ARKANSAS GENERAL ASSEMBLY

Senator Ronald Caldwell
Chair

Representative Andy Mayberry
Chair

SENATE & HOUSE HEALTH SERVICES SUBCOMMITTEES OF THE SENATE & HOUSE PUBLIC HEALTH, WELFARE AND LABOR COMMITTEES

MEMORANDUM

TO: **Representative John Burris, House Chair**
Senator Cecile Bledsoe, Senate Chair
House and Senate Interim Committees of Public Health, Welfare and Labor

FROM: **Rep. Andy Mayberry, House Subcommittee Chair**
Senator Ronald Caldwell, Senate Subcommittee Chair
House and Senate Interim Subcommittee on Health Services

SUBJECT: **Subcommittee Report on Public Hearing Regarding the Community First Choice Option (CFCO) Plan**

DATE: **September 23, 2014**

The House and Senate Health Services Subcommittee met August 28, 2014 and held an informational hearing on the Community First Choice Option (CFCO). This hearing was held at the request of the House and Senate Public Health, Welfare and Labor Committees. The hearing began at 9:00 AM and concluded at 12:15 PM.

The subcommittee meeting began with a presentation by DHS officials that explained the CFCO program which included **(EXHIBIT A)**:

- John Selig, Director, Department of Human Services (DHS)
- Charlie Green, PhD, Director, Division of Developmental Disabilities Services (DDDS), DHS
- Anna Lansky, Assistant Director for Program Management, DDDS, DHS
- Krista Hughes, Director, Aging and Adult Services, DHS

Mr. Selig explained how the CFCO program would work as a part of the Health Care Payment Improvement Initiative; which DHS has been implementing for the last two years in an effort to hold down Medicaid spending and to improve medical outcomes. He noted that DHS submitted a Medicaid State Plan Amendment for the CFCO in March of 2014 **(EXHIBIT B)**.

The Community First Choice Option (CFCO) is a federal option under the Affordable Care Act, which allows states to provide a wide range of home and community based services including personal attendant services and supports in their State Medicaid Plan. CFCO allows for both self-directed and agency models. To be eligible for services under this option, individuals must be assessed as requiring an institutional level of care. It is specifically intended for those individuals who, without services and supports, would be unable to care for themselves at home and would need to enter an institutional setting. **(EXHIBIT C)**.

The federal government is offering incentive money to states to make it easier for them to use the Community First Choice Option. The incentive is an additional 6% increase in the Federal Match Rate for providing home and community-based attendant services and supports.

Several legislators had questions for DHS and wanted additional information about the implementation of the Community First Choice Option (CFCO) and they were **(EXHIIT D)**:

- Senator John Cooper
- Representative Josh Miller
- Senator Jonathan Dismang
- Senator Missy Irvin
- Senator Stephanie Flowers

Several groups and associations that spoke in support of the Community First Choice Option (CFCO) are listed below:

- Sara Israel, Executive Director, Developmental Disabilities Provider Association **(EXHIBIT E-1)**
- Jerry Mitchell, President, Arkansas Association of Area Agencies on Aging
- Keith Vire, President, Arkansas Waiver Association
- Dianna Varady, Director, Arkansas Autism Resource & Outreach Center (AAROC) **(EXHIBIT E-5)**
- Herb Sanderson, Associate State Director for Advocacy, AARP Arkansas
- Matthew Glass, Member, Arkansas Governors Developmental Disability Council
- Brenda Stinebuck, Executive Director, Centers for Independent Living in Arkansas
- David Deere, Partners for Inclusive Communities
- Tom Masseau, Executive Director, Disability Rights Center of Arkansas **(EXHIBIT E-2)**

Also, several individuals spoke in favor of the Community First Choice Option (CFCO) and they were:

- Jane Browning, Mother of a Developmentally Disabled Child **(EXHIBIT E-4)**
- Teresa Dodson, Mother of a Developmentally Disabled Child
- Debbie New, Mother of a Developmentally Disabled Child
- Mark George, Father of a Developmentally Disabled Child **(EXHIBIT E-3)**

Two people had concerns and questions for DHS regarding the implementation of the Community First Choice Option (CFCO) and they were:

- Carole Sherman, Mother of a Developmentally Disabled Child **(EXHIBIT F-1)**
- Jim Cooper, Arkansas Health Care Association **(EXHIBIT F-2)**

EXHIBIT LIST:

Exhibit A:	Community First Choice Option (CFCO) Plan
Exhibit B:	Arkansas Community First Choice Option, State Medicaid Plan Amendment
Exhibit C:	Description of the Medicaid Waiver Procedure & Description of the Medicaid State Plan Amendment
Exhibit D	Questions about the Community First Choice Option Plan Posed by Legislators & Responses by DHS
Exhibits E-1 – E-5	Statements Regarding their Support for Community First Choice Option from Associations, Groups, & Individuals
Exhibits F-1 & F-2	Questions About Community First Choice Option Posed by Interested Parties & Responses by DHS

EXHIBIT A

Building a healthier future for all Arkansans

Community First Choice Option

CFCO overview
July 11, 2014

Over 14,000 individuals are currently served by Home and Community-Based (Waiver) services (HCBS)

Current Situation

Program focus	Population[1]	Client Needs	Profiles of an individual
Individuals of all ages with developmental disabilities	• 4,173 served • 2,800 on waitlist due to cap	• Supportive Living[2] • Assistive technology and adaptive equipment[3] • Relief care services • Consultation services • Positive behavior support services • Specialized medical supplies	Stacy is 14 years old and lives in Jonesboro. She has a developmental disability and a mental illness. She requires support to address behavior issues and adaptive living skills so that she can stay at home with her family
Elderly persons with physical, cognitive or medical conditions	• 7,318 served	• Attendant care and supports[4] • Home delivered meals • Relief care services • Adult Day Care/Adult Day Healthcare • Adult Family Home	Joseph is 76 years old and lives in Cabot. He has Parkinson's disease. He requires attendant services and meals delivered 5 days a week so that he can remain in his home and be more independent
Adults with physical disabilities	• 2,690 served	• Attendant care and supports[4] • Assistive technology and adaptive equipment[3] • Case Management and Counseling Support	Dennis is 32 years old and lives in Hope. He had a motor vehicle accident and is readjusting to life at home. He needs assistance in accomplishing tasks of daily living so that he can continue to live in his own home

1. Arkansas DHS. *2013 Statistical report.* March 2014
2. Services and supports may include assistance in developing skills necessary for independent living and non-medical transportation
3. Similar services and supports include technology and equipment, personal emergency response systems, environmental modifications and vehicle modifications
4. Care and supports may include personal care, companion care, attendant care, and home maker

Through CFCO, Arkansas can choose a cost effective option to deliver HCBS

CFCO is an attractive option

Program provides a new funding source for existing services

- State will benefit from 6% improvement to Federal match rate for the duration of the program[1]

Program does not create new/open eligibility

- Program relies on existing state plan eligibility categories and rules. Individual must be:
  - Eligible for medical assistance
  - Meet institutional level of care (ILOC)
  - Any current rules regarding transfer of assets, home equity and estate recovery remain in place

CFCO has appropriate cost controls

- Eligibility criteria for Medicaid program within State plan and Waivers
- ILOC definition
- Independent standardized assessment to determine services
- Control over the package of services and benefit limits

Benefits of CFCO

CFCO is projected to save $365M of State General Revenue (SGR) over the next 12 years[2]

CFCO will fill service gaps and enhance payment improvement initiative

Eliminates DD waitlist

- Program provides HCBS services to the 2,800 individuals on waitlist

Improves integration of HCBS

- Individuals with disabilities receive services in the most integrated care settings

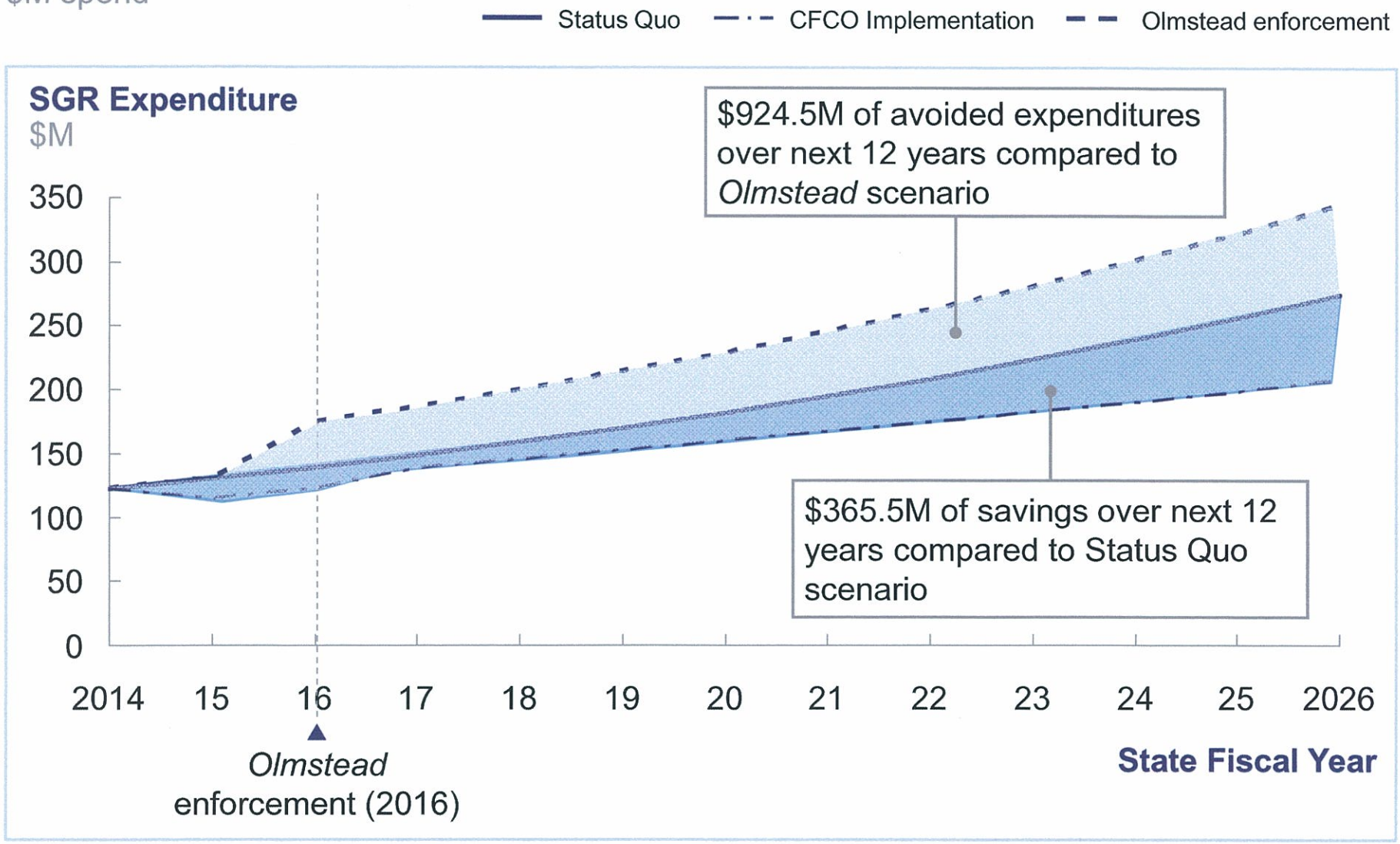
Avoid *Olmstead* litigation and enforcement [3]

- U.S. Department of Justice (DOJ) and advocacy groups have brought litigation in other states to enforce *Olmstead* decision and eliminate unnecessary institutionalization of individuals with disabilities
- Adverse decisions in litigation resulted in years of court oversight in other states and frequently forced very expensive remedies on state programs by court appointed monitors

1. Medicaid Program; Community First Choice Option (CMS-2337-F)
2. FMS Analysis. Jul 10, 2014
3. Olmstead mandates that persons with disabilities receive services in most integrated, least restrictive setting. DOJ previously filed suit against AR alleging State failed to i) provide services to individuals with DD in the most integrated setting appropriate for care and ii) manage the waiver waiting list in a manner that provided community service options for people on waiting lists at risk of institutionalization

Projected State General Revenue (SGR) expenditures for HCBS services under three scenarios

$M spend



Source: FMS Analysis. Analysis of Net Effect of CFCO Program on State General Revenue, Jul 10 2014

Appendix: Analysis of HCBS expenditures to State General Revenue (SFY 2014-2026)

$M spend

	State Fiscal Year													
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
A Status Quo	121.7	130.2	139.4	149.1	159.6	170.7	182.7	195.5	209.2	223.8	239.5	256.2	274.2	2,451.7
B Scenario: CFCO Imple-mentation	121.7	114.6	123.3	139.3	146.6	154.0	161.2	168.2	175.5	183.1	191.1	199.4	208.2	2,086.1
C Scenario: *Olmstead* enforcement	121.7	130.2	174.8	187.0	200.1	214.1	229.1	245.1	262.3	280.7	300.3	321.3	343.8	3,010.6
Cost Savings for CFCO from Status Quo (A-B)	**0.0**	**15.6**	**16.1**	**9.9**	**12.9**	**16.8**	**21.5**	**27.3**	**33.7**	**40.7**	**48.4**	**56.8**	**66.0**	**365.5**

Source: FMS Analysis. Analysis of Net Effect of CFCO Program on State General Revenue, Jul 10 2014

FMS Key Assumptions: A) current Federal match rate is 70.7%, annual HCBS growth rate is 10% to SFY2014 and 7% thereafter due to Payment Improvement Initiative and population growth . B) Federal match increases by 6% for duration of CFCO, individuals on waitlist are enrolled in HCBS in SFY2015-16. C) Olmstead enforcement in 2016, Federal match rate remains at 70.7%, annual HCBS growth rate is 10% to SFY2014 and 7% thereafter due to Payment Improvement Initiative and population growth

EXHIBIT B

Attachment 3.1 - K

State Plan Under Title XIX of the Social Security Act

ARKANSAS:

Arkansas Community First Choice State Plan Program

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

The State determines eligibility for Arkansas Community First Choice (ACFC) services in the manner as prescribed in Social Security Act §1915(k) (1).

ACFC services are available to individuals eligible for medical assistance under the Arkansas State Plan and are in an eligibility group that includes nursing facility services or are below 150% of federal poverty level if they are not in an eligibility group that includes nursing facility services.

A standardized instrument will be used to determine if the individual meets the institutional intermediate level of care (LOC) provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases for individuals under age 21 and age 65 and older.

The annual institutional level of care redetermination requirement may be waived if it is determined there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment or functional capacity based on Arkansas' established criteria. For those individuals who do not meet the established criteria, an annual redetermination will be conducted.

Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one home and community-based waiver service per month. Individuals receiving services through ACFC will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waivers, grants or demonstrations but will not be allowed to receive duplicative services in ACFC or any other available home and community-based services.

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During the five-year period that begins January 1, 2014, spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under 1915(k).

ii. Service Delivery Models

__X_ Agency Model - The Agency Model is based on the individual-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

_X_ Self-Directed Model with service budget – This Model is one in which the individual has both a person-centered service plan and service budget based on the individual-centered assessment of functional need.

_____ Direct Cash

_____ Vouchers

_X___ Financial Management Services in accordance with 441.545(b) (1).

___ Other Service Delivery Model as described below:

iii. Service Package

A. The following are included CFCO services (in addition to service descriptions, please include any service limitations):

1. Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and health-related tasks through hands-on assistance, supervision, or cueing.

Attendant Services and Supports

Attendant services and supports consists of assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, and/ or cueing.

Hands-on assistance, supervision, and/or cueing are defined as:

- "Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the individual complete activities without hands-on assistance.
- "Hands-on assistance" means a provider physically performs all or part of an activity because the individual is unable to do so.
- "Monitoring", a form of supervision, means a provider must observe the individual to determine if intervention is needed.
- "Redirection", a form of supervision or cueing, means to divert the individual to another more appropriate activity.
- "Set-up", a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.
- "Stand-by", a form of supervision, means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.
- "Supervision" means a provider must be near the individual to observe how the individual is completing a task.
- "Support", a form of supervision, means to enhance the environment to enable the individual to be as independent as possible.
- "Memory care support", a blend of supervision, cueing and hands-on assistance, Includes services related to observing behaviors, supervision, and intervening as appropriate in order to safeguard the service recipient against injury, hazard or accident. These specific supports are designed to support individuals with cognitive impairments.

Activities of daily living:
- Eating
- Bathing
- Dressing
- Personal hygiene (grooming, shampooing, shaving, skin care, oral care, etc.)
- Toileting
- Mobility/ambulating, including mastering the use of adaptive aids and equipment

Instrumental activities of daily living:
- Meal planning and preparation
- Managing finances
- Laundry
- Shopping and errands

- Communication
- Traveling and participation in the community
- Light housekeeping
- Chore services
- Assistance with medications (to the extent permitted by nursing scope of practice laws)

Attendant services and supports may include Homemaker/Chore services that consist of general household tasks and are intended to ensure that the individual's home is safe and allows for independent living. Examples of "general household tasks" may include meal preparation, routine household care, laundry, etc. These services must be incidental to other attendant services and supports and may not exceed 20% of total service time provided.

The provision of ADLs and IADLs does not entail nursing care.

Health-Related Tasks:
Health-related tasks are tasks beyond activities of daily living that are delegated or assigned by a licensed medical professional. Arkansas recognizes two types:

A. Consumer Directed Care (assigned by licensed medical professional): All health maintenance activities (to include oral medication administration/assistance, shallow suctioning, catheterization, oxygen supplementation, maintenance and use of intral-feeding and breathing apparatus /device), except injections and IV's, can be done in the home by a designated care aide. With the exception of injectable medication administration, tasks that participants would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria (numbers 1 through 5 below), specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met:

1. The task is being performed in the client's home, not in a nursing facility, assisted living facility, residential care facility, intermediate care facility, or hospice facility.
2. A competent adult, or caretaker of a child or incompetent adult, has authorized the aide to perform the task;
3. The aide has adequately demonstrated to the competent adult or caretaker that the aide can safely perform the task;

4. The attending physician, advanced practice nurse or registered nurse has determined a designated care aide under the direction of the competent adult or caretaker can safely perform the activity in the child or adult's home; and
5. The task is not among those exceptions stated above.

B. Delegated Nursing Services and Consultation (delegated by licensed medical professional). The state will reimburse nursing services to support health related tasks within the state's nurse practice act. These services include nurse delegation. They do not include direct nursing care. "Delegation" means that a licensed nurse authorizes an unlicensed person to perform a task of nursing care in selected situations and indicates that authorization in writing and pursuant to other criteria promulgated by the State Board of Nursing (ASBN Rules, Chapter 5, Delegation). The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed person and reevaluating the task at regular intervals." These services are designed to assist the individual and care provider in maximizing the individual's health status and ability to function at the highest possible level of independence in the least restrictive setting.

Services include:
Evaluation and identification of supports that minimize health risks, while promoting the individual's autonomy and self-management of healthcare; Medication reviews; assist in monitoring safety and well-being and to address needed changes to the person-centered service plan; and Delegation of nursing tasks, within the requirements of Arkansas' nurse practice act, to an individual's caregivers so that caregivers can safely perform health related tasks.

Benefit limit (does not apply to bundled episode services): none.

Chore Services

Chore services are services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; and/or yard and sidewalk maintenance. Chore services are provided only in extreme circumstances when lack of these services would make the home uninhabitable. Yard and sidewalk

maintenance does not include routine lawn mowing, trimming, raking or mulching leaves for aesthetic purposes.

Benefit limit (does not apply to bundled episode services): 172 units per month, unit = 15 minutes.

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks. (Please specify who is performing these activities.)

Supportive Living

Supportive Living services are an array of individually tailored services and activities to enable persons to reside successfully in the community. Services include functional skills training, coaching, prompting or other means to enable the individual to acquire, maintain, or enhance skills necessary to accomplish ADLs, IADLs or health related tasks. Services will be specifically tied to the assessed needs and person-centered service plan and are a means to increase independence, preserve functioning, and reduce dependency of the service recipient. These services can be provided integrally with the performance of ADLs, IADLs, and health related tasks as described in the earlier section. Assistance may entail hands-on assistance, supervision and/or cueing, as defined above.
Supported Living includes:

- Decision making is an essential element in performing ADLs such as eating, bathing, dressing, personal hygiene activities and toileting as well as IADLs such as meal planning, finances, laundry, shopping, and traveling in the community. It includes the identification of and response to dangerously threatening situations, making decisions and choices affecting the participant's life and initiating changes in living arrangement or life activities;
- Money management is an essential element in performing IADLs such as meal planning, managing finances, shopping, and traveling and participation in the community. It includes handling personal finances, making purchases and meeting personal financial obligations;
- Socialization is an essential element in performing IADLs such as shopping and errands, communication and traveling and participation in the community. It includes participation in general community activities, and includes establishing

and maintaining relationships with peers and other significant persons in the participant's life.

- Community integration experiences is an essential element in performing IADLs such as include activities intended to instruct the participant in community living skills in a clinic and integrated settings. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities and supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the participant's individual needs.
- Communication is an essential element in all ADLs and IADLs. It includes training in vocabulary building, use of augmentative communication devices, receptive and expressive language;
- Behavior shaping and management is an essential element in implementing behavior management plans and in ADLs such as eating, dressing and toileting and IADLs such as communication and participation in the community. It is an essential element for the health and safety of individuals who exhibit inappropriate behaviors and require a behavior management plan. It includes developing appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;
- Reinforcement of therapeutic services is an essential element in performing all ADLs, and IADLs such as communication, participation in the community, housekeeping, shopping and errands. It consists of conducting exercises or otherwise reinforcing physical, occupational, speech and other therapeutic services, including range of motion exercises, to the extent permitted by state scope of practice laws. The success of therapy is contingent upon reinforcement of related tasks in the individual's day-to-day activities and routines.
- Employment Supports is an essential element in performing IADLs such as communication and participation in the community and ADLs such as bathing, dressing, personal hygiene and toileting. It increases the possibility for the individual to become fully integrated into the community as a valued member of the workforce. It includes supports that enable the participant to acquire, retain or improve skills that directly affect the participant's ability to work and live in the community as independently as possible. Activities may include but not be limited to assistance getting ready for work, including personal hygiene, packing lunch etc.; help with ADLs and IADLs, and health-related needs in the workplace including hand-on assistance and cueing, help with transportation to work and job

interviews, coaching on use of public transportation, cueing to help individuals manage behaviors and symptoms while in the workplace, cueing to help individuals stay focused on employment tasks, shopping for work clothing.

- Appropriate use of leisure time and exercise are included based on needs identified in the functional assessment. These are critical to the health and welfare of an individual. For example, persons who are overweight or obese experience health risks. Those risks pose challenges to performing many or all ADLs and IADLs.
- Motor skills are an essential element in performing all ADLs and IADLs such meal preparation, shopping, communication participation in the community and housekeeping.
- Cognitive skills are an essential element in performing all ADLs and IADLs.
- Communication is an IADL essential to all ADLs and IADLs.
- Community nursing services are also in this category of services. Community nurses, within the scope of the state's Nurse Practice Act requirements, assist individuals in the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish health related tasks.

Benefit limit (does not apply to bundled episode services): none.

3. Back-up systems or mechanisms to ensure continuity of services and supports.

Personal emergency response system (PERS)

Personal emergency response system (PERS) is a 24-hour support system with a two-way verbal electronic communication with a battery backup and an emergency control/response center. PERS includes an electronic device that enables certain participants at high risk of institutionalization to secure help in an event of an emergency. The participant may also wear a portable waterproof "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.

For participants with limited or no hand function, PERS devices may include hands-free or voice activated devices. Allowable items under this service may also include a cellular telephone, other cellular devices, and cellular service when a conventional PERS system is not feasible.

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PERS services are limited to those participants who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision to protect their safety. Included in this support are assessment, purchase, installation, maintenance (such as replacing batteries or charger cords) and monthly rental fee.

The goals of the personal emergency response system are:

1. To provide a high-risk participant with the security and assurance of immediate assistance in an emergency, making it possible for them to remain in their home.
2. To eliminate the need for costly in-home supervision provided by a paid attendant that also affords the participant the emotional satisfaction of independent living.

(PERS) can be approved when it can be illustrated to be necessary to protect the health and safety of the participant. PERS is not intended to be a universal benefit. It is specifically for those "high-risk" participants whose needs are determined through the assessment/reassessment process. The criteria for eligibility are based on the participant's level of medical vulnerability, functional impairment and social isolation. Participants receiving PERS services must be physically and mentally capable of utilizing the service or reside in the home with a caregiver who is capable of utilizing the service for the benefit of the CFCO participant.

Benefit limit (does not apply to bundled episode services): Monitoring: allowable units equal to the number of days in a month, unit = 1 day; appropriateness of new installations will be determined based on assessed need

Relief Care Services

The participant's multi-disciplinary care team assists with identifying a regularly-scheduled relief care provider as part of the person-centered care plan or identifies back-up providers or care setting alternatives as part of the care plan in case the participant's primary attendant(s) or supportive living worker becomes ill or is suddenly no longer available or is otherwise in need of relief. Providers may utilize 24 hour, community-based care settings if they are unable to locate an in-home worker to meet immediate care needs.

Benefit limit (does not apply to bundled episode services): none.

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Consultation Services

Consultant services are backup supports for individuals with challenging behaviors or other special conditions who are at risk of institutionalization without additional interventions. Consultation may be in the form of Risk Management Plans and Crisis Intervention. Risk Management Plans. The person-centered care plan identifies the person or organization that will provide backup supports in the form of consultation, training, or support to participants, family members, and service providers for participants with special conditions. The services are indirect and include but are not limited to such measures as training direct services staff or family members in carrying out the individual's person-centered care plan; providing information and assistance to persons responsible for developing the person-centered service plan; designing a behavior intervention plan to be followed by staff and family; developing cross systems crisis plans; training staff or family members in de-escalation techniques; designing special meal plans; training the participant, family, or staff to address special medical conditions; determining the need for and assisting in the selection of assistive technology and environmental and home modifications; training or assisting in the set up and use of assistive technology and environmental and home modifications; and training regarding self-advocacy.

Benefit limit (does not apply to bundled episode services): the maximum annual amount is $2,000.00, not to exceed 24 units per day, unit = 1 hour.

Crisis Intervention

Crisis intervention is a backup support that offers immediate, short-term help to participants who experience an event that produces emotional, mental, physical, or behavioral distress or problems. A number of events or circumstances can be considered a crisis, including but not limited to: life-threatening situations, such as natural disasters, power outages, sexual assault or other criminal victimization, medical illness, mental illness, cognitive impairment, behavioral issues, income/financial issues, safety/cleanliness of a residence, loss of natural supports, poor access to services, thoughts of suicide or homicide, and loss or drastic changes in relationships. The service is provided as a nonscheduled emergency intervention. Activities include but are not limited to: Assessing the situation and the individual's response to the situation. Making contact and begin establishing collaborative relationship. Identifying dangers, problems, or crisis triggers. Educating the participant about alternative response and new coping

strategies. Restoring functioning through implementation of an action plan. Planning follow-up to avoid further crises.

Benefit limit (does not apply to bundled episode services): the maximum annual amount is $2,000.00, not to exceed 24 units per day, unit = 1 hour.

Positive Behavior Support Services

Positive Behavioral Support Services are provided to assist individuals with behavioral challenges due to their disability, that prevent them from accomplishing ADLs, IADLs, and health related tasks. Positive Behavior Support Services include coaching and support of positive behaviors, behavior modification and intervention supports to allow individuals to develop, maintain and/or enhance skills to accomplish ADLs, IADLs and health related tasks. The need for these services is determined through a functional needs assessment and the individual's goals as identified in the person centered planning process. Positive Behavioral Support Services may also include consultation to the care provider on how to mitigate behavior that may place the individual's health and safety at risk and prevent institutionalization.

Services may be implemented in the home and/or community, based on an individual's assessed needs. All activities must be for the direct benefit of the Medicaid beneficiary. Behavior Consultants will work with the individual and, if applicable, the caregiver or other key persons, to assess the environmental, social, and interpersonal factors influencing the person's behaviors. The consultants will develop, in collaboration with the individual and if applicable, caregivers, a specific positive behavioral support plan to address the needs of the person to acquire, maintain and enhance skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living and health related tasks. These services do not include rehabilitation or treatment of mental health conditions. The provision of this service will not supplant the provision of personal attendant services that are based on the individual's assessed needs that are identified in the person-centered plan. Services are provided according to processes directed by best practice.

Benefit limit (does not apply to bundled episode services): the maximum annual amount is $2,000.00, not to exceed 24 units per day, unit = 1 hour.

4. Voluntary training on how to select, manage, and dismiss attendants. Please identify who is performing these activities.

Counseling Support

This service is intended for the self-directed model. Counseling support services is one of two required services a state must offer to support Medicaid recipients in a participant-directed service delivery model. The counseling support system must possess an understanding of the philosophy of participant-direction, person-centered and directed planning, the ability to facilitate the participant's independence and preferences, the ability to develop budget plans and ensure appropriate documentation, and knowledge of the resources available in the participant's community and how to access them.

The support system must be available to the individual prior to enrollment, and as requested, throughout the period of an individual's enrollment. Counseling support services must be accessible to participants, have regularly scheduled phone and in person contacts with participants, monitor whether participants' health status has changed and whether expenditure of funds are being made in accordance with service budget plans.

The supports offered by the counselor to a participant include the following activities:

1. Provide information on the range and scope of individual choices and options;
2. during the initial counseling session the individual is informed about disenrollment;
3. initial counseling and on-going counseling includes information about preventing worker discrimination and violation of labor laws and regulations;
4. provide information, training, counseling and assistance, and assist participants with their employer-related responsibilities, including managing their workers and budgets, as desired by participants, that help participants effectively manage their services and budgets;
5. help participants develop their service budget plans by allowing the participant to involve family, friends, and professionals;
6. help participants effectively fulfill their employer related responsibilities;
7. act as agents of the participant and are primarily responsible for facilitating the participants' needs in a manner that agrees with participants' preferences;
8. help locate and access providers of personal assistance services needed by a participant;

9. assist the participant in managing their personal assistance services and budget plans, including how to hire the person most suitable to the participant, and how to discharge the worker if necessary;
10. provides supportive services so that:
a. the participant has knowledge about the specific dollar amount available for their personal assistance services;
b. how they can adjust their budget plan;
c. how they can purchase goods and services that increase independence or substitute for human assistance;
d. how discretionary funds may be spent; and
e. how the participant may request a fair hearing if a request for a budget adjustment is denied or the amount of the budget is reduced.
11. prior to recommending that a participant is unable to self-direct their personal assistance services can only occur after additional information and training was provided to the participant by the counselor; and
12. should a participant's health condition change, more frequent face-to-face and phone monitoring by the counselor;
13. Provide information on the risks and responsibilities of self-direction and assist the participant in developing a back-up plan

Fiscal Management Services

The entity selected to provide Financial Management Services (FMS) will meet the requirements of 441.545(b) (1) by acting as a Vendor Fiscal/Employer Agent under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70. Additionally, the FMS provider will coordinate criminal background checks for in-home Medicaid caregivers as required by the State while adhering to 441.555 (B). The FMS provider maintains the results of the criminal background check electronically and provides original documentation to the Arkansas Department of Human Services upon receipt.

5. Support System Activities
- Appeal process
- Free choice of providers
- Information regarding how to report abuse
- Provider criminal background checks

- Risk management
- Conflict of interest standards

Individuals under twenty-one (21) years of age pursuant to EPSDT may receive additional services if determined to be medically necessary.

B. The State elects to include the following CFCO permissible service(s):

1. X Expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for human assistance.

Non-Medical Transportation

Non-medical transportation can be provided for eligible participants receiving CFC services

Benefit limit (does not apply to bundled episode services): none.

Environmental Modifications

Environmental Modifications provide physical adaptations and other modifications to an individual's environment, but only to the extent that the need for such has been identified in the individual's person-centered service plan and that the adaptation will increase the individual's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance, as described in 441.520(b) (1) or (b) (2).

Benefit limit (does not apply to bundled episode services): A beneficiary's annual expenditure for environmental modifications cannot exceed $7,700 per person per year. If the beneficiary is also receiving adaptive equipment services and/or vehicle modification, the COMBINED total cannot exceed $7,700.

Vehicle Modifications

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Vehicle Modifications are adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptations are specified by the Person Centered Service Plan as necessary to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant. Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made Permanent vehicle modifications may be replaced if the vehicle is stolen, damaged beyond repair as long as the damage is not through negligence of the vehicle owner, or used for more than its reasonable useful lifetime.

Vehicle modifications apply only to modifications and are not routine auto maintenance or repairs for the vehicle. Exclusions: The following are specifically excluded:

1) Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;
2) Purchase, down payment or lease of a vehicle;
3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Benefit limit (does not apply to bundled episode services): A beneficiary's annual expenditure for vehicle modifications cannot exceed $7,700 per person per year. If the beneficiary is also receiving adaptive equipment services and/or environmental modification, the COMBINED total cannot exceed $7,700.

Specialized Medical Supplies

Specialized medical equipment and supplies covered under CFC include:

1) Specialized medical supplies and equipment as available under State Plan
2) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
3) Such other durable and non-durable medical equipment not otherwise available under the state plan that is necessary to address participant functional limitations;
4) Necessary medical supplies not otherwise available under the state plan.

Items reimbursed with CFC funds exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Additional supply items not covered under state plan can be covered under CFC a Waiver service when they are considered essential for home and community care. A physician must order all items. When such items are included as a Medicaid state plan service, CFC can provide for extension of such services. A denial of extension of benefits by utilization review will be required prior to approval for CFC funding by DDS.

Additional items covered by CFC include:

1) Nutritional supplements;
2) Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.
3) Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under the state plan are exhausted.

Benefit limit (does not apply to bundled episode services): An individual's annual expenditure for specialized medical supplies cannot exceed $1000 per person per year.

Assistive Technology and Adaptive Equipment

Assistive technology is "any item, piece of equipment, or product system, hardware or software, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities" in accordance with assessed functional need and person-centered plan. It includes devices, controls and appliances that will enable participants to perceive, control or communicate with the environment in which they live and to perform daily life tasks that would not be possible otherwise. Assistive technology can be a product purchased off the shelf, modified, or commercially available which is used to help an individual perform some task of daily living. The term assistive technology encompasses a broad range of devices from "low tech" (e.g., pencil grips, splints, paper stabilizers) to "high tech" (e.g., computers, voice synthesizers, braille readers). These devices include the entire range of supportive tools and equipment from adapted spoons to wheelchairs and computer systems for environmental control.

This service includes all of the following possibilities, as specified at §441.520(b) (2):

- evaluation of the technology needs of the individual, including a functional evaluation in the individual's customary environment;
- purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for individuals with disabilities;
- selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing of assistive technology devices;
- coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- assistive technology training or technical assistance with assistive technology for an individual with a disability, or, where appropriate, the family of an individual with disabilities;
- training or technical assistance for professionals, employers, or other individuals who provide services to, employ, or otherwise are substantially involved in the major life functions of individuals with disabilities.

This service includes (a) evaluation of the individual's technology needs, (b) acquisition of the necessary technology, (c) coordination of technology use with other therapies and interventions, and (d) providing training for the individual, the individual's family, and the school staff in the effective use of the technology.

All requests must be prescribed by a physician.

Educational aids and therapeutic tools that therapists employ in the course of therapy are not included.

Monitoring/Surveillance/Video-Telecommunication Equipment: Electronic equipment needed to monitor medical or behavioral conditions when the need is documented by medical or behavioral professionals and such equipment will serve to lessen the need for hands on direct care staff. The system includes patented technology that identifies developing health problems and alerts for potential emergencies by detecting changes in key behaviors. It detects changes such as prolonged inactivity, extreme temperatures, and other activity and captures this to a web-based program that is monitored by around the clock emergency response operators.

This service includes the cost of installation, training individual(s) in equipment use and monthly fees charged by monitoring entities. Video communication equipment to allow

participant to communicate electronically with service providers, in lieu of face to face visits, can be approved to purchase and install equipment for the participant but in no way can be used to reimburse for any provider expenses in this regard.

Recognizing that electronic monitoring /video communication can be intrusive, it can be approved only with the consent of the participant/legal representative with a written, signed and witnessed agreement acknowledging that at any time the participant/legal representative so requests, the entire Monitoring/Surveillance System or any component thereof (cameras specifically) will be turned off.

Medication Monitoring Device: Stores dosages of medication and provides reminder to take the medicine. It also has a button to push which notifies the monitoring company that he/she has acknowledged taking the medication. If the person does not acknowledge, the medication will be rotated around into a locked area (to prevent taking meds too close to the next dosage time) and will call to notify somebody of the need to make contact with the participant. Service includes battery backup and notification when unit needs to be refilled.

Benefit limit (does not apply to bundled episode services): A beneficiary's annual expenditure for assistive technology and adaptive equipment cannot exceed $7,700 per person per year. If the beneficiary is also receiving environmental modification services and/or vehicle modification, the COMBINED total cannot exceed $7,700.

Home-Delivered Meals

Home-delivered meals are services that provide one (1) meal per day of nutritional content equal to one-third of the Recommended Daily Allowance. Provision of home-delivered meals reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner.
The goals of home-delivered meals are:

1. To facilitate participant independence by allowing participants the choice to remain in their own homes rather than entering an institution;
2. To provide one (1) daily nutritious meal to participants at risk of being institutionalized;
3. To provide a daily social contact to participants to insure the participant's safety and wellbeing.

Home-delivered meals under CFC are allowed for participants:

1. Who have an assessed need for meal preparation and shopping; and
2. For whom the provision of a home-delivered meal is the most cost-effective method of ensuring a nutritionally adequate meal.

Benefit limit (does not apply to bundled episode services): number of meals equal to the number of days in a month.

Goods and Services

Goods and Services allows the program participant, who has chosen participant directed model, to purchase those items and services that help the program participant receive assistance at times of the day that best meet his or her assessed needs and individual preferences. The service supports the purchase of goods and services that lessen the need for human assistance while increasing the participant's ability to maintain independence in the community.

Following is a list of possible uses of goods and services:

A. Prescription Medication Not Covered by Insurance, Medicaid or Medicare Part D
B. Non-prescription health and personal hygiene items
C. Safety Devices
D. Education/training
E. Other items and services that directly address assessed need of an individual and increase independence or reduce the need for human assistance

Benefit limit (does not apply to bundled episode services): none.

2. _X_ Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the individuals with intellectual disabilities to a community-based home setting where the individual resides.

Community Transition Services

Community Transition Services are non-recurring set-up expenses linked to an assessed need for participants who are transitioning from a nursing facility, institution for mental disease, or intermediate care facility for individuals with intellectual disabilities to a

home and community-based setting where the participant is directly responsible for his or her own living expenses. Funds can be accessed once it has been determined that Medicaid is the payer of last resort.

Allowable expenses are those necessary to enable a participant to establish a basic household that does not constitute room and board and may include:

(b) Security deposits that are required to obtain a lease on an apartment or home;
(c) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
(d) First month's rent;
(e) First month's utilities;
(f) Moving expenses;
(g) Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
(h) Services necessary for the participant's health and safety such as one-time cleaning prior to occupancy; and
(i) Necessary home accessibility adaptations;

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process clearly identified in the person-centered service plan and the participant is unable to meet such expense or when the services cannot be obtained from other sources. Duplication of Environmental Modifications will be prevented through DMS control of prior authorizations for approvals. Costs for Community Transition Services furnished to participants returning to the community from a Medicaid institutional setting, may be billable while in the institution as long as the individual is reasonably expected to return to the community and will be eligible for Medicaid in the community.

Exclusions: Community Transition Services may not include payment for room and board except for the first month's rent; monthly rental or mortgage expense; food, regular utility charges except for the first month's utilities; and/or household appliances or items that are intended for purely diversional or recreational purposes. Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a Medicaid provider where the provision of these items and services are inherent to the service they are already providing. Diversional or recreational items such as televisions, cable TV access or video players are not allowable.

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Benefit limit: maximum benefit is equal to $5,000 per transition from nursing home; lifetime maximum of $10,000. If Money Follows the Person (MFP) funding is available, the State must utilize MFP funds first.

iv. Use of Direct Cash Payments

A. _X_ The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves in accordance with 441.545(b)(2).

B. ___ The State elects not to disburse cash prospectively to CFCO participants.

v. Assurances

(A) The State assures that any individual meeting the eligibility criteria for CFCO will receive CFC services.

(B) The State assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFCO services.

(C) The State assures the provision of consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

(D) With respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

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(E) The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports.

(F) The State assures the collection and reporting of information, including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(G) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

(H) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws.

(I) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of consumers who are individuals with disabilities, elderly individuals and their representatives.

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The State assures:

(a) Necessary safeguards will be taken to protect the health and welfare of enrollees in Community First Choice, including adherence to section 1903(i) of the Act that Medicaid payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid Program.

(b) For the first full 12 month period in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under sections 1115, 1905(a), 1915, or otherwise under the Act, to individuals with disabilities or elderly individuals attributable to the preceding 12 month period.

(c) All applicable provisions of the Fair Labor Standards Act of 1938.

(d) All applicable provisions of Federal and State laws regarding the following:
(1) Withholding and payment of Federal and State income and payroll taxes.
(2) The provision of unemployment and workers compensation insurance.
(3) Maintenance of general liability insurance.
(4) Occupational health and safety.
(5) Any other employment or tax related requirements.

Data

The State will provide the following information regarding the provision of home and community-based attendant services and supports under Community First Choice for each Federal fiscal year for which the services and supports are provided:
(a) The number of individuals who are estimated to receive Community First Choice services and supports under this State plan option during the Federal fiscal year.
(b) The number of individuals who received the services and supports during the preceding Federal fiscal year.
(c) The number of individuals served broken down by type of disability, age, gender, education level, and employment status.
(d) The specific number of individuals who have been previously served under sections 1115, 1915(c) and (i) of the Act, or the personal care State plan option.
(e) Data regarding how the State provides Community First Choice and other home and community-based services.

(f) The cost of providing Community First Choice and other home and community- based services and supports.
(g) Data regarding how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to receive home and community- based services in lieu of institutional care.
(h) Data regarding the impact of Community First Choice services and supports on the physical and emotional health of individuals.
(i) Other data as determined by the Secretary.

Arkansas established a CFCO Development and Implementation Council in 2012, the majority of whom are individuals with disabilities, including age-related disabilities, and their representatives. The first meeting was held on November 20, 2012. The Department consults and collaborates with the Council on a regular basis to inform and elicit feedback regarding the services and supports provided to individuals receiving ACFC services.

An ACFC Website was developed to provide information on the Arkansas Community First Choice program and post updates on the progress of the program development. The website includes general information on ACFC, links to pertinent information, a calendar of the CFCO Development and Implementation Council meetings, and other relevant documents. The site also provided an email address to allow for public input.

vi. Assessment and Service Plan

Describe the assessment process or processes the state will use to obtain information concerning the individual's needs, strengths, preferences, goals and other factors relevant to the need for services:

Indicate who is responsible for completing the assessment prior to developing the Community First Choice individual-centered service plan.

Please provide the frequency the assessment of need will be conducted.

Describe the reassessment process the State will use when there is a change in the individual's needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed.

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A standardized assessment tool will be utilized to assess an individual's specific needs. A complete assessment will include an assessment of the individual's physical, mental, and social functioning, and will identify risk factors, individual choices, and preferences, and the status of the service needs. The tool allows for the identification of needs being met utilizing natural supports, state plan services and waiver services, thus allowing for a full and comprehensive assessment and service plan.

Individuals are actively involved in the assessment process and will have the opportunity to identify goals, strengths and needs. Individuals will be allowed to determine the individuals to participate in the assessment process.

The Division of Developmental Disabilities Services (DDS) assessment process will apply to individuals receiving services through the Developmental Disabilities Home and Community-Based Services (DD HCBS) 1915(c) waiver and any individuals with a developmental disability who requests ACFC services through the State Plan but are not participating in a 1915(c) waiver.

DDS will ensure that all individuals with a developmental disability who apply for ACFC services are assessed using a standardized assessment tool appropriate for the age of the applicant. The assessor may not be related by blood or marriage to the individual being assessed or to any paid caregiver of the individual, financially or legally responsible for the individual, empowered to make financial or health related decisions on behalf of the individual and may not benefit financially from the provision of assessed needs. The assessor may not have provided services to, or be employed by an entity who has provided services to the individual within the past twelve months.

DDS will ensure through its contractor that assessors possess Qualified Developmental Disabilities Professional (QDDP) qualifications as defined in 42 CFR §483.430, as follows:

a. At least one year of experience working directly with individuals with intellectual or physical disabilities; and

b. Is one of the following:
   - A doctor of medicine or osteopathy,
   - A registered nurse,
   - An individual who holds a bachelor's degree in a human services field including, but not limited to: sociology, special education, rehabilitation counseling, or psychology.

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The independent assessment will be used to determine a level of need for individuals, prospective episode amount, and inform the care planning process.

Independent assessments for the purposes of level of need and prospective episode amount determination will be conducted with the following frequency:

1. For adults age 18 and older
    a. Every three years
    b. Whenever an individual experiences a significant change in condition after their initial evaluation and prior to the date of their next regular assessment

2. For children ages 4 through 17 years of age
    a. Annually
    b. Whenever an individual experiences a significant change in condition after their initial evaluation and prior to the date of their next regular assessment

3. For children ages birth through 3 years of age
    a. Annually
    b. Whenever an individual experiences a significant change in condition after their initial evaluation and prior to the date of their next regular assessment
    c. Assessments will be performed by DDS registered nurses or licensed social workers

In additional to the independent standardized assessment, the individual's chosen provider will perform an annual assessment of functional status using a standardized assessment tools. Assessments conducted by the provider will not be used for resource allocation purposes. These assessments will be used to inform the development of the individual's service plan and will ensure the individual's needs are identified and addressed.

The Division of Aging and Adult Services (DAAS) functional assessment process will apply for individuals ages 65 and older or ages 21 and older with a physical disability requesting ACFC services.

The initial individual assessment of the participant is performed by the waiver DAAS RN utilizing the standardized assessment tool. Each DAAS RN is a licensed registered nurse, employed by the Department of Human Services, DAAS. Once the assessment is completed

by the DAAS RN, it is signed and dated by the DAAS RN and the participant, and forwarded to the Division of Medical Services (DMS), Office of Long Term Care (OLTC) for final determination of the participant's level of care and medical need. Medical need eligibility is valid for one year, unless specified otherwise by OLTC.

The process for the initial evaluation and re-evaluation of level of care and medical need eligibility for participants is the same.

Individual-Centered Service Plan Development Process: Describe the process that is used to develop the individual-centered service plan, including:

- Indicate how the service plan development process ensures that the individual-centered service plan addresses the individual's goals, needs (including health care needs), and preferences, by offering choices regarding the services and supports they receive and from whom.
- A description of the timing of the individual-centered service plan to assure the individual has access to services as quickly as possible, frequency of review, how and when it is updated, mechanisms to address changing circumstances and needs or at the request of the individual.
- A description of the strategies used for resolving conflict or disagreement within the process, including the conflict of interest standards for assessment of need and the individual-centered service plan development process that apply to all individuals and entities, public or private.

<u>The Individual Centered Service Plan Process:</u>

All individuals in a HCBS Waiver receiving ACFC services will receive case management services through the HCBS Waiver. The individual centered service plan development process and CMS assurances will be guided by Appendix D, Participant-Centered Planning and Service Delivery, of the HCBS Waiver.

For those eligible individuals who choose not to enroll in a HCBS Waiver program, the individual centered service plan development process will be available through the State Plan targeted case management process. Arkansas is in the process of developing a Health Home program for individuals. Once the Health Home SPA is approved and implemented (estimated implementation date is July 1, 2014), the individual centered service plan

development process will be provided under Health Home Section 2703 authority for those who are not enrolled in a HCBS Waiver.

vii. Home and Community-based Settings

CFC Services will be provided in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities.

Please specify the settings CFC services will be provided.

The home and community-based settings for ACFC services meet the home and community-based criteria in 441.530 which do not include a hospital, a nursing facility, an institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities.

viii. Qualifications of Providers of CFCO Services

Providers must meet population specific requirements through appropriate Certifying Agency in order to provide services to CFCO eligible individuals. DAAS: adults 21-64 years of age with physical disabilities, adults 65 years of age and older with physical or age-related disabilities. DDS: individuals of all ages with Intellectual/Developmental Disabilities, children with physical disabilities.

Attendant Services and Supports, Chore Services
DAAS:

1. Licensed Home Health Agency: Provider must be licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency, as cited in Arkansas Code Annotated section 20-10-809; and Certified by the Division of Aging and Adult Services or Division of Developmental Disabilities Services to provide attendant care services OR Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency as required by Ark. Code Ann. 20-10-807, History: Acts 1987, No. 956, 4; and must be certified by the Division of Aging and Adult Services or Division of Developmental Disabilities Services to provide attendant care services.
2. Licensed Private Care Agency - Medicaid Personal Care: Licensed by the Arkansas Department of Health as a private care agency enrolled as an Arkansas Medicaid

Personal Care Provider, as cited in Act 2273 of 2005; and must be certified by the Division of Aging and Adult Services or Division of Developmental Disabilities Services to provide attendant care services OR Licensed by the Arkansas Department of Health as a Private Care Agency - Medicaid Personal Care as was first required in Act 1537 of 1999, Sect. 133; Act 17 of 2003, first extraordinary session; and Act 2273 of 2005; and must be certified by the Division of Aging and Adult Services or Division of Developmental Disabilities Services to provide attendant care services.

3. Licensed Adult Day Care (at the Adult Day Care center only): Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et seq.
4. Licensed Adult Day Health Care (at the Adult Day Health Care center only): Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.
5. Certified Adult Family Home: Certified by the Arkansas Department of Human Services, Division of Aging and Adult Services or Division of Developmental Disabilities Services as a provider of Adult Family Home services.

DDS:

1. Certified CFC Provider of Attendant Services and Supports: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Attendant Services and Supports.
2. Licensed Provider of Center-Based Community Services: Licensed as a provider of Center-Based Community Cervices by the Arkansas Department of Human Services, Division of Developmental Disabilities Services (DDS).

Supportive Living Services

DAAS:

6. Licensed Home Health Agency: Provider must be licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency, as cited in Arkansas Code Annotated section 20-10-809; and Certified by the Division of Aging and Adult Services or Division of Developmental Disabilities Services to provide attendant care services OR

Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency as required by Ark. Code Ann. 20-10-807, History: Acts 1987, No. 956, 4; and must be certified by the Division of Aging and Adult Services or Division of Developmental Disabilities Services to provide attendant care services.

7. Licensed Private Care Agency - Medicaid Personal Care: Licensed by the Arkansas Department of Health as a private care agency enrolled as an Arkansas Medicaid Personal Care Provider, as cited in Act 2273 of 2005; and must be certified by the Division of Aging and Adult Services or Division of Developmental Disabilities Services to provide attendant care services OR Licensed by the Arkansas Department of Health as a Private Care Agency - Medicaid Personal Care as was first required in Act 1537 of 1999, Sect. 133; Act 17 of 2003, first extraordinary session; and Act 2273 of 2005; and must be certified by the Division of Aging and Adult Services or Division of Developmental Disabilities Services to provide attendant care services.
8. Licensed Adult Day Care (at the Adult Day Care center only): Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et seq.
9. Licensed Adult Day Health Care (at the Adult Day Health Care center only): Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.
10. Certified Adult Family Home: Certified by the Arkansas Department of Human Services, Division of Aging and Adult Services or Division of Developmental Disabilities Services as a provider of Adult Family Home services.

DDS:

3. Certified CFC Provider of Attendant Services and Supports: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Attendant Services and Supports.
4. Licensed Provider of Center-Based Community Services: Licensed as a provider of Center-Based Community Cervices by the Arkansas Department of Human Services, Division of Developmental Disabilities Services (DDS).

Personal Emergency Response System (PERS)

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DAAS:

1. Alarm or Security Company: Provider must possess Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards; and be certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Personal Emergency Response System services.

DDS:

1. Certified CFC Provider of Assistive Technology and Adaptive Equipment Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Assistive Technology and Adaptive Equipment Services.

Relief Care Services

DAAS:

1. Certified Adult Family Home: Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an Adult Family Home.
2. Licensed Residential Care Facility: Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a Residential Care Facility as required by Ark. Code Ann. 20-10-201, et. seq.; and certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Relief Care services.
3. Licensed Adult Day Care Agency: Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as an Adult Day Care agency as required by Ark. Code Ann. 20-10-201, et. seq.; and certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Relief Care services.
4. Licensed Adult Day Health Care Agency: Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.; and certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Relief Care services.

5. Licensed Level I and II Assisted Living Facility: Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a Level II Assisted Living Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001; and certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Relief Care services.
6. Licensed Class A or Class B Home Health Agency: Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency as required by Ark. Code Ann. 20-10-807, History: Acts 1987, No. 956, 4; and certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Relief Care services.
7. Licensed Medicaid Certified Nursing Facility: Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a Medicaid Certified Nursing Facility as required by Ark. Code Ann. 20-10-201, et seq and Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Relief Care services.
8. Licensed Hospital: Licensed Acute Care Hospital and certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Relief Care services.

DDS:

1. Certified CFC Provider of Relief Care Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Relief Care Services

Consultation Services, Crisis Intervention
DAAS:

1. Licensed Home Health Agency: Provider must be licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency, as cited in Arkansas Code Annotated section 20-10-809; and Certified by the Division of Aging and Adult Services to provide attendant care services.
2. Attendant Care Providers: Provider must be certified by the Arkansas Department of Human Services, Division of Aging & Adult Services to provide attendant care services.
3. Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider: Licensed by the Arkansas Department of Health as a private care agency enrolled as an

Arkansas Medicaid Personal Care Provider, as cited in Act 2273 of 2005; and must be certified by the Division of Aging & Adult Services to provide attendant care services.

4. Licensed Home Health Agency: Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency as required by Ark. Code Ann. 20-10-807, History: Acts 1987, No. 956, 4; and must be certified by the Division of Aging & Adult Services to provide attendant care services.
5. Licensed Private Care Agency - Medicaid Personal Care: Licensed by the Arkansas Department of Health as a Private Care Agency - Medicaid Personal Care as was first required in Act 1537 of 1999, Sect. 133; Act 17 of 2003, first extraordinary session; and Act 2273 of 2005; and must be certified by the Division of Aging & Adult Services to provide attendant care services.
6. Licensed Adult Day Care: Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et seq.
7. Licensed Adult Day Health Care: Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.
8. Certified Adult Family Home: Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Adult Family Home services.

DDS:

1. Certified CFC Provider of Consultation Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Consultation Services.

Positive Behavioral Support Services

DAAS:

1. Provider of Positive Behavioral Support Services: Certified by the Arkansas Department of Human Services, Division of Aging and Adult Services as a provider of Positive Behavioral Support Services.

DDS:

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1. Certified CFC Provider of Positive Behavioral Support Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Positive Behavioral Support Services.

Counseling Support - Contracted service
Financial Management Services - Contracted service
Community Transition Services

DAAS:

1. Certified CFC Provider of Community Transition Services: Certified by the Arkansas Department of Human Services, Division of Aging and Adult Services as a CFC Provider of Community Transition Services.

DDS:

1. Certified CFC Provider of Community Transition Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Community Transition Services.

Non-Medical Transportation

DDS/DAAS:
All Providers of Community Transition Services Attendant Services and Supports, Supportive Living, Relief Care Services, Licensed Developmental Day Treatment clinic, Consultation Services/Crisis Intervention services. Non-medical transportation can be provided by any providers of Attendant Services and Supports, Supportive Living, Relief Care Services, Licensed Developmental Day Treatment clinic, Consultation, and Positive Behavioral Supports Services who meet transportation standards.

Environmental Modifications

DAAS:

1. Builder, Tradesman or Contractor: Be licensed (where applicable) as appropriate for the environmental accessibility adaptation/adaptive equipment provider; and certified by the Division of Aging & Adult Services as a provider of environmental accessibility adaptations/adaptive equipment. Proof of a plumber or electrician's license must be provided prior to performing this type of work.

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DDS:

1. Certified CFC Provider of Environmental Modifications Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Environmental Modifications Services.

Vehicle Modifications

DAAS:

1. Builder, Tradesman or Contractor: Be licensed (where applicable) as appropriate for the environmental accessibility adaptation/adaptive equipment provider; and certified by the Division of Aging & Adult Services as a provider of environmental accessibility adaptations/adaptive equipment. Proof of a plumber or electrician's license must be provided prior to performing this type of work.

DDS:

1. Certified CFC Provider of Environmental Modifications Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Environmental Modifications Services.

Specialized Medical Supplies

DAAS:

1. Durable medical equipment/oxygen, orthotic appliances or prosthetic device provider. Providers must meet qualifications as defined in Section II of Prosthetics Provider Manual, 201.000. Durable Medical Equipment, Prosthetics, Orthotics and Medical Suppliers must be enrolled in the Title XVII (Medicare) Program as a durable medical equipment/oxygen, orthotic appliances or prosthetic device provider.

DDS:

1. Certified CFC Provider of Specialized Medical Supplies Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of Specialized Medical Supplies Services.

Assistive Technology and Adaptive Equipment

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DAAS:

1. Builder, Tradesman or Contractor: Be licensed (where applicable) as appropriate for the environmental accessibility adaptation/adaptive equipment provided; and certified by the Division of Aging & Adult Services as a provider of environmental accessibility adaptations/adaptive equipment. Proof of a plumber or electrician's license must be provided prior to performing this type of work.

DDS:

1. Certified CFC Provider of Assistive Technology and Adaptive Equipment Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC Provider of CFC Provider of Assistive Technology/Adaptive Equipment Services.

Home-Delivered Meals

DAAS:

1. Provider of Food Services: Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as a provider of Home Delivered Meals.

DDS:

1. Provider of Food Services: Certified by the Arkansas Department of Human Services, Division of Developmental Disability Services as a CFC provider of Home Delivered Meals.

Goods and Services
Participant directed service

Organized Health Care Delivery System (OHCDS)

Arkansas DHS has established the Organized Health Care Delivery System (OHCDS) option as per 42 CFR447.10 (b) for Arkansas Community First Choice Program providers. Providers agree in writing to guarantee that the services of an OHCDS subcontractor will comply with Medicaid regulations. The OHCDS provider assumes all liability for contract non-compliance. The OHCDS provider must provide at least one Arkansas CFC service directly utilizing its own

employees in order to be eligible to utilize OHCDS to contract for services. The OHCDS provider must also have a written contract that specifies the services and assures that work will be completed in a timely manner and be satisfactory to the person served. OHCDS is optional. When OHCDS is used, the enrolled provider is required to have a duly executed sub-contract in place and must review and assure financial accountability. The provider must ensure that services were delivered and proper documentation was submitted for services delivered under OHCDS.

ix. Quality Assurance and Improvement Plan

Provide a description of the State's Community First Choice quality assurance system. Please include the following information:

- How the State will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement;

- The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

- Describe how the State's quality assurance system will measure individual outcomes associated with the receipt of community-based attendant services and supports.

- Describe the system(s) for mandatory reporting, investigation and resolution of allegations of neglect, abuse, and exploitation in connection with the provision of CFC services and supports.

- Describe the State's standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's individual-centered service plan.

- Describe the quality assurance system's methods that maximize consumer independence and control and provide information about the provisions of quality improvement and assurance to each individual receiving such

services and supports.

- Describe how the State will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit.

- The methods used to continuously monitor the health and welfare of Community First Choice individuals

- The methods for assuring that individuals are given a choice between institutional and community-based services.

ACFC services will be evaluated utilizing performance measures, outcome measures developed in coordination with stakeholders, and satisfaction measures.

Arkansas will utilize a Quality Improvement Strategy (QIS) that supports key quality strategies and addresses areas of concern.

DDS evaluates provider compliance through an annual on-site review by the DDS Quality Assurance Certification and Licensure Unit. The Unit reviews 100% of providers to verify compliance with DDS Standards and Medicaid policies. Staff selects a sample of people served and evaluates compliance through record review, interview, and observation. The Quality Assurance Unit cites deficiencies and issues formal findings in a report to the provider agency in accordance with DDS Standards and Medicaid policies.

The DMS QA Unit reviews the actions of the operating agencies and issues transmittals to the operating agency identifying deficiencies in practice, according to the approved service description and performance measures. The operating agency must submit a plan of correction to the DMS Quality Assurance Unit that addresses any issues found in the Quality Assurance Unit report. The operating agency must remediate any problems noted. DMS submits an Evidence Report to CMS on behalf of the operating agency and works with the operating agency to develop measurable discovery and remediation measures. DMS QA Unit uses file reviews, onsite reviews, and interviews with individuals receiving services to verify compliance.

The DMS QA Unit and the operating agencies meet quarterly to discuss findings, remediation and corrective action plans.

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Arkansas is administering adult consumer surveys developed by the National Core Indicator Project, a collaboration of participating states, HSRI and NASDDS to obtain information from eligible individuals about their perspectives about Developmental Disabilities services.

Arkansas' quality assurances are based on seven broad, participant-centered desired outcomes for delivery of home and community-based services including assuring participant health and welfare:

A. Participant Access: Individuals have access to home and community-based services and supports in their communities.
B. Participant-Centered Service Planning and Delivery: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning the individual's life in the community.
C. Provider Capacity and Capabilities: There are sufficient ACFC providers and they possess and demonstrate the capability to effectively serve participants
D. Participant Safeguards: Participants are safe and secure in their home and communities, taking into account their informed and expressed choices.
E. Participant Rights and Responsibilities: Participants receive support to exercise their rights and in accepting individual responsibilities.
F. Participant Outcomes and Satisfaction: Participants are satisfied with their services and achieve desired outcomes.
G. System Performance: The system supports participants efficiently and effectively and constantly strives to improve quality.

Additional system performance measures, outcome measures and satisfaction measures include the following:

A. The number and percentage of ACFC applicants who had a LOC evaluation indicating need for institutional level of care prior to receiving ACFC services. Numerator = Number of ACFC applicants who have a completed institutional level of care assessment prior to receiving ACFC services. Denominator = Number of records reviewed.
B. The number and percentage of ACFC participants who receive the required annual redetermination of institutional LOC eligibility within 12 months of their

initial institutional LOC evaluation, or within 12 months of their last annual LOC reevaluation. Numerator: All ACFC participants with a LOC redetermination completed prior to 12 months from their initial determination or last redetermination. Denominator: Number of records reviewed.

C. The number and percentage of LOC assessments completed by a qualified evaluator using the appropriate processes and instruments and according to the approved description. Numerator: LOC assessments completed by a qualified evaluator using the appropriate processes and instruments according to the approved description. Denominator: Number of records reviewed.
D. The number and percentage of providers, by provider type, which obtained the appropriate license/certification in accordance with state law and ACFC provider qualifications prior to delivering services. Numerator: Providers that prior to providing ACFC services initially met and continue to meet state law and ACFC provider qualification requirements. Denominator: Number of records reviewed.
E. The number and percentage of providers meeting state and ACFC provider training requirements. - Numerator: Providers that are trained per state law and the approved ACFC. - Denominator: Number of records reviewed.
F. The number and percentage of ACFC participants reviewed who had a service plan (plan of care) that was adequate and appropriate to their needs as indicated by the assessment. Numerator: Number of participants with service plans that address needs. Denominator: Number of records reviewed.
G. The number and percentage of ACFC participants reviewed who had service plans that addressed individual goals and risk factors. Numerator: Number of ACFC service plans that address individual goals and risk factors. Denominator: Number of records reviewed.
H. The number and percentage of service plans that were reviewed and revised as warranted on or before the ACFC participant's annual review date. Numerator: Number of ACFC participant's service plans that were reviewed/revised on or before the annual review date. Denominator: Number of records reviewed.
I. The number and percentage of ACFC participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan. Numerator: Number of ACFC participants' who received services specified in accordance with the service plan. Denominator: Number of records reviewed.
J. The number and percentage of ACFC participants' records reviewed where the participant or family member or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents. Numerator:

Number of ACFC participants receiving information on how to report abuse, neglect, exploitation and other critical incidents. Denominator: Number of records reviewed.

K. The number and percentage of critical incident reviews and investigations that were initiated and completed according to policy and state law. Numerator: Number of critical incident investigations completed according to policy and state law. Denominator: Number of records reviewed.
L. The number and percentage of ACFC claims that were paid using the correct rate. Numerator: Number of claims paid at the correct rate. Denominator: Number of records reviewed.

Arkansas assures that individuals are given a choice between institutional and home and community-based services. The individuals are informed of feasible alternatives for home and community-based services and given a choice as to which type of service they choose to receive. When an individual is determined to require the level of care provided in an institution, the individual or his or her representative will be:

1. Informed of any feasible alternatives available under ACFC or the applicable HCBS Waiver, and
2. Given the choice of either institutional or home and community-based services. The choice of institutional or home and community-based services is documented on each eligible individual's record.

When an individual is determined to require the level of care provided in an institution, Arkansas will give each individual or his or her representative a choice between institutional and home and community-based services. Each individual or representative will also be informed about feasible alternatives for home and community-based services and given a choice as to which type of service they choose to receive. The choices given to an individual or representative regarding institutional or home and community-based services, reasonable alternatives and types of services will be documented in each eligible individual's record.

Payment Methodology

Payment for ACFC services will remain at the current fee-for-service rates pending implementation of the episode-based payment approach.

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Arkansas Episode Based Payment Overview

Arkansas is transforming its fragmented and encounter-based care delivery system into a coordinated, individual-centered, cost-effective care delivery system that coordinates individuals' health and support needs across providers and over time. The primary goals of this transformation are to (1) improve the health of the population; (2) enhance the individual's experience in the areas of quality, access, and reliability; and (3) to reduce, or at least control, the cost of healthcare. To achieve these aims, Arkansas is shifting from fee-for-service payment mechanisms that lead to fragmented care and overutilization to a value-based payment model that rewards effective care coordination and superior outcomes with respect to both quality and cost containment.

There are two approaches for episode-based payment: retrospective episode-based payment (REBP) and assessment-based episode payment. Details can be found in the State Healthcare Innovation Plan. Assessment-based episodes will form the basis of payment for ACFC services. The methodology for assessment-based payment under ACFC is outlined below.

ACFC Payment Methodology

Assessment-based payment will be used for ACFC. The cornerstone of the ACFC payment methodology will be the use of standardized assessment tools that determines an individual's level of need, a prospective budget amount, and informs the individual-centered care planning process. Budget amounts will be determined through analysis of costs for individuals at each level of need.

Provider reimbursement for services provided to eligible ACFC participants will be delivered in uniform, periodic installments (e.g. weekly, monthly) based on the prospectively determined budget amount for each individual. In order to measure the quantity and quality of services, disbursement of periodic payments will be contingent on submission of encounter data that will enable verification of receipt of services. An exception process will be in place to reimburse providers for large, one-time services (e.g. home modifications).

The assessment tools that will be employed are based on the principles of "case-mix" that have been used extensively to match payment levels to level of need in diverse settings including hospitals, nursing homes, home care, and inpatient psychiatric care. These tools have been developed and extensively tested through resource utilization studies that establish correlations between *actual* resource requirements and assessment criteria. This methodology for

determining payment levels based on levels of need is the industry standard in institutional LTSS, and has also been employed in home care settings.

The majority of individuals that will be enrolled in ACFC currently receive home and community based services through 1915(c) waivers. Based on the fact that most waiver services are being transitioned to ACFC without changes, on the effective date (October 1, 2014) Arkansas Medicaid will consider existing individual Plans of Care (POC) valid under ACFC and will initiate reimbursement for those services under approved ACFC State Plan. As each individual POC comes up for annual renewal under the waiver, each POC will be revised to reflect the services that have been transitioned to ACFC as non-waiver services utilizing the ACFC guidelines and the assessment-based episode payment methodology. At that point individuals receiving services will receive information regarding any new options available under ACFC and will be given an option to request a Fair Hearing if they feel aggrieved by a decision they consider adverse. This will assure seamless and transparent transition of services to the ACFC program.

EXHIBIT C

The Committee would like a written explanation of the procedure difference between a Medicaid Waiver and a State Plan Amendment as far as Mandates? Obligations of the state? Match requirements? Terms and Conditions? FMAP? Administrative Costs?

1915(c) HCBS Waiver	CFC State Plan Amendment {1915(k)}
Institutional Level of Care Requirement	Institutional Level of Care Requirement
Medicaid Financial Eligibility Criteria	Medicaid Financial Eligibility Criteria
Allows state to offer waiver services that are not provided to other Medicaid beneficiaries	Services must be available to all eligible Medicaid beneficiaries
Permits the state to limit to specific geographic areas of the state	Must be provided statewide
Allowed to cap the number served	No cap on the number served
Allows state to apply institutional income and resources	Available to individuals eligible for medical assistance under the Arkansas State Plan and are in an eligibility group that includes nursing facility services or are below 150% of federal poverty level if they are not in an eligibility group that includes nursing facility services.
Annual beneficiary functional reassessment requirement	Annual beneficiary functional reassessment requirement
Requires a person-centered service plan based on assessment	Requires a person-centered service plan based on assessment
Allows beneficiary to self-direct services	Allows beneficiary to self-direct services
Requires Quality Assurance plan	Requires Quality Assurance plan
HCBS Settings rule compliance requirement	HCBS Settings rule compliance requirement
Must be submitted to CMS for renewal every 5-years	No expiration date
Regular State FMAP	Regular State FMAP plus a 6% enhanced match
Match rate for Administrative costs 50/50	Match rate for Administrative costs 50/50

The Committee would like to get a copy of the Waiver Request that DHS sent to CMS on CFCO.

Attached – CFCO SPA submitted to CMS

The new 1915(c) HCBS Waivers have not been submitted to CMS.

EXHIBIT D

House & Senate Health Services Subcommittees
August 28, 2014

DHS stated there will be no increase in nursing staff and no increase in administrative costs. If this program is approved before session, it will come back for review by the legislature in November 2014 and implemented around the first of 2015. If it is not approved until after session, it will not be implemented until approximately October 2015. Public comment will be in October 2014.

INFORMATION REQUESTS FROM LEGISLATORS

Senator John Cooper
Question:

- The identification number of each of the three Medicaid CFCO Waivers

Response:

- Alternatives For Persons with Disabilities (APD) 1915(c) Waiver – AR 0312
- ElderChoices 1915(c) Waiver – AR 0195
- DDS Alternative Community Services (DDS ACS) 1915(c) Waiver – AR 0188

Question:

- A comparison of results between states that signed up for this program and the states that did not sign up (and the reasons some states did not sign up for the CFCO program).

Response:

- We have looked at the actions of other states. 3 states; California, Oregon, and Maryland have CFCO State Plan Amendments approved by the Centers for Medicare and Medicaid. 4 others; Minnesota, Montana, Texas, and Wisconsin have formally indicated that they intend to begin implementation in 2014. As CFCO is relatively new, comparative results are not yet available. States do not generally identify why they did or did not pursue program options. However, many do not have conditions (such as a high federal match rate and integrated program divisions) that are as favorable as those in Arkansas.

Representative Josh Miller
Question:

- In the last 5-10 years, how many of the people that were on the waiting list and did not receive services were finally admitted to a care facility.

Response:

- 92 currently on the waiting list have accessed facility based care in the previous 5 years.

Senator Jonathan Dismang
Question: Historical trend of the 2800 people who are currently on the waiting list.

Response:

- 2007: 148

- 2008: 570
- 2009: 1133
- 2010: 1607
- 2011: 1907
- 2012: 2243
- 2013: 2670
- 2014: 2975

Question: The services currently being provided to seniors and DDS clients in detail.

Response:

DAAS Services

ElderChoices waiver services include:

- Adult Day Health Care - provides a continuing, organized program of rehabilitative, therapeutic and supportive health and social services and activities to participants who are functionally impaired and who, due to the severity of their functional impairments, are not capable of fully independent living

- Homemaker Services - consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home

- Respite - services provided to waiver participants unable to care for themselves that are furnished on a short-term basis (8 hours or less per date of service) or long-term basis (a full 24 hours per date of service) because of the absence or need for relief of those persons who normally provide care for the participant

- Adult companion -non-medical care, supervision and socialization services provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.

- Adult day care - services provided in a group program designed to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than twenty-four (24) hours, but more than two (2) hours per day in a place other than the adult's own home.

- Adult Family Home - personal care, homemaker, chore, attendant care, companion, and transportation services to allow the waiver participant access to the community, and medication oversight (to the extent permitted under State law) provided in a certified private home by a

principal care provider who lives in the home. The Adult Family Home provider is responsible for meeting the needs, as described by the waiver service, 24 hours a day, seven days a week. Adult Family Home services shall be included in the service plan only when it is necessary to prevent the permanent institutionalization of a participant as determined by the DAAS RN.

- Chore Services - services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; and/or yard and sidewalk maintenance. Chore services are provided only in extreme circumstances when lack of these services would make the home uninhabitable. Yard and sidewalk maintenance does not include routine lawn mowing, trimming, raking or mulching leaves for aesthetic purposes.

- Home-delivered Meals - services that provide one (1) meal per day of nutritional content equal to one-third of the Recommended Daily Allowance. This service is designed for participants who are unable to prepare meals, and who lack an informal provider to do meal preparation. Provision of home-delivered meals reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner.

- Personal emergency response system (PERS) - an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. The system includes an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. PERS enables an elderly, infirm or homebound participant to secure immediate help in the event of physical, emotional or environmental emergency.

Alternatives for Adults with Physical Disabilities (AAPD) waiver serves individuals ages 21 – 64 and includes the following services:

- Attendant care services - assistance to an individual, who is medically stable with a physical disability, in accomplishing tasks of daily living that the individual is unable to complete independently. Assistance may vary from actually doing a task for the individual, assisting the individual to perform the task or providing safety support while the individual performs the task.

  Attendant care services may also include, housekeeping activities not to exceed 20% of the attendant's overall time worked as authorized on the waiver service plan as well as supervision, companion services, socialization, and transportation assistance when it is incidental to providing attendant care services, accompanying a participant to assist with shopping, errands, etc.

- Counseling Support Management (CSM) - routinely monitoring participants needs and circumstances by maintaining regular contact, either face-to-face or telephone, with

participants, and reporting the participant's status and any changes in a participant's condition, needs or circumstances to the DAAS RN/counselor immediately. CSMs refer waiver participants to resources to assist in meeting their needs; schedule appointments related to gaining access to medical, social, educational and other services appropriate to the participant's needs; and, refer waiver participants for community resources, such as energy assistance, legal assistance or emergency housing. CSMs explain AAPD program policy and monitor compliance, and assist participants in obtaining bids for environmental accessibility adaptations/adaptive equipment if the participant needs this service.

- Environmental Accessibility Adaptations/Adaptive Equipment - physical adaptations to the home that are required by the Alternatives participant's service plan that are necessary to ensure the health, welfare and safety of the participant to function with greater independence in the home and postpone or preclude institutionalization. Adaptive equipment also enables the Alternatives participant to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise, and perceive, control or communicate with the environment in which he or she lives.

Basic Living Choices Assisted Living direct care services are:

- Attendant care services
- Therapeutic social and recreational activities
- Periodic nursing evaluations
- Limited nursing services
- 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
- Medication oversight to the extent permitted under Arkansas law
- Assistance obtaining non-medical transportation specified in the plan of care

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

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

Arkansas State Plan Personal Care - Personal care services are primarily based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Hands-on assistance in at least one of these areas is required. This type of assistance is provided by a personal care aide based on a beneficiary's physical dependency needs (as opposed to purely housekeeping services).

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

DDS Services

- Supportive Living - Supportive living is an array of individually tailored services and activities provided to enable eligible beneficiaries to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include apartments, homes of primary caregivers, leased or rented homes, or provider group homes. Supportive living services may also be provided in clinic and integrated community settings. The services are designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in the home and community based setting

- Respite - Respite services are provided on a short-term basis to beneficiaries unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers.

- Supported Employment - Supported employment services consist of intensive, ongoing supports that enable beneficiaries for whom competitive employment at or above the minimum wage is unlikely or who, because of their disabilities, need intensive ongoing support to perform in a competitive work setting.

- Adaptive Equipment - The adaptive equipment service includes an item or a piece of equipment that is used to increase, maintain or improve functional capabilities of individuals to perform daily life tasks that would not be possible otherwise.

- Environmental Modifications - Environmental modifications are made to or at the waiver beneficiary's home, required by the person centered service plan and are necessary to ensure the health, welfare and safety of the beneficiary or that enable the beneficiary to function with greater independence and without which the beneficiary would require institutionalization

- Specialized Medical Equipment - Specialized medical equipment and supplies include:
  A. Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary for the proper functioning of such items.

B. Durable and non-durable medical equipment not available under the Arkansas Medicaid State Plan that is necessary to address beneficiary functional limitations.

C. Necessary medical supplies not available under the Arkansas Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation.

D. A physician must order or document the need for all specialized medical supplies.

- Supplemental Supports - The supplemental support service helps improve or enable the continuance of community living. This service is only available in response to crisis, emergency or life threatening situations.

- Case Management - Case management services assist beneficiaries in gaining access to needed waiver services and other Arkansas Medicaid State Plan services, as well as medical, social, educational and other generic services, regardless of the funding source to which access is available.

- Consultation - Consultation services are clinical and therapeutic services which assist waiver beneficiaries, parents, guardians, legally responsible individuals, and service providers in carrying out the beneficiary's person centered service plan.

- Crisis Intervention - Crisis intervention services are defined as services delivered in the beneficiary's place of residence or other local community site by a mobile intervention team or professional.

- Community Transition Services - Community transition services are non-recurring set-up expenses for beneficiaries who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Question: What are the federal mandates of State Plan Amendments?

Response: States must assure that the State Plan will be administered in conformity with the specific requirements of Title XIX and other applicable issuances of the Department of Health and Human Services. Within the broad Federal rules each State decides eligible groups, types and range of services, payment levels for services and administrative and operating procedures.

The following federal requirements apply to most State Plan Amendments:

- Statewide Applicability: The changes must apply to Medicaid enrollees throughout the state and not just in certain areas

- Comparability: Comparable services must be available to all people eligible for Medicaid, regardless of their eligibility category. This prevents states from changing services for just one group of Medicaid enrollees.
- Choice of Providers: Medicaid enrollees must be free to choose among health care providers
- Income and resources rules

Question: During the last budget session there was a request for additional employees for the CFCO program, what happened to this request, why did this request fade away and how big was the request?

Response: The request was for social work staff to be designated for conflict free case management, and not CFCO. Case management/care coordination is not a CFCO service. Though we did not get those requested positions, we did request and receive funding for 4 RNs and 1 RN Supervisor. These positions were not in any way related to CFCO. These positions were needed to replace a previous contract whereby contract labor conducted the assessments/reassessments in several counties. In essence, these positions conduct the assessments which are used to determine medical eligibility for our HCBS Waiver programs.

Senator Missy Irvin

Question: What were the previous legislative solutions to this waiting list and why were these solutions not pursued?

Response:

- 2007: DHS requested and received additional revenue to expand the DDS Waiver by 240 slots.
- 2009: An Intermediate Care Facility provider fee was enacted by the legislature that provided revenue enough to fund an additional 150 slots.
- 2009: DHS requested funding for 600 additional waiver slots in the 2010-11 biennial budget
- 2010: An additional 95 slots were created for residents transitioning from the Alexander Human Development Center and the Arkansas State Hospital.
- 2011: A funds transfer from the DHS Division of Children and Family Services (DCFS) created an additional 60 slots for foster children.
- 2013: A funds transfer from DCFS created an additional 40 slots for foster children.

Question: A detailed list of the persons on this waiting list and the services they are currently receiving.

Response:

- 2975 on the waiver waiting list as of 8/1/14
- 1471 of those waiting are under age 18
- 1503 of those waiting are adults
- 530 of the adults on waiting list are receiving Developmental Day Treatment Clinic Services (DDTCS)
- 77 of the children on waiting list are receiving DDTCS Preschool Services
- 12 of the children received Special Needs funding for services such as adaptive equipment, etc.
- 42 of the children received Title V respite services in the past year.
- 8 children received Integrated Support Services such as supported living, community integration activities, etc.

Question: What portion is being spent inside of and outside of the school system for the services to these clients?

Response: This information is not currently available.

Question: What safeguards are in place for the clients who receive in home care, from abusive relatives, caregivers, etc.?

Response: Safeguards against abusive caregivers are embedded throughout the Department's programming policies, procedures and appropriate governing laws/statutes. The Adult Protective Services ("APS") Unit housed within the Division of Aging and Adult Services ("DAAS") is charged with the authority to investigate cases of suspected adult maltreatment of endangered or impaired persons over the age of eighteen in the State of Arkansas. This includes persons residing in long-term care facilities or those receiving Home and Community Based Services in their homes. APS' mandate includes physical and verbal abuse, neglect, self-neglect and financial exploitation. Beyond just its mandate to investigate maltreatment, APS also has the authority to remove endangered or impaired persons from a situation if the investigation reveals that the person is in imminent danger of harm. APS maintains a state-wide toll-free hotline number to ensure that allegations of maltreatment are promptly received and investigated. APS currently employs 58 individuals with a budget of ~$3.5 million.

More information about APS and its services can be found at: http://www.aradultprotection.com/

In addition to the protections provided by APS, the Office of Medicaid Inspector General ("OMIG") is tasked with preventing, detecting, and investigating fraud, waste and abuse in the Arkansas Medicaid program and recovering improperly paid Medicaid funds. OMIG has the power to investigate Medicaid providers, including those providing in-home services, to ensure that services being billed to the Medicaid program are actually being provided. More information about OMIG and the ability to file an online complaint can be reviewed at: http://omig.arkansas.gov/

Any provider who suspects abuse or maltreatment is required by law to report allegations for investigation to Adult Protective Services. Specific covered professions are identified in Arkansas Code 12-12-708. A.C.A. 12-12-1708(a) specifies mandatory reporters who are required to report suspected adult maltreatment, including abuse, exploitation, neglect, or self-neglect of endangered or impaired adults. Mandated reporters include all physicians, nurses, social workers, case managers, home health workers, DHS employees, facility administrators or owners, employees of facilities, and any employee or volunteer of a program or organization funded partially or wholly by DHS who enters the home of, or has contact with an elderly person. HCBS staff, providers, and DAAS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment. "Whenever any of the following persons has observed or has reasonable cause to suspect that an endangered person or an impaired person has been subjected to conditions or circumstances that constitute adult maltreatment or long-term care facility resident maltreatment, the person shall immediately report or cause a report to be made in accordance with the provisions of this section:"

The Department engages in multiple levels of administrative auditing activities (quality assurance) which are designed to identify questionable activities that are then referred for investigations and appropriate action(s) depending on findings.

DDS: Home and Community Based Services for people with developmental disabilities are monitored and regulated by the Division of Developmental Disabilities (DDS). There are extensive standards and policies in place that require service providers to conduct themselves in a manner that is in the best interest of the service recipient. These standards and policies are available for review at: http://humanservices.arkansas.gov/ddds/Pages/WaiverServiceProviders.aspx

DAAS:
Clients aged 60 + participating in Medicaid funded HCBS services are offered Targeted Case management, which in part provide the monitoring and oversight to include client safeguards are ensured. Clients over age 18 enrolled in self-direction HCBS services receive Counseling Support Services or Targeted Case Management, which provide the monitoring and oversight.

Providers are consistently trained to their obligations regarding safeguards and reporting requirements for abuse, neglect and exploitation via the regularly scheduled DHS Training opportunities. Additionally, our DHS RNs are constantly trained to the policies and reporting requirements of appropriate Adult Maltreatment Act, and requisite policy and procedures.

Question: Is the cost of Adult Protective Services included; and what are the procedure, process and cost for initiating these services, if needed.

Response: CFCO generates no additional cost for Adult Protective Services.

The Division of Aging and Adult Services (DAAS), Adult Protective Services (APS) is charged to investigate cases of suspected adult maltreatment of endangered or impaired persons. The purpose of this

authority is to (A.C.A. 12-12-1702(2)) "Ensure the screening, safety assessment, and prompt investigation of reports of known or suspected adult and long-term care facility resident maltreatment", (A.C.A. 12-12-1702(4)) "Encourage the cooperation of state law enforcement, officials, courts, and state agencies in the investigation and assessment of maltreated adults and long-term facility residents, and prosecution of offenders." Adult maltreatment allegations can be received from multiple sources, to include other state agencies, other DHS divisions as well as other DAAS departments. It is through this information sharing and collaboration, e.g. APS and HCBS, which allows DAAS to serve the adult's needs.

This delivery of services may extend into protecting the vulnerable adult who may be found in imminent danger. The Adult Maltreatment Custody Act gives authority to APS to (A.C.A. 9-20-102(1)) "Protect a maltreated adult or long-term care facility resident who is in imminent danger; and (2) Encourage the cooperation of state agencies and private providers in the service delivery system for maltreated adults." APS relies heavily on the expertise on HCBS personnel in the screening and assessment of clients who are endangered or impaired and are in need of being taken into APS emergency custody for their protection and for the initiation of an investigation.

A.C.A. 12-12-1708(a) specifies mandatory reporters who are required to report suspected adult maltreatment, including abuse, exploitation, neglect, or self-neglect of endangered or impaired adults. Mandated reporters include all physicians, nurses, social workers, case managers, home health workers, DHS employees, facility administrators or owners, employees of facilities, and any employee or volunteer of a program or organization funded partially or wholly by DHS who enters the home of, or has contact with an elderly person. HCBS staff, providers, and DAAS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

According to the statute, adult abuse includes intentional acts to an endangered or impaired adult which result in physical harm or psychological injury; or credible threats to inflict pain of injury which provoke fear or alarm; or unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Exploitation includes illegal or unauthorized use of the person's funds or property; or use of the person's power of attorney or guardianship for the profit of one's own self; or improper acts or process that deprive the person of rightful access to benefits, resources, belongings and assets. Neglect is an act or omission by the endangered or impaired person (self-neglect), or an act or omission by the person's caregiver (caregiver neglect) constituting failure to provide necessary treatment, care, food, clothing, shelter, supervision or medical services; failure to report health problems and changes in health condition to appropriate medical personnel; or failure to carry out a prescribed treatment plan.

An Adult Protective Services (APS) brochure is provided to the waiver applicant and his or her family by the DAAS RN when initial contact is made. Additional copies of the brochure are available to other interested parties upon request. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DAAS RNs review this information with participants and family members at the initial assessment and at each annual reassessment

Senator Stephanie Flowers

Question: What are the federal mandates for reforming Medicaid Services offered to developmentally disabled persons?

Response: Recent mandates other than the Olmstead decision include the Centers for Medicare and Medicaid Home and Community Based Settings final rule effective March 17, 2014. The purpose of the HCBS final rule is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community and that the individual's role in service and care planning is optimized. Individuals are to be provided opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as individuals who do not receive HCBS services.

Question: Request full disclosures from the state agencies.

Response: DHS agrees with the principle of full disclosures and strives to work in a transparent manner with all stakeholders.

Question: Ask DHS to provide legislators with the federal mandates in other states (specifically Tennessee & Michigan), that have drastically changed the way these states provide services to their developmentally disabled clients. Then compare them to the federal mandates in Arkansas.

Response: Federal mandates do not differ from state to state. However, other states through litigation have implemented various state selected options to meet compliance requirements.

EXHIBIT E-1

Developmental Disabilities Provider Association

2020 West 3rd Street, Suite 301 | Little Rock, AR 72205 | o: 501.907.5337 | f: 501.907.5338 | www.arkansasddpa.org | ddpa@arkansasddpa.org

Nonprofit Community Programs and HDCs

a full-service continuum for individuals with developmental disabilities

1. DDPA represents nonprofit community programs statewide. DDPA's 66 members provide an array of medical care and related supports and services statewide to over 24,000 children and adults with developmental disabilities and employ over 12,000 Arkansans.

2. Human Development Centers (HDCs) are critical to a full-service continuum for Arkansans with developmental disabilities especially for intense medical/behavioral needs.

3. Individuals and their families have the right to choose their service-delivery setting. HDCs serve 935 persons. The home-and-community-based services (HCBS) waiver program serves 4,131 persons plus nonprofit community day programs serve another 20,000.

4. There are about 50 persons waiting to be served in HDCs and over 2,800 children and adults with developmental disabilities waiting for services through the HCBS program.

5. Elimination of the extensive waiting list for HCBS should be the state's top priority. Many have been on this waiting list for seven to ten years. Without additional funding, there is no realistic chance that they will receive any services in the foreseeable future.

6. Community First Choice (CFC) is the only funding source currently identified to eliminate the waiting list by leveraging an enhanced 6% federal match. DDPA supports CFC in concept though many details have yet to be resolved.

7. CFC is not a windfall to nonprofit community programs. It will simply expand access to services and supports to the over 2,800 children and adults on the HCBS waiting list.

8. CFC does not take funding away from HDCs or result in their demise.

9. DDS's request for funding for HDC capitol improvements is legitimate. DDPA supports HDC families' efforts to ensure their loved ones live in a safe, quality environment.

10. Nonprofit community programs are in dire need of a rate increase. CFC is an opportunity for all DD providers to work together to ensure the long-term sustainability of a full-service continuum for Arkansas' most vulnerable citizens. With irregular rate increases at best, nonprofit community programs are struggling to comply with burdensome federal laws and regulations that significantly increasing operating costs, including the elimination of the companionship exemption and the Affordable Care Act. Funding increases for DDS must consider the equally important resources necessary for Arkansas' nonprofit community programs to continue to serve over 24,000 children and adults daily and the over 2,800 individuals with developmental disabilities waiting for services and supports.

DDPA
Developmental Disabilities Provider Association

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Email: ddpa@arkansasddpa.org
Website: www.arkansasddpa.org

August 12, 2014

RE DDPA's support for Community First Choice (CFC)

Dear Governor Beebe,

There has been quite a bit of confusion among DHS officials, legislators, parent organizations and other advocacy groups about the Developmental Disabilities Providers Association's position with regard to Community First Choice (CFC). It is DDPA's sincere hope that this letter will alleviate any miscommunications and/or misunderstandings with regard to DDPA's position on CFC and make it clear that DDPA supports CFC.

DDPA's official position has not waivered on this issue, and after its August 5 DDPA Board meeting, this position was affirmed with the adoption of the following statements:

- ✓ DDPA supports Community First Choice (CFC)
- ✓ DDPA strongly supports the elimination of the DD waiting list
- ✓ DDPA is open to consideration of any funding options available to eliminate the DD waiting list as long as the course of action required to pursue such funding is not conducted at the expense of individuals with developmental disabilities

We understand that CFC is a major policy decision for this state. DDPA is committed to continue working with DHS, legislators and other stakeholders on options necessary to ensure the sustainability of CFC or any other alternative program developed to eliminate the DD waiting list.

You are encouraged to contact any one of the following if you have any questions or concerns about DDPA's position on any issue:

- Sara F. Israel, J.D., Executive Director, DDPA
  ddpa.exec.dir@arkansasddpa.org & 501-590-4658
- Judy Watson, President, DDPA Board of Directors & CEO, Rainbow of Challenges
  judywatson@rainbowofchallenges.org & 870-538-3041
- Mike McCreight, Chair, DDPA Government Activities Committee & CEO, Pathfinder, Inc.
  mike.mccreight@pathfinder.org & 501-982-0528
- David Ivers, J.D., DDPA's Legislative Consultant, Mitchell Blackstock
  divers@mitchellblackstock.com & 501-378-7870

We look forward to continuing our collective work to improve the DD system of care in Arkansas and to providing quality home and community-based services and supports to children and adults with developmental disabilities.

Kindest regards,

Sara F. Israel
Executive Director

Judy Watson
Board President

Mike McCreight
Government Activities Committee Chair

EXHIBIT E-2

DISABILITY RIGHTS CENTER OF ARKANSAS

Tom Masseau
Executive Director

Health Services Subcommittee
August 28, 2014
Testimony by Tom Masseau, Executive Director

Senator Caldwell, Representative Mayberry and members of the Health Services Subcommittee, thank for you for allowing me this opportunity to provide comments from the Disability Rights Center of Arkansas regarding the Community First Choice Option.

I am Tom Masseau, Executive Director, of Disability Rights Center of Arkansas (DRC). DRC is a private nonprofit organization designated by the Governor to implement the federally authorized Protection and Advocacy systems. Our mission is to assist people with disabilities through education, empowerment and protection of their legal rights. We serve all Arkansans with disabilities of all ages. We provide services through information and referral, direct advocacy and legal representation. DRC also provides training and outreach throughout the state. During fiscal year 2013, DRC provided information and referral to over 1300 individuals and provided direct advocacy and representation to over 350 Arkansans with disabilities.

Every year, the DRC Board of Directors solicits input into the development of the agency priorities. This solicitation is accomplished through public surveys and analyzing the reviewing prior year's request for assistance. In Fiscal Year 2014, the Priorities established are as follows:

- Community Integration and Institutions
- Housing
- Employment
- Education
- Accessibility

The priority and objective that is most relevant today falls under the Community Integration and Institutions priority. This priority focuses on ensuring that individuals with disabilities will be free from abuse, neglect, and the unnecessary use of restraint and seclusion. It focuses also on the idea that individuals should receive quality support services, rights protection and be empowered to make choices in their lives.

Before I begin my comments, I want to thank Dr. Green and his staff for developing a plan that will end the community services waiting list and provide opportunities and choice for all Arkansans.

In 1999, the Supreme Court ruled in *Olmstead v L.C.* that public entities are required to provide community-based services to individuals with disabilities when, a) such services are appropriate; (b) the affected persons do not oppose community-based treatment and, (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other who are receiving disability services. Essentially state and local governments need to provide more integrated community alternatives to individuals in or at risk of segregation in institutions or other segregated settings. (US Department of Justice, Civil Rights Division, "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v L.C.*") Further, the *Olmstead* decision required each state to develop a plan that would place individuals with disabilities in less restrictive settings.

Following the *Olmstead* decision, former Governor Mike Huckabee formed the Governor's Integrated Services Taskforce. This taskforce was charged with assisting the state Department of Human Services in writing an *Olmstead* Plan. In 2003, the Taskforce completed its charge and developed The *Olmstead* Plan in Arkansas. The plan contained over one hundred recommendations for the state Department of Human Services and members of the Legislature to consider. The report highlighted the intent of the state's movement towards providing services in less restrictive settings. Enactment of the Community First Choice Option will help to fulfill some of the recommendations identified over eleven (11) years ago.

We acknowledge the state's efforts to eliminate the waiting list for services and are anxiously awaiting the implementation of the Community First Choice Option. I understand that it will take approximately 18 months to two years to completely eliminate the 2,800 individuals on the waiting list, but it shows there is light at the end of the tunnel.

Individuals want access to waiver services in the community. In fact over 2,800 individuals are on the waiting list for waiver services, as opposed to just around 50 waiting for services at the facilities. The Department of Human Services has invested two years of planning and input gathering from all constituent groups to design a comprehensive system that will serve all eligible Arkansans.

The State and Legislature needs to invest in providing community based services, as it is evident these are the services individuals are demanding. If we need another example, of why community based services is a good thing, then consider that the state is spending twice as much to provide services in the Human Development Centers ($117,459 versus what is being spent on to provide waiver services in the community ($59,126). The implementation of the Community

First Choice Option will save $365 million of state general revenue the next 12 years. Additionally, the State will benefit from a 6% increase to the federal match rate for the program.

We are at a critical point in Arkansas. The State and Legislature should implement the Community First Choice Option to comply with Olmstead and ensure the 2,800 individuals on the community services waiting list receive services in the least restrictive setting.

Again, thank you for allowing me the opportunity to speak before you today and I would be happy to answer any questions you may have.

EXHIBIT E-3

Mr. Chairmen and Subcommittee Members,

I would like to take this opportunity to address a few of the misconceptions about the Community First Choice Option ("CFCO") program that I have heard being expressed by some people. I believe that the most effective method of countering misconceptions is to look at facts, from both a historical and a current perspective.

The law that is the basis for much of the discussion we are having today is the Americans with Disabilities Act. It was signed into law in 1990 by President George H. W. Bush. It was later amended by the ADA Amendments Act of 2008, which was signed into law by George W. Bush. In 1999, the Supreme Court issued its ruling in the Olmstead v. L.C. case. The Olmstead ruling stated that pursuant to the ADA, government services provided to the disabled must be furnished in the most integrated setting appropriate to the individual. One might assume that efforts to reform the institutional bias in the Medicaid program did not begin until some time after the Olmstead ruling.

This is not the case. In June of 1997, almost exactly two years before the Olmstead ruling, a bill was introduced in Congress. Let me quote from the Congressman's introduction of the bill, "Mr. Speaker, I want to introduce today the Medicaid Community Attendant Services Act of 1997 as part of my commitment to empowering all Americans, and to the principles of community-based care. This bill allows for choices for persons with disabilities so that individuals can receive the care that is more appropriate for them. Everyone deserves the opportunity to lead a full and independent life, and people with disabilities are no exception". It sounds like something a leftist liberal might say. In fact, they are the words of Newt Gingrich, who later became the Speaker of the House and campaigned to be the Republican nominee for President.

In 1999, the bill was reintroduced as the Medicaid Community Based Attendant Services and Supports Act. It was reintroduced in 2001, 2003 and 2005. In 2007, an equivalent bill was introduced as the Community Choice Act. It was reintroduced in 2009. For fourteen years prior to the Affordable Care Act, advocates and members of Congress had been trying to enact revisions to the Medicaid program that would permit the same types of attendant care services and supports that are found in the Community First Choice Option. The CFCO is not something President Obama and the Democrats dreamed up. It is a vision of how the Medicaid program can best furnish services to the disabled in compliance to the principles of the ADA, a Republican enacted law. It was included in the ACA because that's how Congress works. While the CFCO certainly qualifies as a health care reform program, it is entirely separate from, and not dependent on, the Medicaid expansion and individual and employer mandate provisions of the Act. It simply allows the right services to be provided to the right people in the right setting, while also helping states to control costs.

This leads me into the next misperception about the CFCO. Some believe that the CFCO will take what is now a capped program and turn it into an entitlement. This view mixes apples and oranges to come up with a belief that in inaccurate. According to the DHS Statistical Report for the State Fiscal Year of 2013, there were 18,345 Medicaid recipients receiving services in nursing facilities. Total expenditures on Long Term Care Facilities were $807 million. The people receiving Medicaid funded nursing home care are individual that are categorically eligible for Medicaid because of age, income or disability. No Medicaid program can deny eligibility to any individual that meets the qualifications of one of the eligibility categories. As such, there is no cap on the number of people than can receive long term care in a nursing home.

Nursing home coverage is a benefit provided under every Medicaid State Plan. It is, always has been, and will continue in the future to be, an entitlement. So, the basic premise that the CFCO will

take a capped program and turn it into an entitlement is wrong. If you do not adopt the CFCO, the state will still be obligated to spend $800 million dollars or more per year to cover the nursing home costs of more than 18,000 people. With an aging population, both the number of recipients and the total cost can be expected to grow and, without the CFCO, there really isn't much you can do to impact that. On the other hand, the CFCO will allow the state to take steps that will not only help reduce and control future costs, but it will have a positive impact on the quality of life of the recipients.

Now let us turn to services and supports provided to the developmentally disabled. Although institutionally based care at the Human Development Centers is arguably uncapped and an entitlement, it is correct that community based services are furnished through waiver programs that have an enrollment cap and where the services are not an entitlement. This is a situation that needs to be changed. While the Olmstead ruling did not say that individuals in institutions had to be removed from the institutions, it did say that individuals in an institution, and those at risk of institutionalization had to be given a choice of receiving services in the most integrated setting appropriate to them. The key concept is choice. Individuals in an HDC have a choice. They can stay or move out in the community. Those individuals currently in one of the waiver programs have a similar choice. They can stay in the community and get the care they need, or they can move to an institution.

However, there are over 3,000 people on a waiting list for the ACS Waiver that are not being provided with any other choice but to be institutionalized, because the availability of community based services is arbitrarily capped. This violates both the letter and the spirit of the law. The CFCO will finally provide these people with real choices. If the CFCO is not adopted, the waiver programs will not go away. There will still be as many recipients as before, and the state will still spend as much money on them as before. It is true that if the CFCO is adopted, the number of people receiving community based attendant services and supports will increase, as will total spending. However, it is reasonable to expect that the savings from the reduction in expenditures on long term nursing facility care will more than offset the increase in costs associated with covering the individuals on the waiting list that will finally become eligible to receive desperately needed services and supports.

I agree that the ability to control costs is an important concern of the Legislature. However, I believe this discussion about the CFCO involves issues that are far more important than money. As a people, we have decided that the elderly and the disabled are an especially vulnerable population and that they deserve our help and understanding to become, or to remain, individuals that are fully included members of society. To share in the American dream of independence and opportunity, these individuals must be given choices on how they lead their lives. Today, tens of thousands of elderly or disabled Arkansans are faced with a heart wrenching choice; they can struggle and suffer while attempting to live independently in their communities, or they can lose their independence and dignity by having to accept placement in an institutional setting. They deserve an opportunity to make real choices. The CFCO will provide them with choices, and will allow the state to better manage its costs in ways that no other program can.

I urge the Legislature to do the right thing for the citizens of Arkansas and approve the CFCO.

Thank you.

Mark George

EXHIBIT E-4

The Story of My Family

By Jane Browning
11 Precioso Lane, Hot Springs Village
Senate District 14, House District 23
and
Paul Browning
1842 Center Street, Arkadelphia
Senate District 12, House District 18

Paul Browning at work at the Honeycomb Restaurant, Arkadelphia

My name is Jane Browning and I live with my husband of 35 years, John, in Hot Springs Village.

Up until three years ago, our son Paul lived with us, but when he turned 27 years old he decided he wanted to move out and live on his own. His older brother, Jack, had gone off to college and made his way in the world years earlier, but Paul has Down syndrome and finding his niche in life was a little more complicated.

Paul does live semi-independently in a home we bought for his 30th birthday, with round-the-clock live-in supervision provided by Group Living, Inc., of Arkadelphia. The bright young men who live and work with Paul are among the small army of "Waiver Workers" that make successful lives possible for people like Paul who have developmental disabilities.

Group Living operates under the Medicaid Waiver system, but Paul's services are not covered by Medicaid. Paul is on the waiting list for waiver services, I think he is now #2023 in line to get his program paid for.

In the meantime, he is supported by what he receives from Social Security Disability Insurance, some State of Arkansas Developmental Disabilities Administration funding, and private pay from us, his parents.

As I mentioned, John and I are retired and receiving Social Security benefits ourselves. We don't have a lot of disposable income these days, but we are happy to continue supporting Paul as long as we are able. However, our days are numbered. John's father died at age 66; my only brother died of cancer at age 58, and my only sister died at age 66. How long can we realistically expect to carry the financial burden?

We kept Paul home with us when other parents enjoyed the financial and personal freedom of turning their children over to the State to be kept in institutions. Paul had a lot of medical issues as a little boy, including open heart surgery at 18 months. We have paid every day for paid companions to stay with Paul after school and as an adult, after he returned home from his program, while John and I were still at work. We provided personal assistance to Paul to help him accomplish daily tasks others take for granted, like shaving and washing his hair, assistance he continues to require.

We live in your district. We are your constituents. We need your continuing help on an ongoing basis to keep Paul safe, healthy and active in the most independent setting possible.

Thank you for being there for us. I hope you will call on me whenever you need help explaining programs and services for people with developmental disabilities to your colleagues, or to answer any of the questions or concerns you may have.

Jane Browning, 410-693-1040, Browning.jane54@gmail.com

Community First Choice Option (CFCO)
Supportive Organizations

We believe that CFCO is an opportunity for the state of Arkansas to offer individuals who are elderly and those with disabilities the choice to receive services in their homes and communities. It is for this reason that we, the undersigned, urge the state to move forward with implementation of CFCO.

- AARP
- Arkansas ADAPT
- Arkansas Area Agencies on Aging (AAA)
- Arkansas Autism Resource & Outreach Center (AAROC)
- Arkansas Governor's Developmental Disabilities Council (DDC)
- Arkansas Mental Health in Education Association (ARMEA)
- Arkansas Residential Assisted Living Association (ARALA)
- Autism Speaks
- Arkansas Support Network, Inc. (ASN)
- Arkansas Waiver Association (AWA)
- Developmental Disabilities Provider Association (DDPA)
- Disability Rights Center of Arkansas (DRC)
- First Step, Inc.
- Gregory Kistler Treatment Center for Children, Inc.
- Independent Case Management, Inc. (ICM)
- Integrity, Inc.
- Lifestyles, Inc.
- Mainstream
- Partners for Inclusive Communities
- Sources
- Spa Area Independent Living Services
- United Cerebral Palsy of Arkansas, Inc. (UCP)

EXHIBIT E-5

Thank you, members of the committee, for giving me the opportunity to speak to you today.

My name is Dianna Varady and I am the director of the Arkansas Autism Resource & Outreach Center, also known as "AAROC". We provide training and help finding services for families in Arkansas who have children diagnosed with autism spectrum disorders. I am also a parent of a child diagnosed with autism who has been on the Medicaid home & community-based waiver list for about 5 years.

As you might imagine, with approximately 1 in 65 Arkansas children now identified with an ASD, we get a lot of phone calls. Many times those calls are from parents of a newly diagnosed child who are seeking information about early intervention services. Sometimes we get calls from parents who are struggling with school issues, and sometimes parents simply call to talk about some of the issues they face at home caring for a child who may be exhibiting difficult behaviors. Sometimes the family is in crisis. One of the first calls I ever received at AAROC was from the father of a 10 year-old boy diagnosed with autism. His son slept an average of 3 hours per night, and not 3 hours in a row. He and his wife both worked,

so they took turns staying up with their son each night and were suffering from some pretty serious sleep deprivation which was taking a toll on their work performance and the general atmosphere at home. Their son had been on the waiver waiting list for many years and they were hoping that we might know of another way to get a caregiver to sit with their son just one night per week so that they might get a full night of sleep.

A more recent call was from a gentleman who was visiting his great aunt from out of state. He said that she was caring for her teenage grandson diagnosed with autism. This child did not have a method to communicate and was in diapers. His grandmother was dealing with her own health issues but was determined to keep her grandson at home with her. When I told this gentleman, who is in the military and who could not remain in Arkansas to help, that waiver services could help, but that they would probably have to wait for many years before receiving these services, he broke down and sobbed.

These calls are the hardest part of my job. There is nothing so heartbreaking than to tell a parent who is in such desperate need that the services they need are available through

Medicaid waiver, but that they will likely wait 8 years or longer to ever start receiving those services. Every time I utter those words there is an audible gasp on the other end of the line. Occasionally, I get a call from a parent telling me that they can no longer care for their child without help, and that they have made the decision no family should be forced to make, which is to say they have decided to place their child in an institution.

AAROC asked families in Arkansas to share with us why home and community-based services are important for them. We received statements from families all over the state, some included photos or even videos:

- We heard from the family of Tina in Marmaduke. Tina is 34 years old and is diagnosed with cerebral palsy. She lives at home with her parents who are experiencing their own health issues. Tina has been on the home & community-based waiver waiting list for 7 ½ years.
- We heard from Chelsea. Chelsea is 25 years old and lives in Farmington. She has high-functioning autism and would like to live independently, but cannot do so without supports. Chelsea loves to bake and her dream is to one day be a pastry chef. She has been on the waiver waiting list for over 5 years.

- We heard from Carson's family. Carson lives in Springdale. He's 11 years old and just graduated from 5th grade. Carson has a developmental disability and right now his older sister helps to care for him so his parents can go to work, but she'll be going to college soon and won't be able to help with Carson's care. Carson is #1881 on the waiver waiting list.
- We heard from Tyler's family in Hot Springs. Tyler is 11 and loves swimming and riding on the ATV with his dad. He is diagnosed with autism, but works hard to make progress every day and just read his first sentence last year. But Tyler is not potty trained and also runs away from his caregivers. His parents find it difficult to work and care for him by themselves. He is about #1600 on the waiver waiting list.

These are just a few of the stories sent to us. Some of the videos are posted on YouTube and I encourage you all to watch them. Sometimes they move me to tears. I am in awe of each and every one of them. They are beautiful and amazing and determined and I am just so proud of their fearlessness in sharing their lives with us. It takes tremendous courage for them to speak up and ask for this help, and truth be told they

probably wouldn't do so if the stakes weren't so terribly high for so many thousands Arkansans. As you consider Community First Choice and weigh all the arguments for and against, please remember Chelsea and Tina and Carson and Tyler and all the other people who need these supports, because it's my hope that doing so will tip the scales in their favor.

Thank you

EXHIBIT F-1

STATEMENT OF CAROLE L. SHERMAN
IN RESPONSE TO NOTICE
OF HOUSE AND SENATE HEALTH SERVICES SUBCOMMITTEES
OF THE
HOUSE AND SENATE PUBLIC HEALTH, WELFARE & LABOR COMMITTEES
AUGUST 21, 2014

QUESTIONS:

Community First Choice Option (CFCO) is an optional incentive program offered to States by the federal government to change long-term care systems. CFCO funding is provided through the Affordable Care Act and offers States 6% more federal funding to shift from providing care in long-term care facilities to providing care in home and community-based programs. [Medicaid pays our state approximately $3 federal for every $1 state for long-term care programs.] If Arkansas applies for CFCO program funding, the following questions come to mind

(1) Will the State maintain separate human service divisions within the Department of Human Services - Division of Aging/Adults with Physical Disabilities (DAAS), Division of Developmental Disabilities (DDS), Department of Behavioral Health (DBH)?

While creation/dissolution of state agencies is the purview of the General Assembly, the Arkansas Department of Human Services (DHS) has no plans to propose any legislation that would result in the dissolution or combination of any of the divisions mentioned above.

(2) Will the State maintain and retain at their current levels (or greater levels) its current specialized public residential programs for its citizens with lifelong cognitive-developmental disabilities (our Human Development Center (HDC) systems)?

Arkansas' state operated HDCs are a vital part of our continuum of care for citizens with developmental disabilities. DHS has no plans to close any of the five HDCs.

(3) Will the State maintain and support specialized residential programs for persons disabled from the effects of aging, including those who are physically frail but without cognitive deficits and those who have dementia but who may also be mobile (this question relates to the need for nursing homes)?

Yes. DHS recognizes the need for the level/type of care provided by nursing facilities in our state.

(4) Will the State maintain and support specialized programs for persons diagnosed with chronic mental illness? (The pressure from the federal bureaucracy appears to be toward elimination of "silos," separate service systems for the differing groups of disabled persons; also related is the move by federal bureaucracy CMS toward standardized assessments for all people with disabilities).
- The question is whether the Arkansas agency heads concur with the above perception as stated?

DHS recognizes the need for specialized treatment for citizens who experience chronic mental health challenges.

(5) CFCO is being presented as part of Arkansas DHS Payment Improvement Initiative (PII).
- Why was there no opportunity for interested parties to learn about and comment on the substance of the State's plan to apply for CFCO grant funds before the Department requested that it be placed on the July 2014 agenda of the Public Health Committees?
- Why were stakeholders not notified by DHS of its July 2014 planned presentation?

CFCO is not part of APII, though they do complement each other in that CFCO funding will allow for strengthening of services needed to meet individuals' needs. DHS has publicly discussed and published its interest in participating in the CFCO incentive plan from as early as the fall of 2012. It was placed on the July agenda simply to allow for discussion, not for formal review.

(6) CFCO is being presented by DHS as part of the Arkansas Payment Improvement Initiative (PII). There has been a lack of adequate information from DHS about the Department's PII program plans for our family members, the targeted population with cognitive-developmental disabilities. The DD Work Group of PII has not met since December 2012. As an early provision of PII, our family members with disabilities were required to undergo a new assessment using a new tool which did not present questions that captured their actual conditions and need for close care and which contained many questions that were not applicable to them or to their situations. As we understand, Arkansas was the first state to receive assessments using the new assessment tool for the population with development disabilities. We are inadequately informed on how the information from the assessments will be used. We ask:
- What specifically is the objective of the new assessments?
- Will information from the new assessments for individuals with developmental disabilities be used by the Department to formulate the programs for our family members' care?
- Will our HDC systems be changed as a result of the information from the new assessments?

As noted in 5, CFCO is not part of APII.

Numerous discussions have occurred with stakeholders regarding the assessment process. We would be happy to have further discussions with you to provide additional information.

(7) CFCO, established in the Affordable Care Act, is an optional incentive program offered by federal agencies to States to change long-term care systems. CFCO offers States 6% more federal funding to shift from providing care in long-term care facilities to care in home and community-based programs. In recent years, Arkansas has applied for and received other federal incentive grants to change our human services system. A purpose of the federal incentive grants is to lower the census at long-term care facilities.
- When did stakeholders have an opportunity to receive information on the details (required changes) of the federal incentive Money Follows the Person (MFP) grant or to express concerns and to submit comments on the MFP grant?
- When was information on MFP provided to legislative committees or to the DDS Board?
- When did stakeholders have an opportunity to receive information on the details (required changes) of the federal incentive Balance Incentive Payment Program (BIPP) grant or to express concerns and/or to submit comments on the BIPP grant?

- When was information on BIPP provided to legislative committees or to the DDS Board?

CFCO is separate from the existing MFP and BIPP initiatives. We have had numerous discussions about both and would be happy to discuss those in more detail with you.

(8) Application for MFP grant funds was submitted by Arkansas Division on Aging and application for BIPP was submitted by Arkansas Division on Medical Services. Both grants affect the population with developmental disabilities, but notice of the grants were not given to the statewide parent-guardian association which advocates for and supports persons with developmental disabilities. We have learned "piece meal" of changes, including the requirement by BIPP of a new assessment for our family members with disabilities.
- Will future admissions to and funding for services in our HDCs be tied to a score produced by the BIPP- required assessments?

Admission to an HDC is described in statute and Division of Developmental Disabilities Services (DDS) policy. There are no plans to change that policy at this time. Results of the universal standardized assessments will be used as a guide to an objective need-based allocation of resources across all settings.

(9) A purpose of the MFP and BIPP grants was to "balance" the Arkansas long-term care system (spend more money on community services than the State spends on institutional services). Stakeholder meetings were apparently held before the MFP application was submitted but our families were not notified of the meetings or informed of the effect on our HDCs. Federal MFP grants reward states financially if they will move persons from institutional programs into community programs. Arkansas DDS is over-balanced toward home and community based care for persons with developmental disabilities - over 4 times as many persons with DD are served through Arkansas' home- and community-based programs than through our HDC programs. There is no need to "balance" the DDS system but over 50% of the MFP grants have been used by DDS to transition persons from our HDCs.
- Does the Department concur with the accuracy of the above statements?
- When did the Department adopt a goal of "balancing" the State's long-term care systems?
- Who gave the Department the authority to embark on "balancing" programs, whatever that may mean?
- When and how were stakeholders and policy makers (the Arkansas legislature) fully informed?

Implementation of the Money Follows the Person and the Balancing Incentive Payment Program followed all mandated processes/protocols regarding public notice and gathering of public input.

(10) HDC families have reported feeling pressured and made to feel guilty by some HDC staff members if they do not transition their family members from the HDCs.
- Has it been a policy directive from DHS to DDS to the HDCs to aggressively transition residents from the HDCs?
- Are HDCs long-term care facilities or transitional facilities, one or the other?

Long standing DDS policy states that individuals must be provided services in the least restrictive setting. All DDS staff are required to follow established policy.

(11) We ask: - For greater specificity on the Arkansas proposed CFCO; - Has an audit showing cost of care, including room and board for individuals qualified for institutional care, been conducted? [CFCO does not include room and board and other costs which are included in the costs of an institution like our HDCs.]- What is a correct interpretation of CFCO regarding housing and meals? Is it to shift costs of room and board to another public program?
- Has the Department sought a plan review by the medical community?
- How will area hospital ERs be affected? Is the new system of community care for persons qualified for institutional care relying on ER and Police to respond to urgencies?
- If the families are unable to provide direct care at home, what will happen under CFCO?
- What role does foster care have in this new plan, if any?
- What are the Department's plans for objective scrutiny of deaths?
- Will required-autopsies be part of CFCO, as they are in our HDCs?

Room and board payments are not part of the services provided either under the current waiver program or the proposed CFCO incentive program. A recipient's income from the Social Security Administration is generally used to offset room and board costs regardless of setting.

Medical and emergency care for persons served in home and community based settings will not change. Nor will foster care.

DDS will continue to review all deaths of people receiving home and community based services per current policy. Autopsies are not required for all deaths at an HDC.

(12) Will CFCO services take the place of Arkansas' existing waivers (DDS Alternatives Services Waiver/ DAAS Elder Choices Waiver)?

The great majority of services will convert to CFCO once implemented. Some waivers will be renewed for purposes of eligibility and provision of a few services that cannot be reimbursed under CFCO.

(13) Will all individuals currently receiving services under the HCBW continue to receive adequate and equivalent services if the State shifts to CFCO?

Yes.

(14) Waivers are now required to be budget-neutral (not cost more than services in an institution). We ask:
- Are CFCO services required to be budget- neutral?
- If the federal government does not require CFCO services to be budget-neutral, may the State require it?
- If the State does not require it, why is that sound fiscal policy?

A demonstration of budget neutrality is not a requirement of CFCO. However, home and community based costs have consistently been much less than services provided in an institutional setting.

(15) CFCO requires a Development and Implementation Council.
- When has the Council been convened?
- Which members of the Council represent the HDC population?
- When did the Council review, revise, make comments on and approve the final CFCO documents as presented as attachments to the July 2014 Public Affairs Committee?
- Did DHS provide public notice to interested stakeholders of all CFCO meetings?

The Council was formed in 2012 and functioned pursuant to guidance from the Centers for Medicare and Medicaid. Its input was critical to development of the CFCO plan.

OBJECTIONS AND CONCERNS:

1. Is the state really providing a choice of home, community or HDCs for its citizens with developmental disabilities? In recent years, DHS has not funded the choice of HDCs for qualified individuals, and DDS has not steadily worked to address the physical plant needs of the HDCs. Normal and expected maintenance and replacement of heavily used facilities is best done steadily and in increments, so that needs do not become crisis-events requiring emergency infusions of general revenue. If Arkansas accepts CFCO funding, will it free up state dollars to address the much-needed maintenance funding for capital improvements at our HDCs?

   DDS has expended over $15 million dollars in capital improvements at the HDCs since January, 2009. Capital improvements are traditionally made with one-time funds rather than operational funding such as would be saved by the implementation of the CFCO program.

2. Why should our state rely on the federal government's assurances in providing more funding indefinitely to serve our most vulnerable citizens out of licensed long-term care facilities? There is an absence of common sense and humanity in federal-DHHS policies when the agency uses generous amounts of discretionary public funds to entice States to stop providing a diverse system for choice of care which better reflects the realities of people with disabilities and their families.

   Regardless of settings, the majority of funding for services for people with developmental disabilities comes from the federal government via the Medicaid program.

3. We object to any actions which might undermine existing public safety net programs (our HDCs), which have historically proven successful in providing specialized care to vulnerable citizens with ongoing challenging health care needs and which do not have a profit-driven motives.

   DDS agrees that the HDCs are a vital part of our service continuum for Arkansans with developmental disabilities.

Carole L. Sherman

Mother and Co-Guardian of John (Arkadelphia HDC resident)
Public Affairs Chair, Families & Friends of Care Facility Residents, Arkansas' statewide parent-guardian association

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EXHIBIT F-2

Arkansas Health Care Association
Questions Regarding CFCO

Projections/Assumptions

- Have there been any independent financial models done on this program?
- Is there a backup plan in case these assumptions aren't good?
- Most proposals apply multiple financial projections based on different scenarios. Is the Department considering other projections based on multiple assumptions?
- Has there been an independent financial analysis performed of the CFCO proposal?
- Has there been an independent analysis conducted on the assumptions of this proposal?

For the entire Medicaid program, expenditure projections are made by DHS, based on the best available data and program expertise. The Department does not routinely contract for independent financial analysis and has not done so for CFCO. The projections presented were developed after considerable discussion of many factors. They are conservative, and there is significant margin for variation while still resulting in net savings. In addition, the presentation noted many additional cost control measures available for use if needed.

Waiting List

- How long has the DD waiting list been a problem?

The waiting list was last cleared in 2004 following the settlement of a lawsuit filed on behalf of one of the persons on the list. The list has gradually increased in subsequent years presently approaching 3000 people.

- What efforts have been made by DHS or asked of the general assembly to address this waiting list?

  - *2007: DHS requested and received additional revenue to expand the DDS Waiver by 240 slots.*
  - *2009: An Intermediate Care Facility provider fee was enacted by the legislature that provided revenue enough to fund an additional 150 slots.*
  - *2009: DHS requested funding for 600 additional waiver slots in the 2010-11 biennial budget*
  - *2010: An additional 95 slots were created for residents transitioning from the Alexander Human Development Center and the Arkansas State Hospital.*

- *2011: A funds transfer from the DHS Division of Children and Family Services (DCFS) created an additional 60 slots for foster children.*
- *2013: A funds transfer from DCFS created an additional 40 slots for foster children.*

- What funds have been requested of the general assembly to solve this problem in the past fiscal sessions?

  See previous answer

- What legislators or legislative committees have been working to solve the problem of the waiting list?

  The Legislative Task Force on Autism and the Community Services Oversight and Planning Council have been consistently involved in advocating a reduction and/or elimination of the waiting list. The Senate and House Public Health Committees have periodically heard testimony and discussed the need for reduction and/or elimination of the list. The Joint Budget Committee has routinely heard testimony regarding the need for revenue to reduce/eliminate the waiting list.

- What is the amount of general revenue dollars needed to solve this problem?

  It would take approximately $40 million in general revenue at the current match rate to serve the entire waiting list. The first two years would require less due to the gradual transition of people from the list.

- What specific services are needed to take care of this population?

  The primary home and community based services utilized by this population are supported living and case management. Also included in the service array are environmental modifications to increase accessibility, specialized medical supplies, adaptive equipment, etc.

- How many clients on the waiting list are receiving partial services?

  607 people on the list are currently receiving Developmental Day Treatment Clinic Services (DDTCS).
  151 (47 of these also received DDTCS) people on the list receiving Personal Care services.
  12 children received Special Needs funding for services such as adaptive equipment, etc.
  42 children received Title V respite services in the past year.
  8 children received Integrated Support Services such as supported living, community integration activities, etc.

- How many people on the waiting list have signed up in anticipation of a long wait but aren't in need of services today?

  Applicants had to demonstrate that they met the criteria to receive services in an institution at the time their name was placed on the list.

Additional Costs to Implement

- Under CFCO, there is no increased federal match for administrative cost to the program. DHS has stated that existing resources will be used to fulfill administrative oversight requirements of the program. What are these existing resources now and what are they being spent on?

  Arkansas Payment Improvement Initiative (APII) changes will allow DHS staff members who are currently engaged in reviewing and issuing prior authorizations for HCBS Waiver recipients to reallocate their time to examine outcomes for people served under the program.

- What required pieces of infrastructure are needed to implement CFCO?

  We don't believe there are requirements for additional infrastructure to implement CFCO.

- Does the 6% match cover the administrative oversights?

  No. Administrative costs are funded at a 50% state, and 50% federal rate.

- Have appropriations been made for these by the general assembly?

  Appropriations for SFY 2015 are in place for the DHS staff members that will provide support for the services provided under this program.

Self Direction Cost & Oversight

- Under CFCO, self direction is encouraged both for citizens ages 19+ with disabilities and the frail elderly to participate in self direction of their care. Has the general assembly been involved in ensuring that the proper fraud & abuse controls are in place and regulations have been promulgated to ensure the safety of these individuals?

  The Self Directed model is a long standing program within the department and already includes safeguards to ensure the services are provided in an appropriate manner. The Arkansas Legislative Council recently approved a contract that further strengthened the department's

ability to monitor the program.

- If no additional money is going to be spent on oversight, how will existing resources be used to ensure safety?

  See previous answer

- Will there be criminal background checks done on participating employees under self direction? Who will be responsible for paying for these background checks?

  Act 1336 of 2013 requires that in-home caregivers, who are paid through Medicaid, submit to, and pay for, a criminal background check in order to work in this program.

AAA Letter

- According to the letter from the AAA Association, there will be savings in other programs that will allow "infused dollars for Home & Community Based Services". Where will these savings come from?
- Have rate increases for other providers been discussed?
- The letter also refers to HCBS services being on par with institutional services. We have also heard this phrase used in meetings with other providers and OHS employees. Is it the policy of the general assembly and/or administration that individuals with minor disabilities in the community have the same priority for general revenue funding as those frail elderly individuals with multiple health problems who require 24 hour skilled nursing care?

  The Payment Improvement effort will generate savings by better targeting resources to specific client needs. Additional savings will be generated by the CFCO enhanced match rate. Some home and community based services, such as Adult Day Care, require rate increases to remain viable, and these savings could help pay for those increases.

  The statement above refers to "individuals with minor disabilities in the community". To be eligible for CFCO home and community based services an individual must meet nursing home level of care. DHS does not consider these individuals to have "minor disabilities" and does believe that they should have viable options to remain at home and in the community.

Legislative Involvement

- Under the Private Option piece of the ACA, legislators were involved and multiple committee hearings were held. What legislators have been involved

in this piece of the ACA changing existing waivers for elderly and disabled citizens in Arkansas? Especially knowing that accepting this as a state plan rather than a waiver, the General Assembly will lose control of program growth.

- When were members of the legislature notified that the state submitted this proposal to CMS?

  The original CFCO State Plan Amendment (SPA) packet was filed with the BLR on March 10, 2014 to begin the public comment period. On March 14, 2014 the SPA was submitted to CMS. A public hearing regarding the CFCO promulgation was held on March 20, 2014.

Other

- Has there been a study conducted to find out the total number of disabled citizens in Arkansas who could meet eligibility requirements for this program who are not currently being served on a waiver?

  We feel strongly that people whose needs are such that they meet the criteria to be served in an institution are actively seeking assistance and for the most part have made themselves known to the department.

- Are there other waiver programs being changed or applied for that would affect the population groups that fall in the criteria of either institutional level of care and non-institutional level of care?

  No

- Has the state of Arkansas submitted intent to apply for other state plans or waivers with CMS that have not been approved by the legislature?

  No

- In the current plan, will all waivers related to elderly and disabled recipients be terminated to be included in CFCO? Or will waivers remain?

  Elder Choices and AAPD will be combined into one waiver named Access to Home Care. The DDS Alternative Community Services waiver will be replaced with the DDS Home and Community Based Services waiver.

- Have we researched other states that have attempted to implement this program?

  We have looked at the actions of other states. 3 states; California, Oregon, and Maryland have CFCO State Plan Amendments approved by the Centers for Medicare and

Medicaid. 4 others; Minnesota, Montana, Texas, and Wisconsin have formally indicated that they intend to begin implementation in 2014.

AMENDMENT
TO
STATEMENT OF CAROLE L. SHERMAN
IN RESPONSE TO NOTICE
OF HOUSE AND SENATE HEALTH SERVICES SUBCOMMITTEES
OF THE
HOUSE AND SENATE PUBLIC HEALTH, WELFARE & LABOR COMMITTEES

AUGUST 27, 2014

Arkansas DHS is engaged in multiple complex and far-reaching policy initiatives for its citizens with cognitive and developmental disabilities. Among these are Arkansas Payment Improvement initiative (PII), the implementation of federal incentive grants and the recent proposal to change the existing Home and Community Based Services (HCBS) Waiver Standards. At least part of the proposed changes to HCBS Waiver standards are reported to be necessary for Community First Choice Option (CFCO) and also for the State to come into compliance with "federally mandated Standards of Settings" requirements. (Memo dated 8-8-2014 from DDS Asst. Director for Quality Assurance). CFCO, a federal incentive grant to change long-term care systems, is described by DDS Director as a change by the Division to "restructure our service delivery system." (Notice from Dr. Charles Green 7/16/2014).

ADDITIONAL QUESTIONS TO THOSE SUBMITTED AUGUST 21, 2014

(1) Is there a single planning document which describes the changes which DHS envisions for the State's human service systems and in which it is engaged?

- *As described above, there are multiple initiatives in development that will allow Arkansans with developmental disabilities to receive more effective and efficient supportive care. These initiatives have been developed with input from providers, advocates and consumers. As they are completed, proposed changes to manuals, the state Medicaid plan, and policy will all be promulgated according to procedures described in the Arkansas Administrative Procedure Act which requires public notice, a chance for public input, and review by the appropriate committees/subcommittees of the Arkansas General Assembly.*

(2) One of the federal financial incentive grants which Arkansas accepted is the Balance Incentive Payment (BIP) grant. BIP requires a No Wrong Door/Single Entry Point (NWD/SEP) for anyone with a disability. What entity in Arkansas has been designated as the single entry point to the service system for anyone with a disability?

- *The point of entry remains at DHS and will include the current various methods of contact (divisions, county offices, facilities, etc.). DHS will also make better use of Access Arkansas website with a self-screening instrument and information about all DHS programs.*

(3) DHS has been working on the initiatives described above and it has also been revising the Arkansas Home and Community Based Services (HCBS) Waiver Standards. Over recent years, Arkansas DHS has adopted policies and strategies which prevent facility placement. Our HDC

families have an interest in the HCBW changes because under current Arkansas DHS policies for people with mental retardation, admissions to HDCs may be likened to that of an extremely long bottleneck of a bottle of wine. That is, very few individuals are being admitted to the HDCs. Ifthe population with cognitive deficits-developmental disabilities cannot access services at the HDCs, they will by necessity be served by Home and Community Based Services. We ask:

- under CFCO and HCBS Waivers, what are the living arrangements proposed for people with cognitive disabilities whose families cannot meet their care needs?

- Is the Department using the state's foster care program to provide residential care for Arkansans who qualify for institutional long-term care programs?

-what will the consequence be to a private community provider organization for operating an unsafe home for vulnerable persons?

- will an organization which operates a dangerous community home be fined?

- will an organization operating a dangerous home be closed?

-will a provider be allowed to place mixed long-term care populations together to share a room or a home? For example, will a person with mental illness or dementia be a roommate for a person who is 45 but who functions on the level of a 2 year old?

- will providers be required to carry liability insurance?

-will providers design and implement their own training for employees?

-will incidents of abuse, neglect, exploitation be recorded and reviewed by an independent entity?

-will infonnation on deaths in the community settings be compiled?

- what independent entity will review mortality data for persons who qualify for institutional care but who live in a community home?

- *Home and Community Based Services for people with developmental disabilities are monitored and regulated by the Division of Developmental Disabilities (DDS). There are extensive standards and policies in place that require service providers to conduct themselves in a manner that is in the best interest of the service recipient. These standards and policies are available for review at:*

http://humanservices.arkansas.gov/ddds/Pages/WaiverServiceProviders.aspx

(4) What are the steps Arkansas OHS will take to become compliant with the recently released final rule for home and community based services? Is there a Plan Compliance document available for review?

- *DDS is conducting an initial review of all 150 community providers' residential sites for compliance with this portion of the rule. After a provider has demonstrated substantial*

compliance with the rule at a residential site, based on either the initial onsite review or a follow-up review, they will receive a regular license for HCBS services for that site. Providers may be provided with temporary licenses for noncompliant sites upon submission of a plan to address any issues that place the site out of compliance. Compliance with HCBS services offered in a Developmental Day Treatment Clinic Services setting are also included in the Standards. Onsite verification of compliance with day settings characteristics will proceed along a separate but similar track. This information will be included in documents when HCBS applications and/or amendments are submitted to CMS.

(5) In the August 28 Subcommittees Hearing- Exhibit C ("Health Care Payment Improvement Initiative – Community First Choice Option – CFCO Overview"), the Department refers to the U.S. Supreme Court decision in Olmstead in several places. The Department projects savings based on avoiding an "Olmstead Scenario" and presents an analysis of anticipated expenditures based on "Olmstead Enforcement in 2016." Where can one find infonnation about these "Olmstead" situations?

- *The department's projections were based on a situation in which the state was required to provide waiver services to the people on the waiting list at the current match rate of approximately 30%.*

The Department's footnote on Olmstead (Exhibit C, p. 2) is selectively and incompletely stated.The Olmstead Supreme Court case does not mandate that persons with disabilities must leave long-term care facilities. In June, 2011, an Arkansas federal Court dismissed a lawsuit against Conway HDC brought by the U.S. Department of Justice which alleged discrimination for HDC residents under the Americans with Disabilities Act. DOJ did not appeal the Arkansas decision. "There is no requirement that community-based treatment be imposed on persons who do not desire it." Page 80 Findings of Fact & Conclusions of Law, USA y. State of Arkansas (Conway HDC case). Under Olmstead, a person in a long term care facility might move to a community program if the following criteria are met:

OThe state's treatment professionals determine that such placement is appropriate;

The affected person does not oppose community placement; and

The community-based placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

Carole L. Sherman
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