



# ARChoices In Home Care

December 10, 2019




# ARChoices In Homecare HCBS Waiver Program General Information

- ▶ All ARChoices providers must meet the Provider Participation and enrollment requirements to be eligible to participate in the Arkansas Medicaid Program.
- ▶ Requirements can be found in Section I 140.00 of the Medicaid Provider Manual.
- ▶ Requirements can be found in Section II of the Medicaid Provider Manual for Compliance Desk Review Audits.

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# Obtaining Provider Manuals

- ▶ All provider manuals, manual updates, notices of rule making, official notices and RAs are available for downloading, without charge, from the Arkansas Medicaid website (<https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>).



What's new for Arkansas Medicaid providers at can be located at the following website;

All policy changes including manual updates, notices of rule making, official notices and RA messages are posted weekly on

<https://medicaid.mmis.arkansas.gov/Provider/newprov.aspx>



# Program Coverage



- ▶ The Arkansas Medical Assistance (Medicaid) Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to persons age 21 through 64 who are determined to have a physical disability through the Social Security Administration or the DHS Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or are 65 years of age or older and require an intermediate level of care in a nursing facility



# ARChoices available services if eligible

## Waiver Services

- ▶ Attendant Care Services
- ▶ Home-Delivered Meals
- ▶ Personal Emergency Response System
- ▶ Adult Day Services
- ▶ Adult Day Health Services
- ▶ Prevocational Services are available to ARChoices waiver participants with physical disabilities who wish to join the general workforce. Prevocational Services comprise a range of learning and experiential type activities that prepare a participant for paid employment or self-employment in the community.
- ▶ Respite Care
- ▶ Environmental Accessibility Adaptations/Adaptive Equipment

## Non-waiver Services

- ▶ Personal Care
- ▶ Targeted Case Management



# Requirements for meeting eligibility for the ARChoices Program

- ▶ To be determined an individual with a functional need; an individual must meet at least one of the following three criteria, as determined by a licensed medical professional:
- ▶ The individual is unable to perform either of the following:
  - ▶ At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon another person; or
  - ▶ At least 2 of the 3 ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or
- ▶ 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 themselves or others; or
- ▶ 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.



# Requirements for meeting eligibility for the ARChoices Program

- ARChoices applicants must also meet financial requirements in addition to medical criteria.
- All applicants must apply starting with the Department of County Operations. DCO determines financial eligibility.
- A referral is sent to DAABHS from the DCO worker.
- The referral is then entered into ARIA, Optum's assessment system.
- An Optum RN completes the assessment.



# Level of Care

- ▶ The final determination of Level of Care and functional eligibility is made by the Office of Long-Term Care (OLTC).
- ▶ A Level of Care is issued to DAABHS.
- ▶ The DAABHS RN contact the ARChoices client/representative to schedule a home visit to establish the client's Person Center Service Plan and Individual Services Budget.



# Individual Services Budget (ISB)



- ▶ In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.
- ▶ During the development of each person-centered service plan, after considering the participant's assessed needs, priorities, preferences, goals, and risk factors, and to ensure that the cost of all ARChoices services for each participant does not exceed the applicable Individual Services Budget amount



# Methodology for Determining Individual Services Budgets

- ▶ Intensive: The participant requires total dependence or extensive assistance from another person in all three (3) areas of mobility, feeding and toileting.
- ▶ Intermediate: The participant requires total dependence or extensive assistance from another person in two (2) of the area of mobility, feeding and toileting.
- ▶ Preventative: The participant meets the functional need eligibility requirements for ARChoices.



# ARChoices Forms

- ▶ 9503 Person Centered Service Plan
- ▶ 9510 Start of Care form - providers will receive with the 9503 for new clients and changes in service. Must be returned to the DAABHS RN. Section II of the 9510 must be completed by the provider and should be sent back to the DAABH RN by the date on the top of the form. BE SURE TO INCLUDE THE UNITS.
- ▶ 9511 Change of Status form - this form is used by providers to inform the RN there has been a change for the client for example client admitted to the hospital or/and returned to the home. The client's health may have changed. This form is also used by the DAABHS RN to inform the provider a client's case may be pending closure or has closed.

**AAS-9510 Start Services Form • ARDHS • Long-Term Services and Supports**

Please return this form to the DHS RN within 3 working days of starting services. If the provider does not return this form within 10 working days from the date the DHS RN mailed this form to the provider, action may be taken to secure another provider. If there have been any changes in services or if services have been discontinued, the DHS RN must be notified by form AAS-9511 immediately.

RETURN TO DHS RN BY: \_\_\_\_\_ 2<sup>nd</sup> Request \_\_\_\_\_ 3<sup>rd</sup> Request \_\_\_\_\_

**SECTION I - TO BE COMPLETED BY THE DHS RN**

TO:  ARChoices  PC  TCM  Assisted Living \_\_\_\_\_

DATE: \_\_\_\_\_ (Mailed to Provider(s) Co. of Residence: \_\_\_\_\_

FROM: DHS RN Name and Address \_\_\_\_\_

DHS RN Email \_\_\_\_\_

RE: \_\_\_\_\_ Client's Name \_\_\_\_\_ Client's SS#/Medicaid# \_\_\_\_\_

PCSP:  ASSESSMENT  Prov.  Comp.  REASSESSMENT  CHANGED PCSP

**SECTION II - TO BE COMPLETED BY THE (check the appropriate box)**

ARCHOICES PROVIDER  LIVING CHOICES PROVIDER  TCM

PLEASE CIRCLE ONE OF THE FOLLOWING:

Date Service Began Date Service Changed Date Service Continues

Enter a DATE only when indicating a "Began" or "Changed" service.

Attendant Care Date \_\_\_\_\_ Began/Changed/Continues at \_\_\_\_\_ hrs/month

ADS Date \_\_\_\_\_ Began/Changed/Continues at \_\_\_\_\_ hrs/wk, min. freq. \_\_\_\_ x wk

ADHS Date \_\_\_\_\_ Began/Changed/Continues at \_\_\_\_\_ hrs/wk, min. freq. \_\_\_\_ x wk

HDM Date \_\_\_\_\_ Began/Changed/Continues at \_\_\_\_\_ u/wk,  HOT or  COLD

PERS Date \_\_\_\_\_ Began/Changed/Continues at 24 hrs/day

RESPITE Date \_\_\_\_\_ Began/Changed/Continues at \_\_\_\_\_ hrs/mth, \_\_\_\_\_ hrs/yr. (PRN)

AFH Date \_\_\_\_\_ Began/Changed/Continues at \_\_\_\_\_ 1 day/month (1 unit=1 day; maximum 31units/month)

**NON-WAIVER SERVICES:**

PC Date \_\_\_\_\_ Began/Changed/Continues

Enter allocated personal care service units per month in the appropriate spaces below:

January	_____units	July	_____units
February	_____units	August	_____units
March	_____units	September	_____units
April	_____units	October	_____units
May	_____units	November	_____units
June	_____units	December	_____units

**One Unit = 15 minutes**

The units assigned to meet the client's functional needs are based on Optum's independent assessment.

TCM Date \_\_\_\_\_ Began/Changed/Continues according to the PCSP.

DIAPERS/PADS WERE ORDERED ON THE PCSP  Yes  No (TCM, please verify when/ if ordered.)

Provider Chooses NOT to Implement Provisional PCSP.

Client Chooses NOT to Accept Provisional PCSP.

ASSISTED LIVING: Verify services that you are going to apply:  AL BUNDLED SERVICE Tier Level \_\_\_\_\_

WAIVER PROVIDER NAME \_\_\_\_\_

NAME/TITLE OF PERSON COMPLETING FORM \_\_\_\_\_

Arkansas Department of Human Services  
Division of Aging, Adult, and Behavioral Health Services  
Provider Communications Form AAS-9511 – Change of Client Status

The purpose of this Form 9511 is to provide a means of communication between DAABHS and Providers of Services when there's been a change in a DAABHS client's status. This form must be completed by the provider or DAABHS staff immediately upon learning of a change in the client's status. This form must be retained in the DAABHS client's case record according to all applicable state and federal policies.

Instructions: Complete each item in Section I. Under Section II, click the box that best applies to the client's change of status. Finally, click on the text box next to the item you selected and include as many relevant details to the change as possible. It is vital that you submit this form whenever you stop service to a client for any reason. If you need assistance completing this form, contact your local DAABHS RN or DAABHS central office administrative staff.

I. Client is:  ARChoices  Living Choices  PACE  Personal Care

Client Name \_\_\_\_\_ Date of Change \_\_\_\_\_

Medicaid# \_\_\_\_\_ Date Submitted \_\_\_\_\_

Client's Last Known Address \_\_\_\_\_

Name of Agency/Facility Submitting Form \_\_\_\_\_

Name of Person Completing Form \_\_\_\_\_

II. Status Change

- 1. Health Improved (Explain): \_\_\_\_\_
- 2. Health Deteriorated (Explain): \_\_\_\_\_
- 3. New Address (Services still provided by agency?): \_\_\_\_\_
- 4. No Longer Providing Services (Reason): \_\_\_\_\_
- 5. New Phone Number: \_\_\_\_\_
- 6. Unable to Locate (Details, if any): \_\_\_\_\_
- 7. Hospitalized (Date of Admission/Release, Name of Hospital): \_\_\_\_\_
- 8. Entered Nursing Home (Date of Admission, Name of Facility): \_\_\_\_\_
- 9. Returned Home/to Facility (Re-entered Program): \_\_\_\_\_
- 10. Finances Improved (Eligibility re-determination needed? Client employed?): \_\_\_\_\_
- 11. Death (Date, if known): \_\_\_\_\_
- 12. Refused Service (Reason): \_\_\_\_\_
- 13. Change of Provider Requested (Reason): \_\_\_\_\_
- 14. Transferred to Another Agency/Facility (Date and name, if known): \_\_\_\_\_
- 15. Waiver Case Closed (Date and reason, if known): \_\_\_\_\_
- 16. Requesting Reconsideration (Adverse action and why needed): \_\_\_\_\_
- 17. Other (Be specific): \_\_\_\_\_



# Absence from the Home due to Institutionalization

- ▶ When a waiver beneficiary is admitted to a hospital, the DHS Division of County Operations will not take action to close the waiver case unless the beneficiary does not return home within 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the DHS RN will notify the DHS Division of County Operations and action will be initiated to close the waiver case.
- ▶ If the DHS Division of County Operations becomes aware that a beneficiary has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of the admission, but the Medicaid case will be left open. When the beneficiary returns home, the waiver case may be reopened effective the date the beneficiary returns home. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the beneficiary's admission to the facility.



# Relatives Providing ARChoices Services

- ▶ A relative or family member shall be defined as all persons related to the beneficiary by virtue of blood, marriage, or adoption.
- ▶ The following is applicable for all waiver services:
- ▶ Under no circumstances may Medicaid payment be made for any waiver service rendered by the waiver beneficiary's:
  - ▶ 1. Spouse
  - ▶ 2. Legal guardian of the person
  - ▶ 3. Attorney-in-fact granted authority to direct the beneficiary's care



# Documentation

- In addition to the service-specific documentation requirements listed in the Arkansas Medicaid Manual, ARChoices providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:
  - A copy of the beneficiary's PCSP
  - A brief description of the specific service(s) provided
  - The signature and title of the individual rendering the service(s)
  - For records created through an electronic data system such as telephony, computer or other electronic devices, a unique identifier such as a PIN number assigned to and entered by the employee at the time of data input may suffice as an electronic signature and title, and
  - The date and actual time the service(s) was rendered. For Attendant Care or In-Home Respite Care, it is not necessary to itemize the time spent on each individual ADL or IADL task.
  - A provider's failure to maintain sufficient documentation to support his or her billing practices may result in recoupment of Medicaid payment.
  - No documentation for ARChoices services, as with all Medicaid services, may be made in pencil.



# Completion of CMS-1500 Claim Form

- ▶ Send claims to DAABHS Attention of Jessica Johnson RN  
P.O. Box 1437, Slot W241 Little Rock, AR 72203
- ▶ Send only claims requesting reimbursement for services provided on the day a client was admitted to a hospital.



# Completion of CMS-1500 Claim Form

- ▶ Please read the Arkansas Medicaid Manual Section II instructions to complete the claim form correctly.
- ▶ **262.310 Completion of CMS-1500 Claim Form**
- ▶ **Most common errors**
- ▶ **Rounding units**
- ▶ **Missing Code, Modifier, Diagnosis pointer, chargers, units.**
- ▶ **No Spanning dates of service**
- ▶ **Timely filing**

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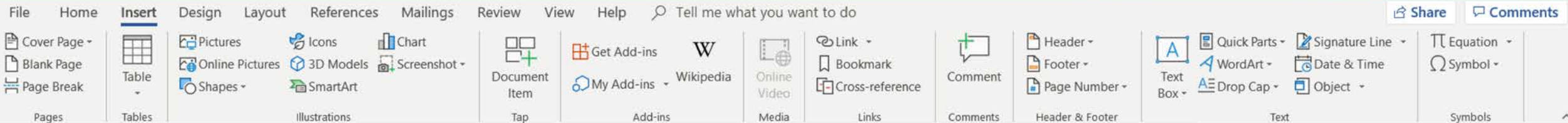
# Medicaid Manual Desk Review Audits

- In October 2019, several Medicaid Waiver providers were requested to turn in documentation for a Medical Manual Desk Review Audit.
- The purpose of the audit is to determine compliance with the Medicaid Manual for the providers in the ARChoices, Living Choices and PACE Waivers.
- Letters were sent to providers requesting specific documentation on from a random sampling selection.
- The random sampling is generated from a canned random sampling program.

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# Medicaid Manual Desk Review Audits

- Each Provider Type, e.g., Home Delivered Meals, Personal Emergency Response Systems, Adult Day Care, Environmental Modification, Assisted Living, etc., will receive a letter identifying specific documentation be sent to DAABH.
- The provider will have 14 days in which to submit the required documentation
- After DAABH receives the documentation, we will compare to the Medicaid requirements.
- Should a deficient practice be identified the provider will receive a letter identifying the deficient practices. The provider will then have 30 days in which to submit a Corrective Action Plan.
- Samples of the letters and the CAP:



**Provider Type:** Adult Day Care - 55

**Dates of Service:** 09/01/19-12/31/19

**Agency Records Request**

**Please send the following for your agency:**

- Program description
- Dated and signed initial 9510 and any subsequent 9510s related to changes
- Days of the week and hours of operation
- Services available with cost of each service
- Log showing last three months of group activity
- Copy of the last 4 weeks of menus served with portions and serving sizes
- Copy of complaint process policy/procedure for clients and family
- List of all volunteers and employees

**Beneficiary Record Request**

<u>Full Name</u>	<u>Medicaid ID</u>	<u>DOB</u>
Boop, Betty	1234567-001	07/17/1942
Oil, Olive	7890123-001	04/05/1927
Cogburn, Rooster	0000112-001	09/28/1938

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**Please send photocopies of the following documentation:**

- DHS RN Person Centered Service Plan (AAS-9503)
- Start of Care (Form-AAS-9510) and any subsequent AAS-9510s from changes
- Client's initial intake form
- Signed Admission and Discharge agreements

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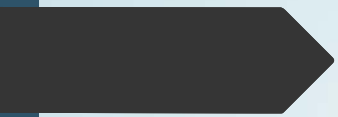
ARKANSAS DEPARTMENT OF HUMAN SERVICES Division of Aging, Adult and Behavioral Health Services				
Areas of Non-Compliance Corrective Action Plan		MEDICAID PROVIDER NUMBER:  12345678		DATE REVIEW COMPLETED Living Choices Waiver 11/19/2019
NAME OF PROVIDER OR SUPPLIER  XYZ ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Address AnyTown, AR 71913		
INSPECTED BY: S. Proffer, RN				
MEDICAID MANUAL REFERENCE TAG #	SUMMARY NON-COMPLIANT DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL MEDICAID POLICY REQUIREMENT)	MEDICAID MANUAL REFERENCE TAG #	PROVIDER'S CORRECTIVE ACTION PLAN (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE TO BE COMPLETED
212.000	Living Choices Assisted Living Services  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 beneficiary 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 beneficiary does not receive any Living Choices services between midnight of that day and midnight of the following day....  A. Basic Living Choices Assisted Living direct care services are: 3. Periodic nursing evaluations,  Based on record review of recipient records submitted by the facility, the facility failed to submit Quarterly Nursing evaluations on six (6) of six (6) recipients receiving Living Choices Waiver services as requested in the letter to the provider dated xx/xx/xx.	212.000	This is where the Provider Lists their Correction Action Plan. Who, what, when, where, why and how.	The date should always be as soon as possible



# Medicaid Manual Desk Review Audits

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