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**200.000 LIVING CHOICES ASSISTED LIVING GENERAL INFORMATION****1-1-13**

The Arkansas Medicaid Living Choices Assisted Living Program is a home and community-based services waiver program, operating under the authority of Section 1915(c) of the Social Security Act.

In the text of this manual, the Living Choices Assisted Living Program is generally referred to informally as “Living Choices” or “the Living Choices Program,” with a few recurring exceptions.

**200.100 Qualifying Criteria for Living Choices Assisted Living Providers****10-1-22**

Living Choices providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of the Arkansas Medicaid provider manual as well as the criteria below to be eligible to participate in the Arkansas Medicaid Program.

- A. Assisted living facilities (ALF) are licensed and regulated by the Division of Provider Services and Quality Assurance (DPSQA). Licensed Level II Assisted Living Facilities (ALFs) are qualified to enroll with Medicaid as Living Choices Assisted Living Facilities—Direct Service Providers if all other requirements for enrollment are met.
- B. Home health agencies in Arkansas are licensed and regulated by the Arkansas Department of Health. Licensed Class A home health agencies may contract with the Level II ALF to provide the bundled services covered in the Living Choices Program. In such an arrangement, federal regulations permit Medicaid to cover the services only if the home health agency, instead of the ALF, is the Living Choices provider.

Living Choices Assisted Living Waiver Services providers must meet the Provider Participation and enrollment requirements detailed in the Medicaid provider manual.

A licensed home health agency may qualify for Living Choices waiver services provider enrollment only by first contracting with a licensed Level II ALF to provide Living Choices bundled services to Living Choices clients who reside in the ALF.

- C. Option to Temporarily Limit Certification and Enrollment of New Assisted Living Facilities: Consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the concurrence of the federal Centers for Medicare and Medicaid Services (CMS), DPSQA may temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers in the Living Choices HCBS waiver program. Such temporary caps, limits, or moratoria on the certification and enrollment of new assisted living facility providers shall be initially limited to no more than six (6) months, may be extended in six (6) month increments subject to DPSQA and CMS approval, and may be applied on a regional or another geographic basis. If DPSQA determines temporary caps, limits, or moratoria are appropriate and would not adversely impact clients' access to assisted living facility services, it will initiate the process through filing a Request for State Implemented Moratorium (Form CMS–10628) with CMS.

## 200.105

## Provider Assurances

10-1-22

## A. Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all clients for whom they have accepted a Living Choices Assisted Living Waiver person-centered service plan (PCSP).

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the client they are to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any Living Choices Assisted Living Waiver service(s). This orientation shall include, but not be limited to, a:
  - a. Description of the purpose and philosophy of the Living Choices Assisted Living Waiver Program;
  - b. Discussion and distribution of the provider agency's written code of ethics;
  - c. Discussion of activities which shall and shall not be performed by the employee;
  - d. Discussion, including instructions, regarding Living Choices Assisted Living Waiver record keeping requirements;
  - e. Discussion of the importance of the person-centered service plan (PCSP);
  - f. Discussion of the agency's procedure for reporting changes in the client's condition;
  - g. Discussion, including potential legal ramifications, of the client's right to confidentiality.

## B. Quality Controls

The Provider agrees to continually monitor client satisfaction and quality of service delivery and to document his or her findings in the client's record. The Provider must immediately report changes in a client's condition to the DHS registered nurse (DHS nurse) via Form AAS-9511 (Change of Status).

## C. Code of Ethics

The Provider agrees to develop, distribute, and enforce a written code of ethics with each employee providing services to a Living Choices Assisted Living Waiver client that shall include, but not be limited to, the following:

1. No consumption of the client's food or drink;
2. No use of the client's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the client;
4. No acceptance of gifts or tips from the client or their caregiver;
5. No friends or relatives of the employee or unauthorized individuals are to accompany the employee to the client's assisted living facility apartment unit;

6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery nor in the client's assisted living facility apartment unit;
7. No smoking in the client's assisted living facility apartment unit;
8. No solicitation of money or goods from the client;
9. No breach of the client's privacy or confidentiality of records.

D. Home and Community Based Services (HCBS) Settings

All Level II Assisted Living Facilities licensed by DPSQA and participating in the Arkansas Medicaid waiver must meet the following Home and Community Based Services (HCBS) Settings regulations as established by CMS. The federal regulations for the new rule is 42 CFR 441.301(c) (4)-(5). Facilities who enroll in the waiver on or after the date of this policy change must meet these HCBS settings requirements prior to certification. Those facilities already enrolled in the waiver before this policy change must comply with the HCBS settings requirements under the timeframe established by the HCBS settings transition plan.

Settings that are HCBS must be integrated in and support full access of client's receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as clients not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
  - a. Choice must be identified/included in the person-centered service plan.
  - b. Choice must be based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services, supports, and who provides them.
5. In a provider-owned or controlled residential setting (e.g., Assisted Living Facilities), in addition to the qualities specified above, the following additional conditions must be met:
  - a. The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
  - b. Each individual has privacy in their sleeping or living unit:
    - i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

- ii. Clients sharing units have a choice of roommates in that setting.
- iii. Clients have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- c. Clients have the freedom and support to control their own schedules and activities, and have access to food at any time.
- d. Clients are able to have visitors of their choosing at any time.
- e. The setting is physically accessible to the individual.
- f. Any modification of the additional conditions specified in items a through d above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
  - i. Identify a specific and individualized assessed need.
  - ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
  - iii. Document less intrusive methods of meeting the need that have been tried but did not work.
  - iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
  - v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
  - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
  - vii. Include the informed consent of the individual.

**200.110      Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Facilities**

**10-1-22**

Level II ALFs, located within the state of Arkansas, either licensed or certified, as applicable, by the Division of Provider Service and Quality Assurance (DPSQA), are eligible to apply for Medicaid enrollment as Living Choices providers. Qualified Level II Assisted Living Facility providers contract with Medicaid as Living Choices Assisted Living Facility providers to provide and claim reimbursement for Living Choices bundled services instead of contracting with another entity (e.g., a licensed home health agency) that is enrolled with Medicaid to provide and receive payment for those services. Living Choices includes provisions for alternative methods of delivering services because assisted living facilities have different business and staffing arrangements and the Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service. Additional details in this regard are provided in this manual.

All owners, principals, employees, and contract staff of a Living Choices Assisted Living provider must have a criminal background check and central registry check. Criminal background and central registry checks must comply with Arkansas Code Annotated §§20-33-213 and 20-38-101 *et seq.* Criminal background checks shall be repeated at least once every five (5) years. Central registry checks shall include:

- A. Child Maltreatment Central Registry;
- B. Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and,
- C. Certified Nursing Assistant/Employment Clearance Registry.

**200.111      Electronic Signatures**

**1-1-13**

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 *et seq.*

**200.120**      **Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Agencies**      **10-1-22**

Within their licensing regulations, Level II ALFs may contract with home health agencies and other entities and individuals to provide required and optional services for residents of the ALF. In the Living Choices Program, an ALF that chooses not to be the Medicaid-enrolled provider of Living Choices services may contract only with a licensed home health agency to furnish Living Choices bundled services. The Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service.

A Licensed Class A Home Health Agency is eligible to enroll in the Arkansas Medicaid Program as an Assisted Living Agency provider only if it has a contract with a Level II Assisted Living Facility to deliver all Living Choices bundled services furnished in that facility. A home health agency must have a separate Medicaid provider number for each ALF in which it is the Living Choices provider.

To enroll as a Living Choices Assisted Living Agency, the agency must comply with certain procedures and criteria. This section describes those criteria and procedures, as well as the actions DMS takes to facilitate enrollment.

- A. The provider must be licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.
- B. The provider must submit to the Medicaid program's Provider Enrollment Unit and to DPSQA the following items, in addition to the other documentation required in this section.
  1. A copy of its contract with the ALF (financial details may be omitted). The contract must describe in detail the agency's contractual obligations to provide Living Choices bundled services to the ALF's Living Choices clients.
  2. Copies of contracts (financial details may be omitted) with any entities or individuals the agency has sub-contracted with to provide components of Living Choices bundled services.

**200.130**      **Reserved**      **1-1-13**

**200.200**      **Provider Staffing Requirements for the Delivery of Bundled Services**      **1-1-13**

The purpose of this section is to describe the types of employment and contractual arrangements that Medicaid regulations allow Living Choices facilities and agencies to make for the delivery of Living Choices bundled services. The legal basis for these requirements is the Social Security Act (the Act) at Section 1902(a)(27), Section 1902(a)(32) and Section 1902(a)(23).

- A. The referenced sections of the Act require the following.
  1. There must be a provider agreement between a state Medicaid agency and each provider furnishing Title XIX (Medicaid) services.
  2. State Medicaid agencies must make payment directly to the providers of services.
  3. Individuals receiving Medicaid benefits must have free choice among available and qualified providers who are willing to furnish the service.
    - a. To be considered "qualified," an individual or entity must meet applicable provider qualifications set forth in the state's Title XIX State Plan or in an approved Medicaid waiver.
    - b. Qualifications must be considered reasonable by the Centers for Medicare and Medicaid Services (CMS).

- c. CMS considers qualifications reasonable when they are directly related to the demands of the Medicaid service to be furnished.
- B. The requirements—and alternative requirements, if any—set forth in the following sections resulted from CMS interpretations of those three stipulations of the Act. They represent the only legal methods currently available to fulfill staffing needs to deliver Living Choices services. Providers will be notified of alternatives as they are approved and implemented.

**200.210      Staffing Requirements for Living Choices Assisted Living Facilities (ALF)—Direct Services Providers      10-1-22**

- A. Medicaid requires a Living Choices ALF—Direct Services Provider to furnish, with its own employees, not with contractors, Living Choices bundled services described in this manual.
  - 1. An individual or entity may not enroll in Medicaid to provide a service or services, and then sub-contract actual service delivery to others. Such arrangements do not satisfy the stipulations of the Social Security Act stated above in Section 200.200.
  - 2. Federal Medicaid regulations do permit an exception to the employee-only rule with respect to one (1) component of Living Choices bundled services. The exception is described in part C of this section.
- B. The employee-only rule satisfies the requirement that providers must be qualified to furnish the services they are enrolling to provide. CMS considers that a provider of bundled services may be deemed qualified if the provider furnishes the services through employees, which enables the provider to review and approve the qualifications of the individuals that actually deliver services. An ALF provider is responsible for verifying and maintaining pertinent documentation that individual employees are qualified to perform the functions for which they are hired.
  - 1. An ALF employee is an individual who is employed by an ALF and who has on file with the ALF administration a current IRS form W-4.
  - 2. Employees providing Living Choices services must be qualified to do so. The provider is responsible for ensuring that all Living Choices services are provided and documented, with documentation retained, in accordance with the provisions of this manual.
- C. The employee-only rule may be waived, in one (1) instance, with respect to nursing services in an ALF. Level II ALF licensing regulations require an ALF to engage nurses and Certified Nursing Aides to provide services that the regulations specify. Under those regulations, the nurses may be employees or contractors. If a nurse or aide is a contractor and the contract provides for him or her to furnish services required by the Living Choices Program, the arrangement does not violate the employee-only stipulation. However, the fact of this particular arrangement's exemption from that requirement does not exempt the facility from the employee-only requirement with respect to any other staff member providing Living Choices services.

**200.230      Staffing Requirements for Living Choices Assisted Living Agencies      10-1-22**

Living Choices Assisted Living Agencies have available two (2) methods by which they may engage staff to furnish Living Choices bundled services.

- A. The traditional method is using only employees, not contractors, to furnish the services. Its home health license confirms that the agency is qualified to provide home health services. The provider meets the state's qualification requirement by virtue of its licensure, and its enrollment as a Living Choices services provider, which is based on the agency's contract with a Level II ALF. These qualification criteria easily pass the CMS test of reasonableness.



- B. Another method is to use both employees and contractors to provide services. Federal regulations allow home health agencies to contract for provision of component parts (but not all component parts) of the full service (home health) they are licensed to provide. However, the enrolled provider is held responsible for the provision of the service “in total” and each component of the service (whether furnished directly by the provider or by someone else under contract to the provider) must meet the applicable standards set forth by the Medicaid agency for the provision of that component of care.

**202.000**      **Reserved**      **11-1-09**

**202.100**      **Records that Living Choices Assisted Living Facilities and Agencies Must Keep**      **10-1-22**

- A. Living Choices Assisted Living facility and agency providers must maintain required personal care aide training program documentation as specified in this manual.
- B. A provider must also maintain the following items in each Living Choices client's file.
1. The client's attending or primary care physician's name, office address, telephone number and after-hours contact information.
  2. A copy of the client's current person-centered service plan (form AAS-9503).
  3. Written instructions to the facility's attendant care staff.
  4. Documentation of limited nursing services performed by the provider's nursing staff in accordance with the client's person-centered service plan. Records must include:
    - a. Nursing service or services performed,
    - b. The date and time of day that nursing services (exclusive of attendant care services) are performed,
    - c. Progress or other notes regarding the resident's health status and
    - d. The signature or initials and the title of the person performing the services.
  5. Documentation of periodic nursing evaluations performed by the ALF nursing staff in accordance with the client's person-centered service plan.
  6. Records of attendant care services as described in this manual.
  7. 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 client's condition to the DHS nurse, who is the only authorized individual who may adjust a client's person-centered service plan. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify the DHS nurse immediately of any change in the client's physical, mental or environmental needs the provider observes or is made aware of that may affect the client's eligibility or necessitate a change in the client's person-centered service plan; to continually monitor client satisfaction and quality of service; and to notify the DHS nurse in writing within one (1) week of services being terminated, documenting the termination effective date and the reason for termination.

**202.110**      **Attendant Care Service Documentation**      **10-1-22**

Living Choices Facilities and Agencies must keep the following records documenting attendant care services.



- A. Documentation of attendant care services performed in accordance with a resident's person-centered service plan and a Registered Nurse's written instructions is required. The attendant may document these services by means of a checklist if:
  - 1. The checklist is individualized to correspond to the individualization of the direct care services plan;
  - 2. The checklist's nomenclature corresponds to the names and descriptions of services ordered by the direct care services plan and
  - 3. The attendant can note, within the same document, comments or observations required by the assisted living RN or notes regarding changes or perceived changes in the client's needs or requirements.
- B. Each person providing attendant care services must date the service log and sign it with an original signature or initial it over his or her typed or printed name. Documentation of time in and time out is not required.

## 202.200

## Living Choices Assisted Living Facility Cost Report Requirements

7-1-24

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:

- A. Annually not later than ninety (90) days after the end of the fiscal year of the facility;
- B. Within sixty (60) days of any significant change in the facility's ownership, management, or financial status or solvency; and
- C. At any time within sixty (60) days of a written request from the department or the Office of Medicaid Inspector General.

The department shall post the cost-reporting instructions, forms, and schedules on its website.

- A. 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 days before written notice to each Medicaid-certified Level II licensed assisted living facility.
- B. 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 include all information required by the forms, schedules, certifications, and instructions specified by the department and otherwise comply with generally accepted accounting principles and cost-reporting instructions of the department.
- E. Failure to file a cost-report may result in penalties and sanctions as set forth in Arkansas Code 20-10-2401 et seq.

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

The rules and regulations for licensure of Level II Assisted Living Facilities (ALF) are administered by the Division of Provider Services and Quality Assurance (DPSQA). As agencies of the Arkansas Department of Human Services (DHS), DAABHS, DMS and the Division of County Operations (DCO) administer the policies, procedures, rules, and regulations governing provider and client participation in the Living Choices Program.

Individuals found eligible for the Living Choices Program may participate in the program when residing in a licensed Level II ALF that is enrolled as a Living Choices waiver provider in the Arkansas Medicaid Program.

## 211.000 Scope of the Program

10-1-22

The *Level II Assisted Living Facilities Rules and Regulations* manual defines assisted living as: "Housing, meals, laundry, social activities, transportation (assistance with and arranging for transportation), one (1) or more personal services, direct care services, health care services, twenty-four (24) hour supervision and care, and limited nursing services." Medicaid, by federal law, may not cover clients' room and board except in nursing and intermediate care facilities. Medicaid covers some services only under certain conditions. This home and community-based services waiver program permits Medicaid coverage of assisted living services as described in this manual.

Individuals participating in the Living Choices Program reside in apartment-style living units in licensed Level II ALF and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity, and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery, facility, or program operation. The environment promotes client's self-direction and personal decision-making while protecting their health and safety.

Assisted living includes twenty-four (24) hour on-site response staff to assist with clients' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living provider staff perform their duties and conduct themselves in a manner that fosters and promotes residents' dignity and independence. Supervision, safety, and security are required components of the assisted living environment. Living Choices includes therapeutic social and recreational activities suitable to residents' abilities, interests, and needs.

Services are provided on a regular basis in accordance with individualized person-centered plans that are signed by a DHS nurse. Assisted living clients reside in their own living units, which are separate and distinct from all others. Laundry, meal preparation, and service are in a congregate setting for clients who choose not to perform those activities themselves.

## 211.050 Definitions

10-1-22

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

1. The individual is unable to perform either of the following:
    - a. At least one (1) of the three (3) activities of daily living (ADL's) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or
    - b. At least two (2) of the three (3) activities of daily living (ADL's) of transferring/locomotion, eating or toileting without limited assistance from another person; or,
  2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,
  3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.
- B. APPROVED ASSESSMENT INSTRUMENT means DHS approved the instrument used by registered nurses employed by the Independent Assessment Contractor to assess functional need.
- C. INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the approved assessment instrument to assess functional need.
- D. INITIAL INDEPENDENT ASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need. This assessment is used by DHS as part of the initial process to make a final determination of eligibility and, if the person is determined to be eligible, to be used in the development of the PCSP.
- E. EVALUATION means the process completed by the DHS PCSP/CC Nurse in conjunction with the client, at a minimum of every twelve (12) months, to determine continued evidence of established medical and functional eligibility or a change in medical condition that may impact continued medical and functional eligibility. The evaluation may result in a reassessment being requested by DHS if the DHS Eligibility Nurse determines that there is evidence of a material change in the functional or medical need of the client.
- F. REASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need when requested by a DHS Eligibility Nurse, based on evidence of a material change in medical and functional eligibility documented at the evaluation performed by a DHS PCSP/CC Nurse. This information is used by DHS as part of the process to make a final determination of continued eligibility and, if the person is determined to be eligible, to be used in the development of the PCSP.
- G. DHS ELIGIBILITY NURSE means a registered nurse authorized by DHS to perform reviews of all functional and medical information available and, based on available information, to make an eligibility determination and, if determined eligible, a level of care determination. DHS eligibility nurses are also responsible for reviewing evaluation documentation for material changes to medical or function need and requesting a reassessment if warranted.
- H. DHS PCSP/CC NURSE means a registered nurse authorized by DHS to perform evaluations, develop person-centered service plans, and serve as the primary care coordinator and DHS contact for assigned clients.
- I. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.

- J. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.
- K. TOILETING means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.
- L. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.
- M. TRANSFERRING means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.
- N. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three (3) or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.
- O. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.
- P. SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.
- Q. TOTAL DEPENDENCE means the individual needs another person to completely and totally perform the task for the individual.
- R. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to person-centered service plan; and such services are required on a twenty-four (24) hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.
  - 1. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.
  - 2. Intravenous injections and hypodermoclysis or intravenous feedings.
  - 3. Levin tubes and nasogastric tubes.
  - 4. Nasopharyngeal and tracheostomy aspiration.
  - 5. Application of dressings involving prescription medication and aseptic techniques.
  - 6. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.
  - 7. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.
  - 8. Initial phases of a regimen involving administration of medical gases.
  - 9. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.

10. Ventilator care and maintenance.
  11. The insertion, removal and maintenance of gastrostomy feeding tubes.
- S. INTELLECTUAL AND DEVELOPMENTAL DISABILITIES means a level of intellectual disability as described by the American Association on Intellectual and Developmental Disabilities' Manual on Intellectual Disability: Definition Classification, and systems and supports. For further clarification, see 42 CFR § 483.100-102, Subpart, C- Preadmission Screening and Annual Resident Review (PASSARR) of Individuals with Mental Illness and Intellectual Disability.
- T. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.

#### **211.100 Eligibility for the Living Choices Assisted Living Program**

**10-1-22**

- A. To qualify for the Living Choices Program, an individual must meet the targeted population as described in this manual and must be found to require a nursing facility intermediate level of care. Individuals meeting the skilled level of care, as determined by the Division of County Operations, are not eligible for the Living Choices Assisted Living Program.

The Living Choices Program processes for client intake, assessment, evaluation, and service plan development include:

1. Determination of categorical eligibility;
  2. Determination of financial eligibility;
  3. Determination of nursing facility level of care (LOC);
  4. Development of a person-centered service plan (PCSP); and,
  5. Notification to the client of his or her choice between home- and community-based services and institutional services.
- B. Candidates for participation in the program (or their representatives) must make an application for services at anyDHS office or on any electronic format provided by DHS for application through an interactive process. Medicaid eligibility is determined by the Division of County Operations and is based on non-medical and medical criteria.
- C. Individuals who require skilled level of care as defined in the Department of Human Services regulations are not eligible for the Living Choices Waiver.
- D. An Independent Assessment Contractor will perform independent assessments that gather functional eligibility information about each Living Choices waiver client using the approved instrument. The information gathered is used by the DHS Eligibility Nurse to determine the individual's level of care. If an applicant is determined both financially and medically eligible, the Division of County Operations approves the application. For more information on the approved assessment tool, please see the approved Provider Manual.
- E. An evaluation is initiated by the DHS PCSP/CC Nurse responsible for care coordination, at least every twelve (12) months and provided to the DHS Eligibility Nurse for review. Based on the review, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment. The assessment is sent to DHS Eligibility Nurse to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and medically eligible, the Division of County Operations approves the application.

- F. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition that is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than twenty-one (21) days.
- G. Individuals diagnosed with a serious mental illness or intellectual and developmental disability are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or intellectual and developmental disability and meet the other qualifying criteria. A diagnosis of severe mental illness or intellectual and developmental disability must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or intellectual and developmental disability when they meet the other qualifying criteria.
- H. Eligibility for the Living Choices waiver program is determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the person-centered service plan is signed by the DHS PCSP/CC Nurse and client. If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process. If a client is moving from a Provider-Led Arkansas Shared Savings Entity (PASSE) to the Living Choices waiver program, the eligibility date will be no earlier than the first day following disenrollment from the PASSE.
- I. The Living Choices waiver provides for the entrance of all eligible persons on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements. However, once all waiver slots are filled, a waiting list will be implemented for this program and the following process will apply. Each Living Choices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of their eligibility for services; that all waiver slots are currently filled; and the applicants' number in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the Living Choices program.
  - 1. Each Living Choices application will be accepted; medical and financial eligibility will be determined.
  - 2. If all waiver slots are filled, the applicant will be notified of their eligibility for services, that all waiver slots are currently filled, and the applicants' number in line for an available slot.
  - 3. 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 due to administrative error;
    - b. Waiver application determination date for persons residing in a nursing facility and being discharged after a ninety (90) day stay; or waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six (6) months or longer;
    - c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS); and
    - d. Waiver application determination date for all other persons.

**211.150 Level of Care Determination****10-1-22**

A prospective Living Choices client must require a nursing facility intermediate level of care.

The initial intermediate level of care determination is made by medical staff with the Department of Human Services (DHS). The determination is based on the assessment performed by the

Independent Assessment Contractor RN, using standard criteria for functional eligibility in evaluating an individual's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance with nursing home admission criteria, must be completed and the individual deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving Living Choices services.

An evaluation is initiated by the DHS PCSP/CC Nurse responsible for care coordination, at least every twelve (12) months and provided to the DHS Eligibility Nurse for review. Based on the review, should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment. The assessment is sent to DHS Eligibility Nurse to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and medically eligible, the Division of County Operations approves the application.

The results of the level of care determination and the evaluation are documented on form DHS-704, Decision for Nursing Home Placement.

**NOTE: While federal guidelines require level of care determination at least annually, the Independent Assessment Contractor may reassess a client's level of care and/or need any time it is deemed appropriate by the DHS Eligibility Nurse to ensure that a client is appropriately placed in the Living Choices Assisted Living Program and is receiving services suitable to his or her needs.**

#### 211.200 Person-Centered Service Plan

10-1-22

- A. Each client in the Living Choices Assisted Living Program must have a person-centered service plan, also referred to as an individualized Living Choices person-centered service plan (AAS-9503). The authority to develop a Living Choices person-centered service plan is given to the Medicaid State agency's designee, the DHS PCSP/CC Nurse. The Living Choices person-centered service plan developed by the DHS PCSP/CC Nurse includes without limitation:
1. Client identification and contact information to include full name and address, phone number, date of birth, and Medicaid number;
  2. Diagnosis;
  3. Contact person;
  4. Physician's name and address;
  5. The amount, frequency and duration of required Living Choices services and the name of the service provider chosen by the client or representative to provide the services;
  6. Other services outside the Living Choices services, regardless of payment source identified and/or ordered to meet the client's needs. Living Choices providers are not required to provide these services, but they may not impede their delivery;
  7. The election of community services by the waiver client;
  8. The name and title of the DHS PCSP/CC Nurse responsible for the development of the person-centered service plan; and,
  9. Each client, or his or her representative, has the right to choose the provider of each non-waiver service. Non-waiver services are the services listed on the person-centered service plan that are not included in the bundled services of the Living Choices Program (e.g., medical equipment rental). The person-centered service plan names the provider that the client (or the client's representative) has chosen to provide each service.
- B. A copy of the person-centered service plan signed by the DHS PCSP/CC Nurses and the waiver client will be forwarded to the client and the Living Choices service provider(s)



chosen by the client or representative, if waiver eligibility is approved by the Division of County Operations. Each provider is responsible for developing an implementation plan in accordance with the client person-centered service plan. The original person-centered service plan will be maintained by the DHS PCSP/CC Nurse.

The implementation plan must be designed to ensure that services are:

1. Individualized to the client's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the client's welfare;
4. Monitored and adjusted as needed, based on changes to the waiver person-centered service plan, as reported by the DHS PCSP/CC Nurse;
5. Provided within a system that safeguards the client's rights; and,
6. Documented carefully, with assurance that appropriate records will be maintained.

**NOTE: Each service included on the Living Choices person-centered service plan must be justified by the DHS PCSP/CC Nurse. This justification is based on medical necessity, the client's physical, mental, and functional status, other support services available to the client and other factors deemed appropriate by the DHS PCSP/CC Nurse**

Living Choices services must be provided according to the client's person-centered service plan. Providers may bill only for services in the amount and frequency that is authorized in the person-centered service plan. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

**NOTE: Person-centered service plans are updated at least once every twelve (12) months by the DHS PCSP/CC Nurse and sent to the assisted living provider prior to the expiration of the current person-centered service plan. However, the provider has the responsibility for monitoring the person-centered service plan expiration date and ensuring that services are delivered according to a valid person-centered service plan.**

**Services are not compensable unless there is a valid and current care plan in effect on the date of service.**

- C. The assisted living provider employs or contracts with a Registered Nurse (the "assisted living provider RN") who implements and coordinates person-centered service plans, supervises nursing and direct care staff and monitors client's status. At least once every three (3) months, the assisted living provider RN must evaluate each Living Choices client.
- D. The DHS PCSP/CC Nurse must evaluate a client's medical condition within fourteen days of being notified of any significant change in the client's condition. The assisted living RN is responsible for immediately notifying the DHS nurse regarding clients whose status or condition has changed and who may need an evaluation.

**REVISIONS TO A PERSON-CENTERED SERVICE PLAN MAY ONLY BE MADE BY THE DHS PCSP/CC NURSE.**

**NOTE: All revisions to the person-centered service plan must be authorized by the DHS PCSP/CC Nurse. A revised person-centered service plan will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on a Living Choices person-centered service plan, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the Living Choices person-centered service plan are subject to recoupment.**

**212.000 Living Choices Assisted Living Services****10-1-22**

Once a Living Choices eligibility application has been approved, waiver services must be provided in order for eligibility to continue. Medicaid covers Living Choices services on a daily, all-inclusive basis, rather than on an itemized per-service basis. With the exception explained in the NOTE below, a day is a covered date of service when a client receives any of the services described as a covered ALF service in this manual, when the service is received between midnight on a given day and midnight of the following day. A day is not a covered date of service when a client does not receive any Living Choices services between midnight of that day and midnight of the following day.

**NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.**

**Living Choices waiver services are not allowed on the same day as an individual is admitted to an inpatient facility, regardless of the time of day. If the inpatient facility (hospital, rehab hospital, nursing facility or ICF/IID) is reimbursed by Medicaid on any given day, the ALF waiver provider is not allowed reimbursement for Living Choices service on the same day.**

**For example: If a waiver client is taken and admitted to the hospital on 6/10/12 at 10 a.m. and discharged on 6/13/12 at 10:00 p.m., the hospital will be reimbursed by Medicaid for that date of admission, 6/10/12, but will not be reimbursed for the date of discharge, 6/13/12. In this scenario, the individual left the ALF II facility, was admitted to the hospital, and was returned to the ALF II facility after 3 days of hospitalization.**

**Date of Admission – 6/10/12 at 10:00 a.m. – Reimbursement to the hospital**

**6/11/12 – Reimbursement to the hospital**

**6/12/12 – Reimbursement to the hospital**

**Date of Discharge – 6/13/12 at 10:00 p.m. – Reimbursement to the ALF facility**

**The time of admission and the time of discharge are not relevant. Payment is made to the two facilities based on the dates of service.**

- A. 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 and
  7. Assistance obtaining non-medical transportation specified in the person-centered service plan.
- B. Living Choices clients are eligible for pharmacist consultant services. Level II ALFs are required by their licensing regulations to engage a Consultant Pharmacist in Charge.

**NOTE: The removal of Pharmacy Consultant Services as a waiver service does not change the provision of the service, as required under the Level II ALF licensing regulations.**

Living Choices waiver clients are eligible for the same prescription drug benefits of regular Medicaid, plus three (3) additional prescriptions for a total of nine (9) per month. No prior authorization is required for the three (3) additional prescriptions. Living Choices waiver clients who are dual eligible (receiving both Medicare and Medicaid) must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

#### 212.100 Attendant Care Services

10-1-22

- A. Attendant care is a direct care service to help a medically stable individual who has physical dependency needs in accomplishing activities and tasks of daily living that the individual is usually or always unable to perform independently.
  - 1. Living Choices clients are furnished attendant care on an individualized basis for assistance with eating and nutrition, dressing, bathing and personal hygiene, mobility and ambulation, and bowel and bladder requirements.
  - 2. Attendant care may include assistance with incidental housekeeping and shopping for personal care items or food.
  - 3. Regarding assistance with medication (for clients who elect to self-administer their medications) attendant care services include only the very limited functions detailed in Section 702.1.1.5F of the Level II Assisted Living Facilities Rules and Regulations.
- B. Activities that constitute assisting a person with physical dependency needs vary.
  - 1. One might perform the entire task (e.g., buttoning his shirt for him), or assist the person in performing the task (e.g., helping him line up button and buttonhole).
  - 2. Assistance might consist of simply providing safety support while the person performs the task (e.g., providing support so he can let go of his cane while he buttons his shirt).
  - 3. Attendant care services may include supervision, visual or auditory cueing, or only observation of a person performing a task or activity to ensure completion of the activity or the safety of the individual.
- C. The assisted living provider RN's attendant care instructions must be based, at a minimum, on the waiver person-centered service plan.
- D. The minimum qualifications of an individual providing attendant care in the Living Choices Program are those of a certified personal care aide. See personal care aide training and certification requirements in this manual.
- E. Individuals participating in the Living Choices Program are not eligible to access personal care services or extended personal care services through the Arkansas Medicaid Personal Care Program.

#### 212.200 Periodic Nursing Evaluations

10-1-22

The assisted living provider RN must evaluate each Living Choices Program client at least every three (3) months, more often if necessary. The assisted living provider RN must alert the DHS PCSP/CC Nurse to any indication that a client's direct care services needs are changing or have changed, so that the DHS PCSP/CC Nurse can evaluate the individual.

Each Living Choices client will be evaluated at least every twelve (12) months by a DHS PCSP/CC Nurse. The DHS PCSP/CC Nurse evaluates the resident to determine whether a

nursing home intermediate level of care is still appropriate and whether the person-centered service plan should continue unchanged or be revised. Evaluations and subsequent person-centered service plan revisions must be made within fourteen (14) days of any significant change in the client's status.

**212.300 Limited Nursing Services****10-1-22**

Limited nursing services are acts that may be performed by licensed personnel while carrying out their professional duties, but do not include twenty-four (24) hour nursing supervision of clients. Limited nursing services provided through the Living Choices Program 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 (RNs), licensed practical nurses (LPNs) and Certified Nursing Assistants (CNAs).

**212.310 Registered Nurse (RN) Limited Nursing Services****10-1-22**

RN limited nursing services include:

- A. Assessing each Living Choices client's health care needs,
- B. Implementing and coordinating the delivery of services ordered on the assisted living person-centered service plan,
- C. Monitoring and assessing the client's health status on a periodic basis,
- D. Administering medication and delivering limited medical services as provided by Arkansas law and applicable regulations and
- E. Making referrals to physicians or community agencies as appropriate.

**212.320 Licensed Practical Nurse (LPN) Limited Nursing Services****10-1-22**

LPN limited nursing services are provided under the supervision of an RN and include:

- A. Monitoring each waiver client's health status,
- B. Administering medication and delivering limited medical services as provided by Arkansas law or applicable regulation and
- C. Notifying the RN if there are significant changes in a client's health status.

**212.330 Certified Nursing Assistant (CNA) Limited Nursing Services****2-1-15**

Certified Nursing Assistants (CNAs) under the supervision of an RN or 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:

- A. Taking vital signs (temperature, pulse, respiration, blood pressure) and height/weight and
- B. Recognizing and reporting abnormal changes and death and dying.

While attendant care services as outlined in Section 212.100 may be provided by CNAs, attendant care services are not limited nursing services.

**212.400 Therapeutic Social and Recreational Activities****10-1-22**

Living Choices providers must provide therapeutic social and recreational activities as ordered on the person-centered service plan.

**212.500 Non-Medical Transportation 10-1-22**

Living Choices providers must assist clients with obtaining and accessing non-medical transportation as required on the person-centered service plan.

**212.600 Reserved 1-1-13****213.000 Additional Services 10-1-22**

Other individuals or agencies may also furnish care directly or under arrangement with the Living Choices provider, but the care provided by other entities may only supplement that provided by the Living Choices provider and may not supplant it.

Clients in the Living Choices Assisted Living Program may receive Title XIX (Medicaid) State Plan services that are provided by enrolled Medicaid providers (e.g., medical equipment rental, prescription drugs) if all eligibility requirements for the specific Medicaid covered service have been met. Clients may not receive services under the Arkansas Medicaid Personal Care Program.

**214.000 Benefit Limits 10-1-22**

- A. Living Choices Assisted Living bundled services are limited to one (1) unit per day.
- B. Living Choices Assisted Living Program clients may have as many as nine (9) prescription drugs per month covered by Medicaid. Dual eligibles: receiving both Medicare and Medicaid, receive prescription drug coverage through Part D Medicare. Medicare has no restrictions on the number of prescription drugs that can be received during a month. Section III of this manual contains information about available options for electronic claim submission.

**215.000 Living Choices Forms 10-1-22**

Living Choices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging and Adult Services. These forms include without limitation:

- A. Person-centered service plan – AAS-9503
- B. Client Change of Status – AAS-9511

Providers may request form AAS-9511 by writing to the Division of Aging, Adult and Behavioral Health Services. [View or print the Division of Aging, Adult and Behavioral Health Services contact information.](#)

Form AAS-9503 will be mailed to the provider by the DHS PCSP/CC Nurse.

Instructions for completion and retention are included with each form. If there are questions regarding any waiver form, providers may contact the DHS PCSP/CC Nurse in your area.

**216.000 Personal Care Aide Certification Requirement 10-13-03**

Living Choices attendant care services must be provided by an individual who, at minimum, is a certified personal care aide. There is no licensing authority or a single certifying authority for personal care aides in Arkansas. Providers and private training programs that follow the training guidelines in this manual may train and certify personal care aides.

**216.100 Personal Care Aide Training Programs 10-13-03**

A personal care aide training program may be offered by any organization meeting the standards in this manual for:

- A. Instructor qualifications,
- B. Content and duration of personal care aide training and
- C. Documentation of personal care aide training and certification.

#### **216.200      Personal Care Aide Training Subject Areas**

**10-1-22**

A qualified personal care aide training and certification program must include instruction in each of the following subject areas.

- A. Correct conduct toward clients, including respect for the client, the client's privacy and the client's property.
- B. Understanding and following spoken and written instructions.
- C. Communications skills, especially the skills needed to:
  - 1. Interact with clients,
  - 2. Report relevant and required information to supervisors and
  - 3. Report events accurately to public safety personnel and to emergency and medical personnel.
- D. Record-keeping, including:
  - 1. The role and importance of record keeping and documentation,
  - 2. Service documentation requirements and procedures,
  - 3. Reporting and documenting non-medical observations of client status and
  - 4. Reporting and documenting, when pertinent, the client's observations regarding his or her own status.
- E. Recognizing and reporting to the supervising RN changes in the client's condition or status that require the aide to perform tasks differently than instructed.
- F. State law regarding delegation of nursing tasks to unlicensed personnel.
- G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.
- H. Safe transfer techniques and ambulation.
- I. Normal range of motion and positioning.
- J. Recognizing emergencies and knowledge of emergency procedures.
- K. Basic household safety and fire prevention.
- L. Maintaining a clean, safe, and healthy environment.
- M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the client with:
  - 1. Bed bath,
  - 2. Sponge, tub, or shower bath,
  - 3. Shampoo (sink, tub, or bed),

4. Nail and skin care,
5. Oral hygiene,
6. Toileting and elimination,
7. Shaving,
8. Assistance with eating,
9. Assistance with dressing,
10. Efficient, safe, and sanitary meal preparation,
11. Dishwashing,
12. Basic housekeeping procedures and
13. Laundry skills.

**216.210 Personal Care Aide Training Requirements****10-1-22**

Classroom and supervised practical training must total at least forty (40) hours.

- A. Minimum classroom training time is twenty-four (24) hours.
- B. Minimum time for supervised practical training is sixteen (16) hours.
  1. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge by performing tasks on an individual while the trainee is under supervision.
  2. Trainees must complete at least sixteen (16) hours of classroom training before beginning any supervised practical training.
  3. Supervised practical training may occur at locations other than the site of the classroom training.
    - a. Trainees must complete at least twenty-four (24) hours of classroom training before undertaking any supervised practical training that involves Living Choices clients or Medicaid-eligible individuals who receive Arkansas Medicaid Personal Care services.
    - b. The training program must have the written consent of Living Choices clients or other Medicaid-eligible individuals (or their representatives) if aide trainees furnish any Attendant Care or personal care to those individuals as part of the supervised practical training.
      - i. A copy of each such consent must be maintained in the trainee's file.
      - ii. The client's (or the personal care client's) daily service documentation must include the names of the supervising RN and the personal care aide trainees.
  4. The training of personal care aides and the supervision of personal care aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse with current Arkansas licensure.
    - a. The qualified registered nurse must possess a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of in-home health care.
    - b. Other individuals may provide instruction under the supervision of the qualified registered nurse.
    - c. Supervised practical training with a consenting Living Choices client or personal care client as the subject must be personally supervised by:
      - i. A qualified registered nurse or



- ii. A licensed practical nurse under the general supervision of the qualified registered nurse.

**216.220 Personal Care Aide Training Documentation****10-1-22**

- A. Medicaid requires the following documentation of training:
  - 1. The number of hours each of classroom instruction and supervised practical training.
  - 2. Names and qualifications of instructors and current copies of licenses of supervising registered nurses.
  - 3. Street addresses and physical locations of training sites, including facility names when applicable.
  - 4. If the training includes any supervised practical training in the homes of personal care clients or in the residences of Living Choices clients, the forms documenting the client's consent to the training in their home.
  - 5. The course outline.
  - 6. Lesson plans.
  - 7. A brief description of the instructor's methods of supervising trainees during practical training.
  - 8. The training program's methods and standards for determining whether a trainee can read and write well enough to perform satisfactorily the duties of a personal care aide.
  - 9. The training program's method of evaluating written tests, oral exams (if any) and skills tests, including the relative weights of each in the minimum standard for successful completion of the course.
  - 10. The training program's minimum standard for successful completion of the course.
  - 11. Evidence and documentation of successful completions (certificates supported by internal records).
- B. The Living Choices provider is responsible for the upkeep of all required training program documentation, regardless of whether the training is in-house or by contract.

**216.230 Waiving Personal Care Aide Training****10-13-03**

- A. A qualified training program may waive the training component of personal care aide certification requirements for individuals who can document previous experience as personal care aides, Certified Nursing Assistants or in similar occupations requiring at minimum, the training and skills required of a personal care aide.
  - 1. The qualified training program must verify and document the individual's previous experience.
  - 2. The individual must pass the personal care aide examinations and skills tests.
- B. Certified Nursing Assistants with current valid credentials are deemed qualified personal care aides.
- C. Certified Home Health Aides with current valid credentials are deemed qualified personal care aides.

**216.240 Personal Care Aide Selection****10-1-22**

- A. A personal care aide must be at least eighteen (18) years of age at the time of personal care aide certification.

- B. A Living Choices client may receive attendant care services only from a certified personal care aide who is not a legally responsible family member or legally responsible caregiver. The Medicaid agency defines, “a legally responsible family member or legally responsible caregiver” as:
  - 1. A spouse.
  - 2. A legal guardian of the person
  - 3. An attorney-in-fact authorized to direct care for the client.
- C. Living Choices attendants must be selected on the basis of such factors as:
  - 1. A sympathetic attitude toward the care of the sick,
  - 2. An ability to read, write, and carry out directions and
  - 3. Maturity and ability to deal effectively with the demands of the job.
- D. The Living Choices provider is responsible for ensuring that attendants in its employ:
  - 1. Are certified as personal care aides,
  - 2. Participate in all required in-service training and
  - 3. Maintain at least “satisfactory” competency evaluations from their supervisors in all attendant care tasks they perform.

**216.250 Personal Care Aide Certification****10-13-03**

- A. A personal care aide trainee must pass an examination based on the curriculum of a personal care aide training course.
  - 1. Some of the examination may be oral.
  - 2. Examinations must include written questions requiring written answers, in sufficient number for instructors or other qualified training program personnel to determine that trainees meet or surpass a minimum standard for reading and writing.
- B. The personal care aide candidate must demonstrate the ability to perform all tasks required of personal care aides, by meeting or exceeding minimum standards in a personal care services skills test.
- C. An aide trainee successfully completing training must receive a dated certificate confirming that the individual is a Certified Personal Care Aide qualified for employment in that capacity.
  - 1. The certificate must contain the name of the training entity.
  - 2. The certificate must contain the signature of an individual authorized by the training program to certify the qualifications of personal care aides.

**216.260 In-Service Training****10-1-22**

Medicaid requires personal care aides to participate in least twelve (12) hours of in-service training every twelve (12) months after achieving Personal Care Aide certification.

- A. Each in-service training session must be at least one (1) hour in length.
  - 1. When appropriate, in-service training may occur at an assisted living facility when the aide is furnishing services.
  - 2. In-service training while serving a Living Choices client may occur only if the client or the client's representative has given prior written consent for training activities to occur concurrently with the client's care.

- B. The Living Choices provider and the personal care aide must maintain documentation that they are meeting the in-service training requirement.
- C. Providers are required to attend at least one in-service per calendar year. Required in-services are co-sponsored by DMS and DAABHS.

## **240.000 PRIOR AUTHORIZATION**

10-13-03

Prior authorization is not applicable to the Living Choices Assisted Living Program.

## **250.000 REIMBURSEMENT**

### **250.100 Reimbursement of Living Choices Assisted Living Facilities and Agencies**

10-1-22

Medicaid reimbursement to Living Choices assisted living facility and agency providers is based on a statewide daily (per diem) rate, as determined by DMS and specified in the Fee Schedule under Section 250.210. The daily rate pays for all direct care services in the client's person-centered service plan. Reimbursement is direct care for services only; room and board are to be paid by the client or his or her legal representative.

A day is a covered date of service when a Living Choices client receives any of the services described in Sections 212.100 through 212.500 between midnight of that day and midnight of the following day.

### **250.200 Reserved**

1-1-13

### **250.210 Fee Schedules**

12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

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

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

### **251.000 Rate Appeal Process**

10-13-03

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of

Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and a recommendation will be submitted to the Director of the Division of Medical Services.

## 260.000 BILLING PROCEDURES

### 261.000 Introduction to Billing 10-1-22

Living Choices Assisted Living providers use form CMS-1500 to bill the Arkansas Medicaid Program on paper for services provided to Medicaid clients. Form CMS-1500 is the official paper counterpart of the Professional (837P) electronic transaction format. Each claim may contain charges for only one (1) client.

Section III of this manual contains information about available options for electronic claim submission.

### 262.000 CMS-1500 Billing Procedures

#### 262.100 Living Choices Assisted Living Procedure Codes 1-1-19

Procedure Code	Modifier	Description
T2031		Living Choices Assisted Living

#### 262.200 Living Choices Assisted Living Place of Service Code 7-1-07

Electronic and paper claims now require the same National Place of Service codes.

The only place of service code applicable to Living Choices Assisted Living is **12**, "Home."

#### 262.300 Billing Instructions – Paper Only 10-1-22

The numbered items in the following instructions correspond to the numbered fields on form CMS-1500. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

**NOTE: A provider delivering services without verifying client eligibility for each date of service does so at the risk of not being reimbursed for the services.**

#### 262.400 Special Billing Procedures

#### 262.400 Special Billing Procedures

**262.410 Unit of Service****10-1-22**

Each procedure code Medicaid covers in the Living Choices Assisted Living Program represents one (1) level of service. One (1) unit equals one day of service. Units of service may not exceed the number of days in the service month. Each unit of service billed must be supported by a date of service.

**262.420 Dates of Service****1-1-13**

Dates of service may be itemized or expressed in a date of service range; i.e., "From Date" and "Through Date." A date of service range may include only covered days.

**262.430 Reserved****1-1-13**