☒ **No. This waiver does not provide participant direction opportunities. Appendix E is not required.**

F. Participant Rights. **Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

- ☒ **Not Applicable**
- ☐ **No**
- ☐ **Yes**

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

- ☒ **No**
- ☐ **Yes**

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

- ☐ **Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make participant-direction of services as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

--

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery

processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

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

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

Notices of amendments and renewals of the waiver are posted on the DHS website <https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/> for at least 30 days to allow the general public to submit comments on changes. Notices of amendments and renewals are also published in a statewide newspaper with instructions for submitting comments to DMS.

The public notice for this amendment was published in the Arkansas Democrat-Gazette for three consecutive days from MMDDYYYY to MMDDYYYY. The 30-day public comment period ended MMDDYYYY. Physical copies of the entire proposed waiver renewal were mailed to constituents upon request and were posted on the DHS website on the proposed rules page at <https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/>. The entire proposed waiver amendment was also emailed to an Interested Parties list.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Pitman

First Name:

Elizabeth

Title:

Director

Agency:

Arkansas Department of Human Services; Division of Medical Services

Address:

PO Box 1437, Slot S-295

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 244-3944

Ext:

☐

TTY

Fax:

(501) 682-8009

E-mail:

elizabeth.pitman@dhs.arkansas.gov

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

Last Name:

Hill

First Name:

Jay

Title:

Division Director

Agency:

Arkansas Dept. of Human Services; Division of Aging, Adult, and Behavioral Health Services

Address:

P. O. Box 1437, Slot W-241

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 686-9981

Ext:

☐

TTY

Fax:

(501) 686-9182

E-mail:

Jay.Hill@dhs.arkansas.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section

VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Arkansas

Zip:

Phone:

 Ext: ☐ TTY

Fax:

E-mail:

Attachments**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (select one):
- ☐ The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (select one):
 - ☐ The Medical Assistance Unit.

Specify the unit name:
(Do not complete item A-2)
 - ☐ Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- Ⓒ The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

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

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

Division of County Operations (DCO) is responsible for processing Living Choices applications, determining medical and financial eligibility.

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

An Independent Assessment Contractor will perform independent assessments that gather functional eligibility information about each Living Choices waiver applicant using the Arkansas Independent Assessment (ARIA) instrument. The information gathered is used by the DHS Eligibility Nurse to determine the individual's level of care. The assessment is sent to the DHS Eligibility Nurse to determine if the applicant's functional need is at the nursing home level of care.

- ☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ☒ **Not applicable**
- ☐ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

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

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

The monthly reports include the following:

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

The annual report includes the following:

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

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

Appendix A: Waiver Administration and Operation

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☐	☒	☐
Waiver enrollment managed against approved limits	☐	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Level of care evaluation	☐	☒	☒
Review of Participant service plans	☐	☒	☐
Prior authorization of waiver services	☐	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☐	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of policies and/or procedures developed by DAABHS that are reviewed and approved by the Medicaid Agency (DMS) prior to implementation.

Numerator: Number of policies and/or procedures developed by DAABHS that are reviewed and approved by the Medicaid Agency (DMS) before implementation;

Denominator: Number of policies and procedures developed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Office of Rules and Promulgation, Rule or Policy Revision Request Form

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☐ Annually

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

Performance Measure:

Number and percent of active and unduplicated participants served within approved limits specified in the approved waiver. Numerator: Number of active and unduplicated participants served within approved limits; Denominator: Number of active and unduplicated participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

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

	☐ Other Specify: 	
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Data Source (Select one):

Other

If 'Other' is selected, specify:

ACES report of active cases (Point in Time)

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of participants with delivery of at least one waiver service per month as specified in the PCSP in accordance with the agreement with the Medicaid Agency.

Numerator: Number of participants with delivery of at least one waiver service per month as specified in the PCSP in accordance with the agreement with the Medicaid Agency;

Denominator: Number of participants served

Data Source (Select one):

Other

If 'Other' is selected, specify:

No Waiver Service Report

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Overlapping Services Report or similar data preferred by the Operating Agency and

approved by Medicaid Agency.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - General					
	☒	Aged	65		☒
	☒	Disabled (Physical)	21	64	
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

N/A

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of

participants affected by the age limit (*select one*):

- ☐ Not applicable. There is no maximum age limit
- ☒ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

The participant who ages out in the Disabled (Physical) target subgroup at age 65 automatically remains in the waiver under the Aged target subgroup.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ☒ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

- ☐ A level higher than 100% of the institutional average.

Specify the percentage:

- ☐ Other

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. *Complete Items B-2-b and B-2-c.*

The cost limit specified by the state is (*select one*):

- ☐ The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

- ☐ Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

- ☐ May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

- ☐ The following percentage that is less than 100% of the institutional average:

Specify percent:

- ☐ Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (check each that applies):

- ☐ The participant is referred to another waiver that can accommodate the individual's needs.
- ☐ Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	1725
Year 2	1725
Year 3	1725
Year 4	1725
Year 5	1725

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- ☐ The state does not limit the number of participants that it serves at any point in time during a waiver year.
- ☒ The state limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1200
Year 2	1200
Year 3	1200
Year 4	1200
Year 5	1200

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals

experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- ☒ **Not applicable. The state does not reserve capacity.**
- ☐ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- ☒ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ☐ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ☒ **Waiver capacity is allocated/managed on a statewide basis.**
- ☐ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

PROPOSED

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

Entrance onto the Living Choices waiver program is on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements.

However, once the unduplicated number of participants is reached, a waiting list will be implemented for this program and the following process will apply.

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

- a) Waiver application determination date for persons inadvertently omitted from the waiver waiting list (administrative error);
- b) Waiver application determination date for persons residing in a nursing facility and being discharged after a 90 day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;
- c) Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
- d) Waiver application determination date for all other persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. 1. **State Classification.** The state is a (*select one*):

- ☒ §1634 State
☐ SSI Criteria State
☐ 209(b) State

2. **Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

- ☐ No
☒ Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ Low income families with children as provided in §1931 of the Act
☒ SSI recipients
☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
☐ Optional state supplement recipients
☐ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- ☐ 100% of the Federal poverty level (FPL)
☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
☐ Medically needy in 209(b) States (42 CFR §435.330)
☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and

community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- ☐ No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- ☒ Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- ☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217
- ☒ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- ☒ A special income level equal to:

Select one:

- ☒ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

- ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- ☐ Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
- ☐ Aged and disabled individuals who have income at:

Select one:

- ☐ 100% of FPL
- ☐ % of FPL, which is lower than 100%.

Specify percentage amount:

- ☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- ☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

- ☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (select one):

- ☒ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ☐ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

- ☐ **The following standard included under the state plan**

Select one:

- ☐ **SSI standard**
- ☐ **Optional state supplement standard**
- ☐ **Medically needy income standard**
- ☐ **The special income level for institutionalized persons**

(select one):

- ☐ **300% of the SSI Federal Benefit Rate (FBR)**
- ☐ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ☐ A dollar amount which is less than 300%.

Specify dollar amount:

- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ Other standard included under the state Plan

Specify:

- ☐ The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

- ☐ The following formula is used to determine the needs allowance:

Specify:

- ☒ Other

Specify:

PROPOSED

Up to 200% of the Individual SSI Federal Benefit Rate (FBR) which includes:

- 90.8 % of the Individual SSI FBR, rounded up to the nearest dollar, to cover room and board; refer to appendix I-5 for the explanation of the method used by the state to exclude Medicaid payment for room and board.
- 9% of the SSI FBR, rounded up to the nearest dollar, for personal needs
- Up to 100% of the Individual SSI FBR of earned income to cover work-related expenses for participants whose physician's service plan prescribes an employment activity as a therapeutic or rehabilitative measure

ii. Allowance for the spouse only (select one):

- ☒ Not Applicable

- ☐ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

- ☐ SSI standard
- ☐ Optional state supplement standard
- ☐ Medically needy income standard
- ☐ The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

- ☐ The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- ☐ Not Applicable (see instructions)
☒ AFDC need standard
☐ Medically needy income standard
☐ The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ☐ The amount is determined using the following formula:

Specify:

- ☐ Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ☐ Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
☒ The state does not establish reasonable limits.
☐ The state establishes the following reasonable limits

Specify:

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

- ☐ SSI standard
- ☐ Optional state supplement standard
- ☐ Medically needy income standard
- ☐ The special income level for institutionalized persons
- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

- ☐ The following formula is used to determine the needs allowance:

Specify formula:

- ☒ Other

Specify:

Up to 200% of the Individual SSI Federal Benefit Rate (FBR) which includes:

- 90.8 % of the Individual SSI FBR, rounded up to the nearest dollar, to cover room and board; refer to appendix I-5 for the explanation of the method used by the state to exclude Medicaid payment for room and board.
- 9% of the SSI FBR, rounded up to the nearest dollar, for personal needs
- Up to 100% of the Individual SSI FBR of earned income to cover work-related expenses for participants whose physician's service plan prescribes an employment activity as a therapeutic or rehabilitative measure

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ☒ Allowance is the same
☐ Allowance is different.

Explanation of difference:

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ☐ Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
☒ The state does not establish reasonable limits.
☐ The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is

deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

- ☒ **The provision of waiver services at least monthly**
☐ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):

- ☐ **Directly by the Medicaid agency**
☒ **By the operating agency specified in Appendix A**
☐ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ☐ **Other**
Specify:

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

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

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

DEFINITIONS:

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

Level of Care Criteria:

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

Level of Care Evaluation for Institutional Care:

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

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

A participant who is otherwise eligible for waiver services shall not have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than 21 days.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- ☐ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
 - ☒ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

DEFINITIONS:

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

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

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

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

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

Level of Care Evaluation for Institutional Care:

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

Level of Care Instrument for Waiver Program:

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

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

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

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

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

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

DEFINITIONS:

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

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

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

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

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

1. Tier 0 (zero) and Tier 1 (one) indicate the individual's assessed needs, if any, do not support the need for either Living Choices waiver services or nursing facility services.
2. Tier 2 (two) indicates the individual's assessed needs are consistent with services available through either the Living Choices waiver program or a licensed nursing facility.
3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and not through the waiver program.

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

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- ☐ Every three months
- ☐ Every six months
- ☒ Every twelve months
- ☐ Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

- ☒ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ☐ **The qualifications are different.**
Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

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

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

On at least a monthly basis, the DHS PCSP/CC Nurse will identify participants who are due for an evaluation. The DHS PCSP/CC Nurse will complete the evaluation for continued functional/medical eligibility. When requested by the DHS Eligibility Nurse, based on evidence of a material change in medical and functional eligibility documented at the evaluation utilizing DHS Form 703 performed by the DHS PCSP/CC Nurse, the ARIA instrument will be completed by the registered nurse employed by the Independent Assessment Contractor to assess continued need.

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

The reports produced by DCO are used by the DHS PCSP/CC Nurse and DHS RN Supervisor to determine if the assessment is current or has expired. Patterns of noncompliance are documented and disciplinary action is taken if necessary.

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

Records of assessments and evaluations of level of care are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of County Operations (DCO). Records are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations, or court cases are resolved for a participant, whichever is longer.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for

evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of all applicants for whom there is reasonable indication that services may be needed in the future who receive an evaluation for LOC. Numerator: Number of all applicants for whom there is reasonable indication that services may be needed in the future who receive an evaluation for LOC. **D:** Number of applicants for whom there may be need in the future that were reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

- b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monthly Level of Care Report

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

collection/generation (check each that applies):	(check each that applies):	
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DMS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of participants annual re-evaluation LOC determinations where the LOC criteria were applied accurately and as required by the approved description. N: Number of participants annual re-evaluation LOC determinations where the LOC criteria were applied accurately and as required by the approved description; D: Number of participant annual re-evaluations LOC determinations reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

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

The state currently implements a system of monthly monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected monthly from individual participant records, aggregated to produce summation reports, and compared with periodic randomly sampled record reviews and sampled Program Integrity reviews. Record reviews and program integrity reviews are randomly sampled by DMS and DAABHS utilizing the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	☒ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ☒ No
- ☐ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Extended State Plan Service	Extended Medicaid State Plan Prescription Drugs		
Other Service	Living Choices Assisted Living Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Extended Medicaid State Plan Prescription Drugs

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

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

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

N/A

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

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

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Pharmacist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Extended Medicaid State Plan Prescription Drugs

Provider Category:

Individual

Provider Type:

Licensed Pharmacist

Provider Qualifications

License (specify):

Licensed as a pharmacist in the state of Arkansas, a pharmacist holding a current Pharmacy Permit issued by the Arkansas State Board of Pharmacy and issued a DEA number by the Drug Enforcement Agency.

The Division of Provider Services and Quality Assurance rules and regulations include specific experience, education and qualifications for Level II Assisted Living Facilities and their staff. Facilities must fulfill these regulations prior to licensure.

Certificate (specify):

Providers must also be enrolled with the Arkansas Division of Medical Services as a Medicaid State Plan Prescription Drug Program provider.

Other Standard (specify):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The Medicaid program's fiscal agent

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Living Choices Assisted Living Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Service Definition (Scope):	
Category 4:	Sub-Category 4:

Basic Living Choices Assisted Living direct care services are:

1. Attendant care services
2. Therapeutic social and recreational activities
3. Periodic nursing evaluations
4. Limited nursing services
5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing
6. Medication oversight to the extent permitted under Arkansas law
7. Assistance obtaining non-medical transportation specified in the plan of care

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

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

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

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

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

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

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

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

Therapeutic, social and recreational activities are activities that can improve a residents eating or sleeping patterns; lessen wandering, restlessness, or anxiety; improve socialization or cooperation; delay deterioration of skills; and improve behavior management. Therapeutic activities include gross motor activities (e.g., exercise, dancing, gardening, cooking, etc.); self-care activities (e.g., dressing, personal hygiene, or grooming); social activities (e.g., games, music, socialization); and, sensory enhancement activities (e.g., reminiscing, scent and tactile stimulation).

A periodic nursing evaluation by the ALF RN is required quarterly, and revisions made as needed. If required by licensing regulations, and an occupancy admission agreement is in place, the health care services plan portion of the occupancy admission agreement shall be revised within fourteen (14) days upon any significant enduring change to the resident and monitoring of the conditions of the residents on a periodic basis.

As described in B-6, each waiver applicant needing an evaluation and each waiver participant needing a re-evaluation will receive an individual assessment performed by the Independent Assessment Contractor. Each assessment or re-assessment is performed by a licensed registered nurse (RN) using the Arkansas Independent Assessment (ARIA) instrument. The Independent Assessment Contractor's RNs will complete the ARIA instrument for each initial evaluation and subsequent re-evaluation, drawing upon information from a face-to-face meeting with the applicant/participant and, if necessary, information from other parties familiar with the individual's conditions, functional limitations, and circumstances. The Division of County Operations (DCO) will use the assessment results to evaluate level of care for the waiver and medical eligibility for the waiver.

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

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

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

Therapeutic, social and recreational activities are activities that can improve a residents eating or sleeping patterns; lessen wandering, restlessness, or anxiety; improve socialization or cooperation; delay deterioration of skills; and improve behavior management. Therapeutic activities include gross motor activities (e.g., exercise, dancing, gardening, cooking, etc.); self-care activities (e.g., dressing, personal hygiene, or grooming); social activities (e.g., games, music, socialization); and, sensory enhancement activities (e.g., reminiscing, scent and tactile stimulation).

A periodic nursing evaluation by the ALF RN is required quarterly, and revisions made as needed. If required by licensing regulations, and an occupancy admission agreement is in place, the health care services plan portion of the occupancy admission agreement shall be revised within fourteen (14) days upon any significant enduring change to the resident and monitoring of the conditions of the residents on a periodic basis.

As described in B-6, each waiver applicant needing an evaluation and each waiver participant needing a re-evaluation will receive an individual assessment performed by the Independent Assessment Contractor. Each assessment or re-assessment is performed by a licensed registered nurse (RN) using the Arkansas Independent Assessment (ARIA) instrument. The Independent Assessment Contractor's RNs will complete the ARIA instrument for each initial evaluation and subsequent re-evaluation, drawing upon information from a face-to-face meeting with the applicant/participant and, if necessary, information from other parties familiar with the individual's conditions, functional limitations, and circumstances. The Division of County Operations (DCO) will use the assessment results to evaluate level of care for the waiver and medical eligibility for the waiver.

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

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

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

N/A

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

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

- ☐ Legally Responsible Person
☒ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Class A Home Health Agency
Agency	Licensed Level II Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Living Choices Assisted Living Services

Provider Category:

Agency

Provider Type:

Licensed Class A Home Health Agency

Provider Qualifications

License (specify):

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Class A Home Health Agency.

Certificate (specify):

Other Standard (specify):

Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance as a Class A Home Health Agency to be eligible to participate in the Arkansas Medicaid Program. A copy of the Class A Home Health Agency’s current license must accompany the provider application and Medicaid contract. Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency’s written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client’s condition; and, a client’s right to confidentiality. This training must be provided prior to the delivery of waiver services.

The facility must be located within the state of Arkansas.

Provider qualifications, licenses, training, education and experience for the staff of Home Health Agencies are the same as Medicaid enrolled Home Health Agencies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Provider Services and Quality Assurance

Frequency of Verification:

Annual

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

Service Type: Other Service**Service Name: Living Choices Assisted Living Services**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

☒ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

☐ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.

☐ **As an administrative activity.** Complete item C-1-c.

☐ **As a primary care case management system service under a concurrent managed care authority.** Complete item C-1-c.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

--

Appendix C: Participant Services

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

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

PROPOSED

All Living Choices waiver providers employing persons providing direct services (personal assistants, attendants) shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere to any disqualifying criminal offense.

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

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

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

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

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

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

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ☐ **No. The state does not conduct abuse registry screening.**
- ☒ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

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

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

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

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☐ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- ☐ **Self-directed**
- ☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above

the policies addressed in Item C-2-d. *Select one:*

- ☐ The state does not make payment to relatives/legal guardians for furnishing waiver services.
- ☒ The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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

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

- ☐ Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ☐ Other policy.

Specify:

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of new providers by provider type, which obtained the appropriate license in accordance with state law and waiver provider qualifications prior to delivering services. N: Number of new providers by provider type, which obtained the appropriate license in accordance with state law and waiver provider qualifications prior to delivering services. D: Number of new providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider enrollment database

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of licensed providers, by provider type, whose license renewals are in accordance with state law and waiver provider qualifications. Numerator: Number of licensed providers, by provider type, whose license renewals are in accordance with state law and waiver provider qualifications. Denominator: Total number of license renewals.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

DPSQA Database

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

☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☒ Other Specify: DPSQA	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

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

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

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

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:

Number and percent of providers meeting waiver provider training requirement conducted in accordance with state requirements and approved waiver as evidenced by attendance documentation. N: Number of providers meeting waiver provider training requirement conducted in accordance with state requirements and approved waiver as evidenced by attendance documentation; D: Total number of providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Attendance Documentation

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review

☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☒ Other Specify: Division of Provider Services and Quality Assurance	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

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

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

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

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

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

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

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☐ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ☒ No
- ☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

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

- ☒ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ☐ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

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

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

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

- ☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

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

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

PROPOSED

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

Living Choices Assisted Living (LCAL) was implemented starting February 1, 2016.

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

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

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

Review of State Policies and Procedures:

In the first half of 2015, DAABHS identified policies, provider manuals and certification requirement changes needed to comply with settings regulations. HCBS settings policy was integrated into the (LCAL) provider manual to be effective February 1, 2016. This manual went through public comment from August 3, 2015 through September 1, 2015, as part of promulgation. Also, (LCAL) provider manual received Arkansas Legislative Council approval Sept. 26, 2016. HCBS settings policy has been incorporated into this manual. The public comment period for this change was October 23, 2015 through November 21, 2015.

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

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing:

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

The group continues to meet to discuss assessment activities, including provider self-assessment surveys, site visits, and ongoing compliance with the HCBS Settings rule. A small team from this inter-divisional HCBS Settings working group reviewed the provider self-assessment surveys, modified existing HCBS Settings on-site assessment tools to validate provider self-assessments, and analyzed.

DAABHS has required Adult Day Cares (ADC), Adult Day Health Cares (ADHC) and Level II Assisted Living Facilities (ALF) to conduct a provider self-assessment and provide the results to DAABHS. DAABHS has used and will continue to use the information from the provider self-assessments to determine what qualities of home and community-based settings exist in the current setting and to inform the development of standards which will facilitate the transition of settings which may not fully

meet HCBS characteristics to those which include all the necessary characteristics and traits of a fully compliant HCBS setting.

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

- Adult Day Care
- Adult Day Health Care
- Level II Assisted Living Facility

Residential provider self-assessment

To assess compliance with the new HCBS settings requirements, the inter-divisional HCBS Settings working group developed a residential provider self-assessment survey. The survey was developed using the exploratory questions provided in the CMS HCBS Toolkit. Residential providers include Level II Assisted Living Facilities (ALF). The survey questions fall under five general categories: 1) neighborhood characteristics; 2) home environment; 3) community access and supports; 4) services and supports planning process; and 5) setting characteristics and personal experience.

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

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

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

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

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

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

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

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

Validation of self-assessment (site visits)

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

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

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

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

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

The DAABHS beneficiary sample for the residential beneficiary survey was randomly drawn from an unduplicated count of current Medicaid beneficiaries (n=952) residing in a Level II Assisted Living Facility. To determine the number of beneficiaries to randomly sample, we divided the number of unduplicated Medicaid residential beneficiaries at a given ALF by the total unduplicated residential beneficiary count. This process was repeated for all Level II ALFs serving Medicaid beneficiaries. This gave us the percentage of Medicaid beneficiaries at a given ALF in relation to the total number of unduplicated Medicaid beneficiaries. The percentage of Medicaid beneficiaries at a given ALF was multiplied by the target sample size to determine how many beneficiaries to interview at each ALF. The target sample size for the beneficiary survey was derived from a

commonly used statistics website (www.stat trek.org) using a sample size calculator. For an unduplicated beneficiary count of 952 with a 95% confidence interval and a 4% margin of error, our residential beneficiary sample size was 369. We were able to interview approximately 79% (n=291) of our target sample of 369. We interviewed beneficiaries at nearly 100% of the Level II ALFs licensed as Medicaid providers. The only reason we were unable to interview beneficiaries at a particular setting was due to the setting being so new that there were no Medicaid beneficiaries residing there yet. There were multiple reasons that contributed to a lower survey completion rate than we originally expected, including beneficiaries being hospitalized, deceased, non-interviewable (based on diagnosis), as well as beneficiaries refusing to participate and being away from the facility during the site visit. The state has been brainstorming ways to improve outreach efforts to meet the target sample. These efforts may include making announced/planned visits to ensure that the persons we need to interview are willing and able to meet with us at a scheduled day/time. We will also conduct proxy interviews with guardians/family members/advocates on behalf of beneficiaries, as appropriate and necessary. In addition, we will conduct data clean-up activities to generate a more reliable list from which we generate our target sample.

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

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

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

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

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

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

Upon completion of the initial site visits and review of supporting documents provided by the provider, notes from the site review team member were summarized in a standardized report. A cover letter and the corresponding report were mailed to each provider following the on-site visit. The letter summarized the visit, noted areas needing clarification that were observed and documented, requested clarification of provider policies and procedures and/or a corrective action plan, and provided a deadline

with which to comply with the requested action(s). This letter also highlighted discrepancies between the information provided by facility staff on the site visit survey and the information provided by beneficiaries and/or their family members/advocates on the beneficiary survey. Providers were asked to address these discrepancies in their corrective action plans. DHS has provided technical assistance to providers throughout this time period. This technical assistance is frequently initiated by provider phone calls. However, the state has also engaged in several face-to-face training opportunities through provider workshops hosted by the Provider Certification Unit, annual meetings of advocacy organizations, provider membership organizations, and monthly meetings with the small stakeholder group.

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

Remediation

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

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

During the first half of 2017, the HCBS site review subcommittee along with the HCBS Settings working group will monitor provider compliance efforts through corrective action plans and follow-up site visits. Some corrective action plans may only require a desk audit, meaning the site visit and beneficiary surveys did not highlight any non-compliance issues. However, the provider policies may not reflect the true intent of the HCBS Settings rule and as such will need to undergo revisions to become

compliant with the HCBS Settings rule. However, follow-up site visits will be conducted with all providers submitting substantive corrective action plans that require a change in procedure or reflect a culture change within that setting to ensure that providers are implementing the corrective actions outlined in the plan. The State expects corrective action plans to be fully implemented by December 2017.

DAABHS providers who wish to appeal our findings can follow the appeal rights process described in Section 160.00 Administrative Reconsideration and Appeals of the Arkansas Medicaid Provider Manual (<https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/lcal-prov/>).

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

Ongoing Assessment of Settings

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

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

Settings found to have deficiencies will be required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. Providers who wish to appeal our findings can follow the appeal rights process described in Section 160.00 Administrative Reconsideration and Appeals of the Arkansas Medicaid Provider Manual (<https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/lcal-prov/>). New waiver providers will also be subject to an assessment of compliance with the HCBS Settings requirements before being approved to provide services for the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☒ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

**Social Worker***Specify qualifications:***Other***Specify the individuals and their qualifications:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Select one:

- ☒ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) DHS PCSP/CC Nurses will develop initial person-centered service plans for Living Choices in Homecare participants based on the Independent Assessment Contractor's assessment of the participant's needs and information gathered during the service plan development meeting with the participant. The DHS PCSP/CC Nurse will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting. The DHS PCSP/CC Nurse will assist in notifying interested parties if requested by the participant or the representative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Each evaluation of functional/medical eligibility and development of a person-centered service plan is completed at a minimum of twelve (12) months or more often, if deemed appropriate. The service plan may be revised at any time,

based on information relevant to the participant's condition or circumstances. Changes are reported to the DHS PCSP/CC Nurse by the participant, the participant's family or representatives, and service providers. The DHS PCSP/CC Nurse has sole authority for all development and revisions to the waiver service plan. Service plan updates must be based on a change in the participant's status or needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval and are available by the operating agency upon request. DMS reviews a validation sample of participant records which includes the person-centered service plan. For the validation review, DMS reviews 20% of the records reviewed by DAABHS. For the provider file sample, the Raosoft online calculator is used to determine a statistically valid sample with at 95% confidence level and a margin of error of +/- 5%. Every nth name is selected for review until the sample size is reached. The sample is then divided into twelve groups for monthly review by DMS. Reviewed service plans are compared to policy guidelines, the functional assessment, and the narrative detailing the participant's living environment, physical and mental limitations, and overall needs.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

Specify the other schedule:

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

- ☐ Medicaid agency
- ☒ Operating agency
- ☐ Case manager
- ☒ Other

Specify:

The service plan is maintained by the DHS PCSP/CC Nurse in the participant's record and by the Living Choices Assisted Living waiver service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

PROPOSED

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

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

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

LIVING CHOICES PROVIDERS:

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

INFORMATION EXCHANGE:

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

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

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

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

monitoring visits are reported.

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

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

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

b. Monitoring Safeguards. *Select one:*

- ☒ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of participants records reviewed which had PCSPs that were adequate and appropriate to their needs as indicated by the assessment(s).

Numerator: Number of participants records reviewed which had PCSPs that were adequate and appropriate to their needs as indicated by the assessment(s);

Denominator: Number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of participant records reviewed which had PCSPs that addressed personal goals; Numerator: Number of participants records reviewed which had PCSPs that addressed personal goals; Denominator: Number of records reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of participant records reviewed which had PCSPs that address health and safety risk factors; Numerator: Number of participant records reviewed which had PCSPs that address health and safety risk factors; Denominator: Number of PCSPs reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and Percent of PCSPs that were updated when necessary to address a change in participant's needs; Numerator: Number of PCSPs that were updated when necessary to address a change in participant's needs; Number of PCSPs reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of PCSPs reviewed that were updated at least every 12 months.

Numerator: Number of PCSPs reviewed that were updated at least every 12 months;

Denominator: Number of PCSPs reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other	☐ Annually	☐ Stratified

Specify: 		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

d. Sub-assurance: *Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of participants records reviewed who received services in the type, scope, amount, frequency, and duration specified in the service plan.

Numerator: Number of participants records reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan;

Denominator: Number of participant records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of participant records reviewed that indicated choice of provider was offered as evidenced by an appropriately completed and signed freedom of choice form. Numerator: Number of participant records reviewed that indicated choice of provider was offered as evidenced by an appropriately completed and signed freedom of choice form; **D:** Number of participant records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ☒ No
- ☐ Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- ☐ Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
- ☒ No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- ☐ Yes. The state requests that this waiver be considered for Independence Plus designation.
- ☐ No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

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

PROPOSED

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

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

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

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

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ☒ **No. This Appendix does not apply**
☐ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a)

the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ☐ No. This Appendix does not apply
- ☒ Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Division of Aging, Adult, and Behavioral Health Services

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

☒ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

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

PROPOSED

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

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

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

Reporting requirements for DHS employees and contractors:

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

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

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

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

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

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

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

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

Adult Protective Services (APS) Responsibilities:

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

As required by law, investigations are completed and an investigative determination entered as required by state law. APS notifies the client and other relevant parties, including the offender, of the determination.

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

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

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

Division of Provider Services and Quality Assurance (DPSQA) Responsibilities

DPSQA will investigate those incidents that relate to allegations of failed provider practices.

Reports to DPSQA are entered into a tracking system which DPSQA uses to determine if further investigation is needed in the event of multiple complaints at one provider locations or facility..

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

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

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

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

Appendix G: Participant Safeguards

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

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

☒ **The state does not permit or prohibits the use of restraints**

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

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

DHS PCSP/CC Nurses reassess participants annually.

☐ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. *(Select one):*☒ **The state does not permit or prohibits the use of restrictive interventions**

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

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

☐ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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

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

☒ **The state does not permit or prohibits the use of seclusion**

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. This oversight is conducted through incident reports received and monitoring of the participant by the DHS PCSP/CC Nurse, if needed.

☐ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

- ☒ **No. This Appendix is not applicable** (do not complete the remaining items)
☐ **Yes. This Appendix applies** (complete the remaining items)

b. Medication Management and Follow-Up

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

i. Provider Administration of Medications. Select one:

- ☐ **Not applicable.** (do not complete the remaining items)
☐ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** (complete the remaining items)

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- iii. Medication Error Reporting.** *Select one of the following:*

- ☐ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

- (c) Specify the types of medication errors that providers must *report* to the state:

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

IRIS

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

Division of Provider Services and Quality Assurance		
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☒ Other Specify: Division of Provider Services and Quality Assurance	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of abuse. Number of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of abuse;
Denominator: Number of records reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of complaints addressed within required time frame.

Numerator: Number of complaints addressed within required time frame;

Denominator: Number of complaints.

Data Source (Select one):

Other

If 'Other' is selected, specify:

JIRA Complaint Database

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

Specify: 		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of incidents of abuse, neglect, exploitation, and unexplained death that are reviewed/investigated within the required timeframes. N: Number of incidents of abuse, neglect, exploitation, and unexplained death that are reviewed/investigated within the required timeframes; D: Number of incidents of abuse, neglect, exploitation, and unexplained deaths.

Data Source (Select one):

Other

If 'Other' is selected, specify:

IRIS

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: Division of Provider Services and Quality Assurance	
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of neglect. Numerator: Number of records reviewed that indicated the participant guardian or family received information about how to identify and report critical incidents of neglect; Denominator: Number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of exploitation. Numerator: Number of records reviewed that indicated the participant, guardian or family received information about how to identify and report critical incidents of exploitation; **D:** Number of records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.

☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incidents requiring reviews/investigation where the state adhered to the follow-up methods as specified; Denominator: Number of critical incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

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

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☒ Other Specify: Division of Provider Services and Quality Assurance	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

IRIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative

		Sample Confidence Interval =
☒ Other Specify: Division of Provider Services and Quality Assurance	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☒ Other Specify: Division of Provider Services and Quality Assurance	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:**Number and percent of critical incidents where root cause was identified. Numerator:****Number of critical incident where root cause was identified; Denominator: Number of critical incidents.****Data Source** (Select one):**Other**

If 'Other' is selected, specify:

IRIS

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☒ Other Specify: Division of Provider Services and Quality Assurance	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports IRIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid	☐ Weekly	☒ 100% Review

Agency		
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☒ Other Specify: Division of Provider Services and Quality Assurance	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☒ Other Specify: Division of Provider Services and Quality Assurance	☒ Annually
	☐ Continuously and Ongoing
	☐ Other

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Licensure survey

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

Specify: Division of Provider Services and Quality Assurance		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☒ Other Specify: Division of Provider Services and Quality Assurance	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

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

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

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

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

The process for reporting abuse as established in Ark. Code Ann. § 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult Maltreatment Hotline refers the matter to the appropriate investigating agency. Under this statute, a resident of an assisted living facility is identified as a long-term care facility resident, and for the purposes of the statute is presumed to be an impaired person. A report for a long-term care facility resident is to be made to the local law enforcement agency for the jurisdiction in which the long-term care facility is located, and to DPSQA under the regulations of that office. DHS has jurisdiction to investigate all cases of suspected maltreatment of an endangered person or an impaired person. The APS unit of DHS shall investigate all cases of suspected adult maltreatment if the act or omission occurs in a place other than a long-term care facility; and all cases of suspected adult maltreatment if a family member of the adult person is named as the suspected offender, regardless of whether or not the adult is a long-term care facility resident. The DPSQA unit of DHS shall investigate all cases of suspected maltreatment of a long-term care facility resident.

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able

to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

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

As a result of the discovery processes:

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

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

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

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Quality Improvement Committee	☒ Annually
☒ Other Specify: DCO and Contracted Vendor	☐ Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a

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

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

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

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

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

- ☒ No
☐ Yes (*Complete item H.2b*)

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

Pre-Payment Integrity

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

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

Post-Payment Integrity

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

A report of the monthly reviews is provided to the DHS PCSP/CC Nurse Manager for determination of appropriate corrective action. This corrective action is communicated to the DHS PCSP/CC Nurse Supervisor and the DHS PCSP/CC Nurse who developed the person-centered service plan.

The results of reviews are not communicated to providers and a Corrective Action Plan is not required by DAABHS.

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

Any non-compliance or irregularities resulting in an overpayment that are discovered during any post-payment review or audit are reported to DMS for recoupment and other appropriate action to ensure non-compliance and overpayment will no longer occur in the future. The DMS financial team reports any recouped payments for Living Choices Waiver services as a prior period adjustment on the CMS-64 to remove the payments from claims for federal financial participation.

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

The Centers for Medicare and Medicaid Services ("CMS") conducts audits of Medicaid claims (including Living Choices Waiver service claims) in accordance with the Payment Error Rate Measurement ("PERM") regulations every three (3) years. CMS reviews the claims to ensure the services were medically appropriate, provided to an eligible participant, and paid at the correct amount. PERM reviews are intended to:

- identify those Medicaid programs that may be susceptible to significant improper payments;
- estimate the amount of improper payments;
- submit those estimates to Congress; and
- submit a report on actions the agency is taking to reduce improper payments.

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

The Office of Medicaid Inspector General also conducts independent annual random reviews of all Medicaid programs, including the Living Choices Waiver. If a review finds errors in billing and fraud is not suspected, DMS recoups the

payment(s) from the Living Choices Waiver provider. If fraud is suspected, then the provider is referred to the Medicaid Fraud Control Unit and Arkansas Attorney General's office for appropriate action including request for and monitoring of corrective action plan.

All Living Choices Waiver providers who are paid a total of \$100,000 or more during a year by the State of Arkansas are required to submit an independent audit of its financial statements for that year in accordance with the Government Auditing Standards. Living Choices Waiver providers who are paid more than \$750,000 in federal funds during a year must have an independent single audit conducted for that year in accordance with OMB Circular A-133. All required Living Choices Waiver service provider audits are submitted to and reviewed by the DHS Office of Payment Integrity and Audit (OPIA) for compliance with audit requirements. The purpose of the OPIA reviews of provider financial audits is to notify the Division of any deficiencies identified by that provider's CPA. DAABHS is notified of any deficiencies via e-mailed letter upon completion of the review. No CAPs are required and individual claims are not reviewed in the process. If during review of an audit issues are discovered, then OPIA is responsible for notifying DMS for recoupment or other appropriate action. Reviews are consistent across all providers and provider types.

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Recipient Claims History Profile (Chart Reviews)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of reviewed claims with services specified in the participants service plan. Numerator: Number of claims reviewed with services specified in the participants service plan; Denominator: Number of claims reviewed.

PROPOSED

Data Source (Select one):

Other

If 'Other' is selected, specify:

Recipient Profiles

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
☐ Other Specify: 		

Data Aggregation and Analysis:

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

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

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and	☐ Other

	Ongoing	Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of rates which remain consistent with the approved rate methodology throughout the five-year wavier cycle. Numerator: Number of rates which remain consistent with the approved rate methodology throughout the five-year wavier cycle; Denominator: Number of rates.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Rate Review Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☒ Other Specify: 3 years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☒ Other Specify: 3 years

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ☒ No
- ☐ Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

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

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

DMS is responsible for the oversight of rate determinations with consultation by DAABHS. There is an established procedure followed by DMS to conduct rate studies, get provider input, and rebase rates when needed. Rates are published for public comment and are made available to all providers before implementation of the new rate via an official notice from DMS. Upon enrollment with Medicaid, new providers are referred to the Arkansas Medicaid website which has published fee schedules. Various methodologies are used for rate determination depending on the waiver service.

The rates may be found at <https://humanservices.arkansas.gov/wp-content/uploads/LCAL-fees.pdf>

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

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

The rate methodology excludes reimbursement of room and board costs.

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

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

Opportunities for Public Comment: Before submitting this waiver renewal to CMS for federal review and approval, DHS engaged in various opportunities for public comment including a webinar. These are in addition to the public comment process for this waiver renewal and the revised provider manual. Further, both the waiver renewal and the revised provider manual undergo prior review by Arkansas legislative committees.

See Main Section 6-I for additional information.

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

Amendment Effective 03/01/2024:

As the COVID-19 pandemic and Public Health Emergency has continued, there has been an increase in applications for the Living Choices waiver increasing the need for direct care staff, further compounded by all providers competing within a severely tightened health care labor market with increased personnel costs. We are extending the end date of the previously approved rate increase from December 31, 2022 to the expiration of the waiver.

The State of Arkansas will not use ARP Funding for this requested rate increase.

Arkansas is extending the current rate of \$67.25 per person per day to \$81.59 per person per day, with an additional 5% differential for rural facilities, which totals \$85.67. This rate is comprised of two components:

Amendment Effective 07/01/2024:

Pursuant to Arkansas Code Title 20, Chapter 10, Subchapter 24, the Department of Human Services (DHS) Division of Aging, Adult and Behavioral Health Services (DAABHS) has completed the review of cost reports submitted by the Assisted Living Facilities who participate in the Living Choices Assisted Living Facility Waiver program. DHS, through its qualified contractor, Myers and Stauffer, has reviewed each cost report submitted by the Assisted Living Facilities. This statute requires providers to submit annual cost reports and for DHS to consider the cost report results for possible amendment request to the waiver rate.

To calculate a rate for the waiver program Myers and Stauffer used a rate build-up methodology using the hourly wage data and daily staffing ratios from the 2023 cost survey. This methodology was selected due to the diversity of provider characteristics and cost experiences. This methodology reduced the impact of data outliers. The hourly wage data and daily staffing ratios were utilized to calculate a base cost for direct care. Adjustments were applied to this calculation to account for employee benefits costs and inflation. This calculation produced an estimate of the total cost of the direct care labor. Data for contracted positions was also gathered through the cost survey. This cost represents a smaller share of the total direct care staffing costs.

The direct care staffing costs are the primary driver of the waiver costs, and therefore, the primary component of our rate calculation. In addition to the staffing ratios and hourly wage rates, other statistics were necessary to complete the direct care staffing calculation. The median staff benefits percentage from the 2023 cost survey data, 18.08 percent, was used as the benefits percentage. Applying this factor to the direct care wages subtotal (not including contracted staff wages) accounts for the expected cost of providing employee benefits.

An inflation factor is also a common reimbursement element in order to account for expected increases in costs between the data collection period and the rate effective period. An inflation factor was applied to adjust historical costs from the midpoint of the cost data period, December 31, 2022 to the midpoint of the fiscal year 2025 rate period, December 31, 2024. Two inflation factor options were evaluated, the IHS Global Insight, Centers for Medicare & Medicaid Services (CMS) Nursing Home without Capital Market Basket Index (NF Market Basket) and the Consumer Price Index (CPI). The NF Market Basket index is a standard source used to calculate inflation factors for long-term care services. The calculation produced an inflation factor of 6.63 percent. Historically the Department has utilized the Consumer Price Index (CPI), for inflation calculations. This inflation factor was calculated to be 5.67 percent.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Living Choices providers bill for services and are reimbursed directly through MMIS.

Appendix I: Financial Accountability

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

- c. Certifying Public Expenditures** (select one):

- ☒ **No. state or local government agencies do not certify expenditures for waiver services.**
- ☐ **Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- ☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with

42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

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

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

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

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

DAABHS and DMS verify services were provided according to the PCSP through an internal monthly case record review as described in Section I-1.

Adjustments are made when claims are paid incorrectly and, when fraud, waste or abuse is suspected the case is referred to OMIG.

As described in Section I-1, to remove the payments from claims for federal financial participation (FFP), DMS' financial team reports on the CMS-64 that a prior period adjustment is required.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- ☐ No. The state does not make supplemental or enhanced payments for waiver services.
- ☒ Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Arkansas has an approved American Rescue Plan Act (ARP) Spending Plan under section 9817 that outlines the Workforce Stabilization Incentive Program. The effective dates of the Workforce Stabilization Incentive Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program. Arkansas has designed a HCBS Workforce Stabilization Incentive Program to allow providers to customize resources that best fit their organization's size, operational needs, and business priorities. The State allotted funding to providers using the following incentive categories:

Hiring bonus: new direct service providers (DSPs) hired during the ARP effective period (i.e., October 1, 2021 through March 31, 2025) may receive a hiring/recruitment payment after completing a minimum of thirty (30) calendar days of employment. The payment may be made in installments based on the provider's business model but cannot exceed \$1,000 per employee or contractor. Longevity bonus: longevity payments for DSPs who continuously provide service with the same employer for a minimum of three (3) months. The bonus cannot be paid in a one-time lump sum and must recur on a regular cadence determined by the employer. The recurring bonus can be paid through March 31, 2025, or until the provider allocation is depleted. Individual DSPs can earn bonuses up to the Longevity Bonus cap but cannot exceed \$15,000 total per employee or contractor. Complex Care Longevity bonus: complex care longevity payments for DSPs who provide care to at least one (1) individual with complex care needs. Bonus payments are provided on regular and recurring basis determined by the employer and is based upon the DSPs experience, commitment and need for the employee to continue to work with the complex care recipient. DSPs can earn bonuses up to the Complex Care Longevity Bonus cap but cannot exceed \$3,500 total per employee or contractor. Complex Care means a history of: legal involvement, elopement risk, combative or aggressive behavior, multiple inpatient placements, DCFS or DYS involvement, or wheelchair or bed bound.

Supplemental or enhanced payments for the Living Choices Assisted Living Service component, as specified in Appendix C-1/C-3 and J-2-d, were made available to Licensed Level II Assisted Living Facility (Provider Type 94) providers to provide hiring bonuses, longevity bonuses and complex care longevity bonuses to direct care workers who provide all Living Choices direct care services. Providers were required to apply for the program through an online application process. A Remittance Advice notice went to all Living Choices providers on January 14, 2022; a dedicated webpage was developed to explain the program; the ARP Workforce Stabilization Incentive Program Operational Plan is available on that link as well as several recorded Zoom seminars, and Facebook videos that were advertised during January of 2022. Specifically, the Program was made available to Provider Type 94.

Eligible providers proactively applied under their individual Tax Identification Number (TIN) and received one lump sum check based upon the unduplicated recipient count and paid claim amounts for state fiscal year 2021. The allocation formula was 70% of the provider's recipient count and 30% based upon paid claims.

The source of the non-federal share for the Program utilizes State General Revenue and eligible providers are able to retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS.

Appendix I: Financial Accountability**I-3: Payment (4 of 7)**

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- ☒ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ☐ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability**I-3: Payment (5 of 7)**

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ☐ The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability**I-3: Payment (6 of 7)**

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- ☒ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ☐ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- ☒ **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- ☒ **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ☒ **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☐ This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- ☐ This waiver is a part of a concurrent §1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(c) waiver specifies the types of health plans that are used and how payments to these plans are made.
- ☐ If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- ☒ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (2 of 3)**

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (3 of 3)**

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

a. **Services Furnished in Residential Settings.** Select one:

- ☐ No services under this waiver are furnished in residential settings other than the private residence of the individual.
- ☒ As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

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

Room and board costs are separate and excluded from payments for services provided by assisted living facilities. The waiver recipient is responsible for paying room and board costs directly to the facility from their own income. To ensure that room and board is affordable for persons on the Living Choices waiver and within the participant's income, the room and board amount is deducted from the participant's income, just as the personal needs allowance amount is deducted. To cover room and board, 90.8% of the Individual SSI Federal Benefit Rate (FBR), rounded to the nearest dollar, can be set aside from the waiver recipients income. Nine percent of the Individual SSI FBR rounded to the nearest dollar is deducted for personal needs allowance.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- ☒ No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- ☐ Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- ☒ No. The state does not impose a co-payment or similar charge upon participants for waiver services.
- ☐ Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- ☒ **No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☐ **Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment

fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	17209.55	2173.00	19382.55	40959.00	1687.00	42646.00	23263.45
2	17209.55	2244.00	19453.55	42296.00	1742.00	44038.00	24584.45
3	18588.78	2317.00	20905.78	43677.00	1799.00	45476.00	24570.22
4	22155.27	2393.00	24548.27	45102.00	1858.00	46960.00	22411.73
5	22155.27	2471.00	24626.27	46574.00	1919.00	48493.00	23866.73

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	1725		1725
Year 2	1725		1725
Year 3	1725		1725
Year 4	1725		1725
Year 5	1725		1725

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

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

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

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

PROPOSED

Factor D is derived from current reporting of expenditures from the Medicaid DSS and consideration of previous waiver estimates of utilization and growth rates. Factor D was calculated utilizing data from 01/01/2019 through 12/31/2019.

The unduplicated cap of 1725 was used as the number of users for WY1-WY5 to allow for full-year participation of each available slot. Given the average length of stay of 291 days, the state calculates 1,505 as the maximum number of unduplicated participants who can be served under a point-in-time (PIT) maximum of 1,200. The calculation is:

$$1,200 (\text{max PIT cap}) \times 365 \text{ days} \div 291 \text{ days (avg. length of stay)} = 1,505$$

This exact amount was used for the estimated number of users in Appendix J-2-d. Units per user was calculated based on actual usage from 02/01/2016-01/31/2019.

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

The Extended Medicaid State Plan Prescription Drug service was calculated utilizing the actual cost of services from 02/01/2016-01/31/2019.

The state's actuary calculated a composite average of the four (4) Living Choices Assisted Living Services tier rate used during the previous renewal cycle, adjusted to reflect the distribution of participants between the four tiers, of \$80.33. The payment rate recommended by the actuary is \$62.89, which is a 20.7% decrease from the \$80.33 composite average rate. Because this was such a significant decrease, the state phased-in the new rate. On July 1, 2020, the rate decreased to \$67.25; and on January 1, 2021, for the final month of the waiver, the rate should have decreased to the actuary's recommended rate of \$62.89. The state submitted an Appendix K to suspend the final rate decrease and is requesting that under the renewal the rate remain at the current rate of \$67.25.

The dates utilized by the actuary to develop the rate include February 1, 2016 through January 31, 2020.

Amendment Effective 03/01/2024:

The State will continue to utilize the approved Appendix K per person per day rate of \$81.59 with an additional 5% differential for rural facilities, which totals \$85.67 for the Living Choices Assisted Living Service until data can be received and verified in accordance with Arkansas law, and if warranted, the State will seek any needed amendments. Arkansas has identified 2 subcomponents for the Living Choices Assisted Living Services waiver component: Urban Assisted Living Facilities and Rural Assisted Living Facilities.

The data that informed the rates included a 2019 rate study and a 2020 & 2021 provider cost survey to determine the indirect service cost. Additionally, the median hourly rate of nursing and certified nursing assistant staff at our state-run nursing home was taken into consideration and applied a 4.1% inflation factor to trend the rate forward. After establishing the urban rate of \$81.59, we applied a 5% rural differential to get to \$85.67. The applied inflation factor was an average of inflation rates reported from the Consumer Price Index for the years 2018-2022.

In December 2023, using data from DAABHS internal databases, the census of existing assisted living facilities was used to determine the percentage of urban and rural facilities in Arkansas. The designation of rural and urban providers can be sourced to the 2020 US Census maps and definitions for Urban and Non-Urban areas.

Amendment Effective 07/01/2024:

Pursuant to Arkansas Code Title 20, Chapter 10, Subchapter 24, the Department of Human Services (DHS) Division of Aging, Adult and Behavioral Health Services (DAABHS) has completed the review of cost reports submitted by the Assisted Living Facilities who participate in the Living Choices Assisted Living Facility Waiver

program. DHS, through its qualified contractor, Myers and Stauffer, has reviewed each cost report submitted by the Assisted Living Facilities. This statute requires providers to submit annual cost reports and for DHS to consider the cost report results for possible amendment request to the waiver rate.

To calculate a rate for the waiver program Myers and Stauffer used a rate build-up methodology using the hourly wage data and daily staffing ratios from the 2023 cost survey. This methodology was selected due to the diversity of provider characteristics and cost experiences. This methodology reduced the impact of data outliers. The hourly wage data and daily staffing ratios were utilized to calculate a base cost for direct care. Adjustments were applied to this calculation to account for employee benefits costs and inflation. This calculation produced an estimate of the total cost of the direct care labor. Data for contracted positions was also gathered through the cost survey. This cost represents a smaller share of the total direct care staffing costs.

The direct care staffing costs are the primary driver of the waiver costs, and therefore, the primary component of our rate calculation. In addition to the staffing ratios and hourly wage rates, other statistics were necessary to complete the direct care staffing calculation. The median staff benefits percentage from the 2023 cost survey data, 18.08 percent, was used as the benefits percentage. Applying this factor to the direct care wages subtotal (not including contracted staff wages) accounts for the expected cost of providing employee benefits.

An inflation factor is also a common reimbursement element in order to account for expected increases in costs between the data collection period and the rate effective period. An inflation factor was applied to adjust historical costs from the midpoint of the cost data period, December 31, 2022 to the midpoint of the fiscal year 2025 rate period, December 31, 2024. Two inflation factor options were evaluated, the IHS Global Insight, Centers for Medicare & Medicaid Services (CMS) Nursing Home without Capital Market Basket Index (NF Market Basket) and the Consumer Price Index (CPI). The NF Market Basket index is a standard source used to calculate inflation factors for long-term care services. The calculation produced an inflation factor of 6.63 percent. Historically the Department has utilized the Consumer Price Index (CPI), for inflation calculations. This inflation factor was calculated to be 5.67 percent.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was computed based on Actual Expenditures that were extracted from the decision support system (DSS) component of the MMIS for SFY 2020 (07/01/2019 - 6/30/2020). Using the market basket forecasts inflation rate of 3.26% that is based on an average rate for 3 years and the related expenditure report from the DSS system of all waiver eligible recipients' annual expenditures. Note: Costs are indicated for State Category of Service AL (Living Choices), and AX (Extension of 3 prescriptions for Living Choices beneficiaries).

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS for SFY 2020 (07/01/2019 - 6/30/2020). Using the average annual expenditures for nursing home recipients and the market basket forecasts inflation rate of 3.26% that is based on the average rate for 3 years. Factor G was computed for each of the 5 years of the waiver.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was derived using the same methodology as in prior years. It was computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS for SFY 2020 (07/01/2019 - 6/30/2020). Using the average annual expenditures for nursing home recipients. Costs indicated for State Category of Service 58 (Private SNF), 59 (Private SNG Crossover), 62 (Public ICF Mentally Retarded), and 63 (Public SNF) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the Living Choices waiver.

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

Waiver Services	
Extended Medicaid State Plan Prescription Drugs	
Living Choices Assisted Living Services	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
Extended Medicaid State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						29452473.75
Living Choices Assisted Living Service	1 Day	1505	291.00	67.25	29452473.75	
Urban Assisted Living Facilities	1 Day	0	0.00	0.01	0.00	
Rural Assisted Living Facilities	1 Day	0	0.00	0.01	0.00	
GRAND TOTAL:						29686473.75
Total Estimated Unduplicated Participants:						1725
Factor D (Divide total by number of participants):						17209.55
Average Length of Stay on the Waiver:						291

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
Extended Medicaid State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						29452473.75
Living Choices Assisted Living Service	1 Day	1505	291.00	67.25	29452473.75	
Urban Assisted Living Facilities	1 Day	0	0.00	0.01	0.00	
Rural Assisted Living Facilities	1 Day	0	0.00	0.01	0.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						29686473.75 1725 17209.55 291

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
Extended Medicaid State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						31831637.37
Living Choices Assisted Living Service	1 Day	1505	194.00	67.25	19634982.50	
Urban Assisted Living Facilities	1 Day	783	97.00	81.59	6196842.09	
Rural Assisted Living Facilities	1 Day	722	97.00	85.67	5999812.78	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						32065637.37 1725 18588.78 291

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
Extended Medicaid State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						37983837.15
Living Choices Assisted Living Service	1 Day	1505	291.00	86.73	37983837.15	
Urban Assisted Living Facilities	1 Day	0	0.00	0.01	0.00	
Rural Assisted Living Facilities	1 Day	0	0.00	0.01	0.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						38217837.15 1725 22155.27 291

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (9 of 9)****d. Estimate of Factor D.**

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						234000.00
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						38217837.15 1725 22155.27 291

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs	1 Month	250	12.00	78.00	234000.00	
Living Choices Assisted Living Services Total:						37983837.15
Living Choices Assisted Living Service	1 Day	1505	291.00	86.73	37983837.15	
Urban Assisted Living Facilities	1 Day	0	0.00	0.01	0.00	
Rural Assisted Living Facilities	1 Day	0	0.00	0.01	0.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						38217837.15 1725 22155.27 291

PROPOSED

State of Arkansas

As Engrossed: H2/22/23

94th General Assembly

A Bill

Regular Session, 2023

HOUSE BILL 1445

By: Representative Eubanks

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO ESTABLISH COST-REPORTING FOR ASSISTED
LIVING FACILITIES TO THE DEPARTMENT OF HUMAN SERVICES
AS A CONDITION OF PARTICIPATION IN THE ARKANSAS
MEDICAID PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO ESTABLISH COST-REPORTING FOR ASSISTED
LIVING FACILITIES TO THE DEPARTMENT OF
HUMAN SERVICES AS A CONDITION OF
PARTICIPATION IN THE ARKANSAS MEDICAID
PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 10, is amended to add an
additional subchapter to read as follows:

Subchapter 24 – Cost-Reporting of Assisted Living Facilities

20-10-2401. Definitions.

As used in this section:

(1) “Cost report” means all the cost-reporting forms, schedules,
filing certifications, compilation reports, attachments, and supplemental
information specified by the instructions of the Department of Human
Services; and

(2) “Room and board” means all property-related costs, including
rental or purchase of real estate, construction costs, interest,



depreciation, furnishings, equipment, utilities, maintenance of buildings and grounds, maintenance of equipment and furnishings, building and other property insurance, repairs, renovations, improvements, real estate taxes, and related administrative services, and food expenses for three (3) meals a day or other full nutritional regimen.

20-10-2402. Cost reports.

(a) An assisted living facility participating in, or seeking to participate in, the Arkansas Medicaid Program, including any Medicaid waiver program under 42 U.S.C. § 1396n(c) or 42 U.S.C. §1315, shall file a cost report with the Department of Human Services:

(1) Annually not later than ninety (90) days after the end of the fiscal year of the facility;

(2) Within sixty (60) days of any significant change in the facility's ownership, management, or financial status or solvency; and

(3) At any time within sixty (60) days of a written request from the department or the Office of Medicaid Inspector General.

(b)(1) The department shall post the cost-reporting instructions, forms, and schedules on its website.

(2) The department may revise the cost-reporting instructions, forms, and schedules at any time, following consultation with representatives of the assisted living facility industry and sixty (60) days before written notice to each Medicaid-certified Level II licensed assisted living facility.

(3) In the cost-reporting instructions, the department may require electronic submission of cost reports and accompanying information.

(c) In preparation and filing of cost reports, each assisted living facility shall:

(1) Comply with generally accepted accounting principles and cost-reporting instructions of the department;

(2) Follow the accrual method of accounting; and

(3) Maintain the working trial balance used in completing the cost reports for each reporting period for a minimum of three (3) years.

(d) To be considered complete and timely filed, each cost report shall:

(1) Include:

(A)(i) All information required by the forms, schedules,

1 certifications, and instructions specified by the department and otherwise
2 comply with generally accepted accounting principles and cost-reporting
3 instructions of the department.

4 (ii) Failure of full disclosure as required by
5 generally accepted accounting principles and cost-reporting instructions
6 shall constitute an incomplete and misleading cost report;

7 (B) Identification of individuals and firms responsible
8 for facility management, accounting and financial reporting, cost report
9 preparation, and internal or independent audits;

10 (C) Owner and related party information;

11 (D) Statistical, occupancy, and staffing information;

12 (E) Certification by the authorized facility officer;

13 (F) Compilation report by the preparer of the cost report
14 or any portion thereof;

15 (G) General operating expenses, including housekeeping,
16 laundry, dietary services, food and dietary supplies, maintenance, utilities,
17 software, and computer equipment;

18 (H) Direct care expenses for providing medically necessary
19 assistance with Medicaid covered activities of daily living and instrumental
20 activities of daily living;

21 (I) General administrative expenses, including
22 administration, marketing, and property, general liability, and professional
23 liability insurance;

24 (J) Employee benefits and payroll taxes expenses;

25 (K) Ownership costs, property related expenses, and all
26 other room and board expenses;

27 (L) Home office expenses and other shared or allocated
28 expenses within or among organizations, owners or related parties, multiple
29 facilities, or different healthcare-related operations;

30 (M) Legal-related and compliance-related expenses,
31 including attorney fees, payment of court judgments, court costs, civil
32 momentary penalties, other fines or penalties incurred, cost of corrective
33 actions; and other expenses to remedy a deficiency;

34 (N) Copy of any management report, audit report, or
35 written opinion issued by a certified public accountant, accounting or audit
36 firm, or internal auditor or compliance officer concerning the facility's

1 accounting or financial reporting practices, internal auditing practices, or
2 the preparation or contents of the current or any prior cost report;

3 (O) Balance sheet for facility operations and for the
4 consolidated company;

5 (P) Additional information and attachments as necessary to
6 explain cost report contents, provide backup documentation, and describe and
7 justify any variations from the department forms, schedules, or instructions;
8 and

9 (Q) Any other information that the department deems
10 necessary to:

11 (i) Support state or facility compliance with
12 federal requirements, including Medicaid waiver terms and conditions;

13 (ii) Meet generally accepted accounting principles;

14 (iii) Facilitate the performance of independent
15 audits consistent with generally accepted auditing standards and federal and
16 state cost finding standards;

17 (iv) Apply federal and state cost finding standards;
18 or

19 (v) Assess the reasonableness, efficiency, and
20 adequacy of Medicaid payments; and

21 (2) Provide complete, correct, and timely information that the
22 department determines reasonably necessary to:

23 (A) Identify, document, verify, analyze, and audit all
24 facility costs, expenses by type, cost-finding and allocation methods, and
25 cost-related statistics;

26 (B) Identify, document, verify, analyze, and isolate:

27 (i) Reasonable and necessary allowable costs of
28 Medicaid covered direct care services and other reasonable and necessary
29 federally allowable costs; and

30 (ii) Unallowed costs, including all room and board
31 expenses, costs attributable to non-Medicaid residents or non-covered
32 services, and costs that would otherwise be disallowed or considered
33 unreasonable under Medicaid nursing facility cost finding principles;

34 (C) Assist the department in ascertaining and monitoring
35 the financial stability and solvency of assisted living facilities;

36 (D) Verify facility compliance with generally accepted

1 accounting principles and cost-reporting instructions of the department; and
2 (E) Facilitate independent audits consistent with
3 generally accepted auditing standards and federal and state cost finding
4 standards.

5 (e)(1) The department and a designated contractor of the department
6 may request corrections or additional information, including supporting
7 documentation.

8 (2) Facility responses shall be complete, correct, filed timely,
9 certified as true by the facility's authorized executive, and include a
10 preparer's statement if the information was prepared or reviewed by an
11 accountant or auditor.

12 (3) Responses to the department are due within ten (10) days of
13 the request, unless the department authorized additional time in writing.

14 (f)(1) Neither this subchapter nor the content of the cost reports,
15 individually or collectively, requires or implies that the Arkansas Medicaid
16 Program to reimburse for expenses or of cost-based or other payment
17 methodology.

18 (2) This subchapter does not limit the authority of the
19 department regarding assisted living facility licensing or Medicaid provider
20 certification, reimbursement, program integrity, or waiver program policy and
21 operations.

22
23 20-10-2403. Extensions.

24 (a) If an assisted living facility experiences difficulty in
25 completing their cost report by the due date, the assisted living facility
26 may request an extension from the Department of Human Services.

27 (b) An extension request shall be filed in writing with the department
28 before the due date and describe the difficulties affecting timely
29 completion.

30 (c) Extensions are at the discretion of the department and shall not
31 exceed sixty (60) days per facility per year.

32
33 20-10-2404. Review and auditing.

34 (a)(1) The Department of Human Services shall, directly or through a
35 qualified contractor, review or audit each cost report.

36 (2) This review or audit of each cost report may include desk

1 reviews, desk audits, and onsite financial audits of any assisted living
2 facility and the home office of any assisted living facility.

3 (3) In addition to independent audits conducted under subsection
4 (c) of this section, the department shall audit comprehensively and timely
5 the cost reports and financial reports and records of all assisted living
6 facilities, consistent with generally accepted auditing standards, according
7 to the following standards:

8 (A) At least fifty percent (50%) of all assisted living
9 facilities or assisted living facility owners filing a cost report for the
10 first time; and

11 (B) At least twenty-five percent (25%) of all assisted
12 living facilities with each facility receiving a comprehensive field audit at
13 least every four (4) years.

14 (b) An assisted living facility shall provide the following
15 organizations with full and complete access to inspect and copy all records
16 and data pertaining to the operations and finances of the facility, the
17 facility's home office, or multi-facility operation, including cost reports,
18 budgets, expenses, revenues, accounting and financial management practices,
19 audits, staffing, and contracted services:

20 (1) The department and designated contractors of the department;

21 (2) Any independent auditor designated by the department;

22 (3) The Office of Medicaid Inspector General;

23 (4) The office of the Attorney General;

24 (5) The United States Office of Inspector General;

25 (6) The United States Government Accountability Office; and

26 (7) The Centers for Medicare and Medicaid Services.

27 (c)(1) At any time, the department may order and enforce the
28 performance of a comprehensive independent financial audit of any assisted
29 living facility participating in Medicaid.

30 (2) Once ordered in writing by the department, the independent
31 audit shall be initiated within twenty (20) days of the order of the
32 department unless the department authorizes additional time in writing.

33 (3) The independent audit shall be:

34 A) Performed at the expense of the department;

35 (B) Conducted by a qualified audit firm that is procured by the
36 department, with the audit team led by a certified public accountant and

1 including other qualified professional staff as necessary;

2 (C) Completed consistent with a schedule provided by the
3 independent audit firm and procured by the department, with consultation with
4 the facility, and weekly written status reports to the department; and

5 (D)(i) Performed consistent with generally accepted
6 auditing standards and applicable federal and state cost-finding standards
7 identified by the department and include an audit of the accuracy and
8 completeness of the facility's cost reports.

9 (ii) If directed by the department, the scope of the
10 audit may include a forensic accounting examination.

11 (4) The audit firm and members of the audit team shall have no
12 conflicts of interest with the facility, the facility owners, facility
13 management or finance staff, or related parties.

14 (d)(1) The department shall have complete access to all work papers
15 and findings of the independent auditor.

16 (2) All work papers, reports, and findings shall be submitted to
17 the department no later than they are received by the facility.

18 (3) The independent auditor may provide a separate, confidential
19 report to the department, with a copy to the Office of Medicaid Inspector
20 General.

21
22 20-10-2405. Penalties and sanctions.

23 (a) The Department of Human Services may impose any sanction allowed
24 under this section and may suspend or limit new admissions of Medicaid
25 beneficiaries to the facility in the event of any of the following and
26 continued until the facility demonstrates full compliance to the satisfaction
27 of the department:

28 (1) The facility fails to file a complete and timely cost report
29 or fails to provide a complete and timely response to a request by the
30 department or the designated contractor of the department for corrections,
31 additional information, or supporting documentation;

32 (2) The facility obstructs or otherwise fails to fully cooperate
33 with any state or federal inspection and copying of facility records or data;

34 (3) The facility obstructs or otherwise fails to fully cooperate
35 with an independent audit ordered by the department; or

36 (4) The department determines, directly or based on findings of

1 a designated contractor of the department, an independent auditor, or the
2 Office of Medicaid Inspector General that:

3 (A) A reasonable cause to believe that the facility's cost
4 report or responses, or any records supporting the facility's cost report or
5 responses, are false, misleading, or otherwise erroneous exists;

6 (B) The facility lacks the necessary financial records and
7 other documentation to provide a complete and accurate cost report, verify
8 the correctness of information contained in the cost report, or support an
9 independent audit of the cost report and the facility's finances; or

10 (C) The facility lacks the necessary accounting, financial
11 management, recordkeeping, and reporting capabilities and practices to comply
12 with generally accepted accounting principles and the cost-reporting
13 instructions of the department.

14 (b) The department may impose and collect a monetary penalty of five
15 hundred dollars (\$500) per single violation on an assisted living facility in
16 the event of the following:

17 (1) The facility is thirty (30) or more days overdue in filing a
18 complete cost report or a complete response to a request by the department or
19 the designated contractor of the department for corrections, additional
20 information, or supporting documentation;

21 (2) The facility obstructs or otherwise fails to fully cooperate
22 with any state or federal inspection and copying of facility records or data;
23 or

24 (3) The facility obstructs or otherwise fails to cooperate with
25 an independent audit ordered by the department fully.

26 (c)(1) Compliance with the cost-reporting, auditing, and record
27 inspection requirements is a condition of Medicaid certification and Medicaid
28 payment for assisted living facilities.

29 (2) The department shall enforce assisted living facility
30 compliance with the requirements of this subchapter through Medicaid provider
31 decertification and exclusion from participation in the Arkansas Medicaid
32 Program.

33 (d)(1) For material, substantial, or repeated noncompliance with cost-
34 reporting, auditing, and record inspection requirements, the department may:

35 (A) Terminate the facility's Medicaid certification;

36 (B) Limit the number of Medicaid residents in the

1 facility; and

2 (C) Exclude the facility from Medicaid participation for
3 five (5) years.

4 (2) The department shall promptly terminate the facility's
5 Medicaid certification and exclude the facility and the facility's certifying
6 officer and responsible financial officers from participating in Medicaid for
7 a minimum period of five (5) years for:

8 (A) Filing of a false or misleading cost report or
9 response;

10 (B) Providing false or misleading records or other
11 documentation to support a cost report or response; or

12 (C) Providing false or misleading information to an
13 independent auditor or federal or state agency inspecting facility records.

14
15 */s/Eubanks*
16

17
18 **APPROVED: 3/6/23**
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