Division of Aging
and Adult Services

P.O. Box 1437, Slot S-530 · Little Rock, AR 72203-1437
501-682-2441 · Fax: 501-682-8155 · TDD: 501-682-2443

Arkansas
Money Follows the Person Demonstration
Operational Protocol

Version 1.6
January 31, 2014

Table of Contents

I. Project Introduction 4
A. MFP Required Benchmarks 12
II. Demonstration Policies and Procedures 17
A. Participant Recruitment and Enrollment 17
B. Informed Consent and Guardianship 29
C. Outreach and Marketing 37
D. Stakeholder Involvement 45
E. Benefits and Services 49
F. Consumer Support 62
G. Self-Direction 69
H. Quality 74
I. Housing 79
J. Continuity of Care 86
III. Organization and Administration 90
IV. Evaluation 95
V. ADRC/MFP Budget 96
VI. Final Budget 98
VII. Billing and Reimbursement Procedures 101
Table 1: Crosswalk between State Procedures Codes and Type of MFP Services 110
Table 2: Demonstration Services Summary 119

Project Introduction

Abstract

The Operational Protocol is designed to detail the operational components of the MFP demonstration program. Benchmarks**, or cumulative demonstration goals, are explained so that everyone knows what is expected to be accomplished during the overall demonstration period. It provides the larger picture of program undertakings. The reader will learn how MFP information will be disseminated throughout the state, how stakeholders have been and will be involved, how interested persons can seek enrollment and how they will be informed about potential risks and benefits. In addition, the reader will learn about the benefits and services available through MFP and how participants will transition to the qualified types of housing available to them. Lastly, information will be provided specific to critical back-up supports, how quality of care and safety for the participants will be managed, how continuity of care will be guaranteed beyond the MFP demonstration period and how this program will be evaluated to determine the areas of success as well as areas needing further refinement.**

I. Project Introduction

"*Together we improve the quality of life for all Arkansans by protecting the vulnerable, fostering independence and promoting better health.*" This is the mission statement of the Arkansas Department of Human Services (DHS). Money Follows the Person (MFP) is a system to finance, through DHS, Medicaid long term services and supports that enable eligible persons from designated institutions to live the most appropriate and preferred setting of their choice. There are two components involved in MFP. The first component involves sufficient Medicaid funding to be spent on qualified home and community based services (HCBS) when the person moves to the community from an institutional setting, the second component is the process of identifying persons in institutions who wish to transition to the community, and the transitioning process to help them do so. Arkansas is committed to the expansion of an evidence based, quality home and community system of long term care, the elimination of barriers to less restrictive settings, the provision of supports that foster responsive effective transitioning from institutions to community based settings, and the exercising of the rights of the consumers to direct their care in the settings of their choice. This simply means that if a person residing in a long term care institution so chooses, he or she will have the support(s) to transition to a community based residence, have access to a menu of HCBS

options available to address his or her needs and preferences, and have rights, responsibilities and authority in making decisions about his or her care.

Rebalancing efforts to Date: Arkansas has a systematic approach to give individuals a choice of how and where they receive long term care. Over 30 years ago, Personal Care was added to the Medicaid State Plan. Over 20 years ago, the State's first Medicaid waiver was implemented to serve individuals with developmental disabilities. ElderChoices, a waiver for the elderly was added in 1992 and Medicaid nursing home utilization began to drop. Since that time, Alternatives for Adults with Physical Disabilities, IndependentChoices and Assisted Living waiver have further rebalanced our system. **Since their inception, more than 7,000 individuals are now served in the community and there are 3,662 fewer Medicaid recipients in nursing homes, a 22% decrease.**

Growth in Participant Self-Direction: Major efforts to allow individuals to self-direct their services and supports have been implemented in recent years. Arkansas was the first state to implement a national cash and counseling program, called IndependentChoices, in 1998. Self-direction options are available under the Alternatives for Adults with Physical Disabilities. Additionally, Division of Developmental Disabilities is currently working with stakeholders to develop a self-direction option available to participants in the Alternative Community Services (ACS) waiver.

Money Follows the Person Four (4) Key Objectives:

1. Increase the use of home and community based, rather than institutional, long term care services:
    - Long Term Care Options Counseling: Legislation enacted to provide optional long term care options counseling to individuals being admitted to a nursing facility, individuals seeking Medicaid reimbursement for nursing home services and to individuals seeking additional information regarding long-term options.
    - Aging and Disability Resource Center (ADRC): Previously initiated under a CMS grant, the Center became operational January 2008 and is scheduled to expand in phases. In 2010, Arkansas received a $400,000 grant to enhance the

ADRC. One of the many opportunities this will afford is to hire someone to focus solely on Section Q coordination within the ADRC.

- Adult Family Home: An amendment was approved that modified the existing Adult Foster Care service in the ElderChoices Waiver program. The service was revised as the Adult Family Homes service, wherein the goal to increase available supported living/housing opportunities. The Governor approved a 1 time stimulus grant of a $100,000 on November 1, 2009, for the Division of Aging and Adult Services to dedicate more resources to the expansion of this Adult Family Home program, The Division dedicated a full time position CMS agreed to pay for it at the 100% Administrative Match Rate for the position.

  Prior to recent changes in Health Care reform, DAAS was in the process of developing a combined waiver that would have encompassed all of our current waivers: ElderChoices, Adults with Physical Disabilities, Living Choices, and our State Plan Service, Independent Choices. This ombined waiver would offer a more effective array of services across the age spectrum, include specialized services for Acquired Brain Injury, and allow for a more efficient management approach to the waivers. The new options available to states as a result of Health Reform will require our staff to compare costs and determine whether benefits of the combined waiver should be pursued, or if another option is more appropriate for the state. A DHS workgroup has been convened to research and recommend actions.

- Demonstration Services: Intense Transitional Management (ITM), Telemedicine, Transition services, Supported Living, Therapeutic Interventions, In-Home Monitoring technology, Medication Management apart of In-Home Monitoring and 24 hour Attendant Care services will be available during the initial 365 day demonstration period for individual participants. These programs are designed to provide appropriate supports and back-up plans to ensure participant health, safety and welfare. The efficacy of the services will be examined to determine if they should be

continued as an approved HCBS service through the waiver or State Plan amendment process.

- Amending the Medicaid State Plan to include Independent Choices, thereby expanding availability to a greater number of participants, including the Developmental Disabilities Alternative Community Services (ACS) waiver participants. This State Plan Amendment will help further progress toward flexible use of Medicaid funds and individual direction of receiving services in the setting of his or her choice.
- Transitioning Targeted Case Management: A State Plan Amendment was submitted to add the target group of persons 18 and older and disabled and persons over age 60 transitioning from a nursing facility to community based residence. (Note: This amendment was placed on hold at this time but will comply with federal requirements once implemented). As part of LTC Balancing Initiatives in Arkansas, a DHS workgroup has been convened to address "conflict free case management." MFP submitted a technical assistance request to New Editions to designate consultants to assist the state in reviewing current case management practices and identifying the most effective model to have more accountability in the management of participant outcomes, as well as to address the issue of conflict of interest that presently exists in our state in case management.

  Currently, Arkansas has a contract with the University of Michigan to analyze Minimum Data Set (MDS) institutional and HCBS data and determine the various RUG levels in all of levels of care. Another part of this process we are also discussing the potential of altering our eligibility criteria for Long-term Care (LTC). Arkansas working to address the wait list concerns and requisite funding As well as address how the health reform opportunities might be used to our advantage to secure this needed funding.

2. Increase the ability of the State Medicaid program to assure continued provision of HCBS long term care services to eligible individuals who choose to transition from an institution to a community setting:

- Evaluation of the success of demonstration services to determine their inclusion in existing state 1915(c) waivers for statewide services.
- Assurance within the operational protocol for continuity of care to participants following the conclusion of the demonstration.
- Permanent provision, through the State Plan Amendment process, of Independent Choices. This action also expands the scope of services beyond those served in a specified waiver;
- Increased the number of slots for persons served in the DD ACS Waiver.

3. Ensure a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS long term services and to provide for continuous quality improvement.

Goal 1: Increase the use of home and community based, rather than institutional long term care services.

Objectives	Time frame of Objective to MFP	Relationship to MFP
Long Term Care Options Counseling:	Concurrent to the planning period, to be enacted at the same time as MFP	MFP goals and objectives influenced language in legislation and factors to be used to develop algorithms to forecast candidates for successful transition.
Aging and Disability Resource Center	Initiated previous to MFP, expansion in concert with MFP	Critical toward obtaining Optional Benchmark 1, having a coordinated process of providing resource information on long term care to persons in or close to LTC planning decision process.
Adult Family Home	Initiated during MFP planning period. Received 100% funding for the position from MFP March 2010.	Increased interest of earlier inactive program. * Service is critical to increase housing options in category "c" – "a residence in a community-based residential setting, in which no more than 3 unrelated individuals reside."
Demonstration Services	Initiated specific to MFP program	These services are designed to provide appropriate supports to ensure participant health, safety and welfare. They will be evaluated to determine if they need to be permanently added to waiver(s) or State Plan.
State Plan Amendment for Independent Choices	Initiated previous to MFP, to be	This SPA will expand home and community based services, and self-

	implemented during MFP grant period	directed opportunities, to participants previously not able to qualify.
Addition of 240 slots to Developmental Disabilities waiver (ACS)	Initiated during MFP planning period	Additional slots to ensure availability of waiver slot to MFP participant and support transitioning from ICF/MR (through priority status)
State Plan Amendment for Transitioning Targeted Case Management	Initiated during the MFP planning period	This SPA service will allow for more focused effort to assist in the transitioning of persons from nursing facilities to residential settings.
Transition Services	Initiated during planning period for development of transitioning programs.	Identified as a priority service for transitioning efforts. Will be initiated for MFP.

* A service available through the ElderChoices Home and Community-Based Waiver Program that offers an alternative to nursing-home placement. When included on the waiver plan of care and authorized by DAAS, a private single-family home, certified by DAAS, may provide AFH in-home services to a waiver participant, who is unrelated to the provider. AFH allows the participant skillful, one-on-one consideration. Services customarily provided include personal care, homemaking, attendant care, supervision, medication oversight and transportation. The services are provided in a home-like environment that includes a private bedroom, semi-private bathroom, home-cooked meals, a common living area and assistance with activities of daily living.

Goal 2: Eliminate barriers or mechanisms, whether in state law, the State Medicaid Plan, the State budget, or otherwise that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long term services in the settings of their choice:

Objectives	Time frame of Objective to MFP	Relationship to MFP
Flexible Financing	Initiated prior to MFP	Flexible financing
State Plan Amendments to include Independent Choices	Initiated prior to MFP	This change will authorize MFP and other Medicaid recipients to self-direct certain services, such as Personal Care, thereby giving the individual greater control in purchasing support, through services, in the settings of their choice.

Goal 3: Increase the ability of the State Medicaid program to assure continued provision of home and community based long term care services to eligible individuals who choose to transition from an institution to a community setting:

Objectives	Time frame of Objective to MFP	Relationship to MFP
SPA to include Independent Choices	Initiated prior to MFP	Expands option of self directed care to a broader base of participants, allowing flexible use of Medicaid funds, and creating a more permanent

		status for the program.
Continuity of Care post MFP	Initiated during MFP planning specific to MFP	A required element of planning for participant continuity of care.
Demonstration evaluation and inclusion into SPA or Waiver(s)	To be initiated during MFP grant period	MFP demonstration services will be evaluated to determine if they will be permanently added to the Medicaid State Plan or Waiver program.

Goal 4: Ensure a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community based long term services and to provide for continuous quality improvement in such services:

Objectives	Time frame of Objective to MFP	Relationship to MFP
Implementation of Real Choice Systems Change Grant National Core Indicator Project and Participant Experience Survey (developed by Thompson Reuters)	Initiated prior to MFP	The Real Choice Systems Change Grant was started prior to MFP and we will continue to monitor this on a monthly, semi annual and annual basis.
Continuous Quality Improvement Plan (CQI)	Initiated prior to MFP	Arkansas's current CQI plan will be expanded to include the MFP.
Risk Mitigation Plan and Critical Incident Management Process	Initiated during MFP process; Critical Incident Policy initiated prior to MFP but did not apply in existing waiver programs.	Risk Mitigation Plan is specific to MFP and the special considerations of a more fragile population. The Critical Incident Management Process will be expanded from its current level (not previously used in the existing waivers) to a more participant centered level. Data will be gathered, analyzed and recommendations generated for further program improvements.
24 Hour Backup Plan for Critical Services	Initiated prior to and during MFP process – depending on service plan	Several services and plans have been in place as critical service support while others, including some demonstration services, such as in-home monitoring, are in response to the MFP program.

MFP Required Benchmarks

A. MFP Required Benchmarks

Purpose: To measure progress in transitioning individuals to the community and rebalancing its long-term care system.

Five (5) goals (two mandatory and three optional) have been identified as critical to ensuring that Arkansas meets the prior stated mission and commitments relating to the MFP initiatives. They are as follows:

Mandatory:

1. Arkansas will assist individuals, from four target groups of eligible individuals, in transitioning from institutional settings to qualified community based settings, as shown below.

	Aged	**MRDD**	**Physically Disabled**	**Adults with MI**	**Total**
FY 2007	0	0	0	0	**0**
FY2008	5	0	14	0	**19**
FY2009	13	2	12	2	**29**
FY2010	20	16	15	2	**53**
FY2011	6	83	26	1	**116**
FY2012	11	59	35	0	**105**

FY2013	31	74	50	0	**155**
FY2014	24	77	49	0	**150**
FY2015	26	84	54	0	**164**
FY2016	29	92	59	0	**180**
Estimated Transitions	**165**	**487**	**314**	**5**	**971**

2. Arkansas will demonstrate an increase in qualified expenditures for HCBS during each year of the demonstration program.

2011	2012	2013	2014	2015	2016
$310,207,295	**$325,717,659**	**$342,003,542**	**$359,103,719**	**$377,058,905**	**$395,911,851**

- Note: Benchmark expenditures include the following services: Private Duty Nursing, IndependentChoices, Home Health, ElderChoices Waiver, DD ACS Waiver, Targeted Case Management, Alternatives Waiver, Personal Care, Assisted Living and Non-Emergency Transportation. The data source is the Medicaid Claims Data.

This growth has been calculated at 5% a year over the demonstration project.

Optional Goals:

Goal Statement: Arkansas will have a coordinated process of providing resource information on long term care services.

1. Arkansas will staff and manage a fully operational Aging and Disability Resource Center (ADRC), named Choices in Living Resource Center.

Outcome Statements	2011 Outcome Measure	2012 Outcome Measure	2013 Outcome Measure	2014 Outcome Measure	2015 Outcome Measure	2016 Outcome Measure
Hospital D/C planners and/or social workers are aware of ADRC	60%	65%	70%	75%	80%	85%

Responsibility: The DAAS is the recipient of a Systems Transformation Grant (STG), funded in part through CMS. The staff involved in this goal consists of the following positions and expertise: One (1) Software Engineer, three (3) Social Service Workers and one (1) Supervisor. In addition to the grant funded positions, the Transition Coordinators (2) and an Options Counseling RN will be center resources.

2. Increase the number of Adult Family Home (AFH) beds annually through 2016.

Outcome Statements	2011 Outcome Measure	2012 Outcome Measure	2013 Outcome Measure	2014 Outcome Measure	2015 Outcome Measures	2016 Outcome Measures
Increase the number of AFH beds by 50% annually starting with a baseline of 11 beds in 2011.	**11 beds**	**17 beds**	**26 beds**	**39 beds**	**59 beds**	**88 beds**

Responsibility: The Adult Family Homes program provides a family-style living environment for ElderChoices clients who cannot live independently. The goal is to prevent or delay institutionalization. AFH providers complete regular training in health, nutrition, caregiving and related subjects and are First Aid and CPR certified. Each AFH is inspected regularly to ensure that required standards are met.

3. There will be a measurable increase in the availability of self directed opportunities in waivers and State Plan optional services, through growth and revisions in existing programs and development of new programs/services.

Increase availability of self-directed opportunities to HCBS waiver recipients.

Outcome Statements	2011 Outcome Measure	2012 Outcome Measure	2013 Outcome Measure	2014 Outcome Measure	2015 Outcome Measures	2016 Outcome Measures
Independent Choices State Plan service	3541 Participants	3895 Participants	4285 Participants	4714 Participants	5185 Participants	5015 Participants

Each goal has several measureable objectives, and that the State can monitor progress over the next five (5) years of the demonstration. Work has already begun through previous grants and initiatives by one or more of the divisions involved in MFP, as is the case in Optional Goal 1. The enhanced Federal Medical Assistance Percentages (FMAP), by MFP, will be used to accomplish primarily optional goals 2 and 3, and Arkansas's specific objectives mentioned previously under the four (4) key demonstration objectives section. Arkansas's MFP goals and objectives will be detailed later in this protocol.

Choices in services and supports, developed through transitioning efforts created by the MFP grant will be permanently added to existing waivers, newly developed waivers and State Plan amendments. Program evaluation by Mathematica and the University of Arkansas for Medical Sciences (UAMS) College of Public Policy, funded through MFP. This process assesses the various indicators to measure success as and identify opportunities for improvement in our rebalancing efforts.

Consumer involvement with the demonstration:

Consumers are very effective in communicating service needs, gaps in services and recommendations for the development of more responsive consumer focused programs. Specific to MFP, consumers will be asked to assist in the development, implementation and monitoring phases of services provided to Traumatic Brain Injury (TBI) patients; and, will be asked to serve in an advisory capacity to the MFP Program Evaluation. Feedback will be provided in areas of concern, including but not limited to their Transition Experience, Quality of Life indicators, and Demonstration Services efficacy and value. Input will be used to further rebalance Arkansas' Long Term Care System and to improve the process to identify and transition individuals with the desire to live in community settings.

Demonstration Policies and Procedures

II. Demonstration Policies and Procedures

A. Participant Recruitment and Enrollment

Target Population:

	Aged	Physically Disabled	MRDD	Adults with MI	Total
FY 2007					
FY2008	**5**	**2**	**14**	**0**	**21**
FY2009	**13**	**16**	**12**	**2**	**43**
FY2010	**11**	**17**	**33**	**0**	**61**
FY2011	**6**	**22**	**83**	**1**	**112**
FY2012	**24**	**25**	**95**	**0**	**144**
FY2013	**26**	**27**	**104**	**0**	**157**
FY2014	**28**	**34**	**115**	**0**	**177**
FY2015	**30**	**39**	**127**	**0**	**196**
FY2016	**32**	**40**	**139**	**0**	**211**
Estimated Transitions	**175**	**222**	**722**	**3**	**1122**

Qualified Institutions:

Qualified Institutions included in Arkansas MFP are licensed nursing homes, licensed ICF/MRs and the Arkansas Health Center under the administration of the Division of Behavioral Health Services, which meet the statutory requirement of an "eligible institution" per Section 6071 (b)(3) of the Deficit Reduction Act (DRA). We have elected to include all such licensed facilities throughout the state. In addition, for the purposes of establishing the 90 day institutional eligibility time period, acute hospital institutions will be included. Arkansas has infrastructure in place throughout the state to accommodate the projected number of persons transitioning per year.

Enrollment Criteria

Minimum Residency Period and Documentation**:**

The minimum residency period in a qualified institution is 90 days. For persons residing in nursing facilities and Arkansas Health Center (AHC), this information will be verified by the Transition Coordinator, using a combination of Minimum Data Set (MDS) and hospital discharge data verified through the Arkansas Department of Health Center for Health Statistics. Information from the ICF/MRs will be verified by the Developmental Disabilities Intake Specialist who in turn submits this documentation to the Transition Coordinator. Verification will be completed individually with each facility's admissions administrator.

Medicaid Eligibility Documentation: The Transition Coordinator will verify Medicaid status for a minimum of 1 day, upon initial referral, using the Mainframe data system.

Medical Eligibility: In addition to the minimum MFP requirements, Arkansas has decided to exclude participation to persons requiring 24-hour skilled individual nursing and/or supervision on a permanent or long-term basis. This determination is made based on assessment data and professional medical recommendations. Nursing supervision may be necessary for behaviors of an extreme nature involving violence, property destruction, or other manifestations determined by medical professionals as necessary to insure safety of self or others. This criterion is required in Arkansas at this time to ensure participant safety and welfare. We anticipate it taking longer than the initial 12 months of demonstration to determine efficacy of some of the demonstration services and therefore making necessary provisions for their permanent inclusion into the waiver(s) or state plan.

Re-enrollment Policy: A MFP participant may be admitted to a facility for a maximum of 30 days before being considered in an institutional residence and thereby discontinued from the MFP program. Re-enrollment may be granted to this participant without re-establishing the six month minimum residency period under the following conditions:

- A medical statement from the participant's primary physician authorizing his or her participation;

- Re-assessed for a new plan of care that addresses the issue of the previous institutionalizing incident and how this will be alleviated going forward as well as any newly identified safeguards and/or services/supports needed;
- If a participants enrollment is discontinued prior to day 365 of the demonstration period, and is re-enrolled following an institutional stay of more than 30 days the 365 day clock will start at the point in which the participant entered the facility. For example, if the participant completed 90 days on MFP, he/she was admitted to a facility on the 91st, the person may be re-enrolled into MFP. If approved, the clock will start back on day 91 of the original 365 day demonstration period.
- If a participant completes the entire 365 day demonstration period and is then readmitted to an institution, that participant may ***not*** be re-enrolled to MFP.

Note: Persons enrolled into the DDS ACS waiver who are re-institutionalized can maintain their waiver slot through abeyance, for a period of 1 year (12 months).

Disenrollment:

- Death;
- End of individual demonstration period;
- Reinstitutionalization;
- Incident of an extreme nature involving violence, property destruction, arrest or other incident determined by the review team as necessary to insure the safety of self or others. (Upon notice of termination of participation the participant will be given instruction on the appeal process for MFP).

State's Protections:

Adult Protective Services (APS), Division of Aging and Adult Service (DAAS), for the purpose of providing evidence required by the Center for Medicare and Medicaid Services (CMS), identifies and addresses and seeks to prevent instances of abuse, neglect, and exploitation throughout the design of MFP, administered by DAAS, as required by state law ACA 12-12-1701 et. seq. This agreement is set forth to define each section's

role and responsibilities to effectively safeguard the health and welfare of each participant.

I. Principles: A memorandum of understanding is to be based on the following principles:

A. The aforementioned parties have a common and concurrent interest in protecting the health and welfare of each waiver participant.

B. This agreement is in no way intended to modify the responsibilities or authority delegated to the parties;and,

C. This agreement is not intended to override or negate any memorandum of understanding which may already exist between these parties.

II. Terms: This agreement details the roles and responsibilities of APS and program staff. It formalizes the immediate sharing of information on reported incidents of abuse and neglect of program participants, to expedite appropriate intervention(s).

A. Program staff are mandatory reporters under state statute and will report any known or suspected situations of abuse, neglect or exploitation of a participant to the Adult Maltreatment Hotline (800-482-8049).

B. A process will be established to expedite program applications or modifications to existing plans of care when the program services would ameliorate health and welfare issues found during the APS investigative process.

C. Self-directed participants will require all selected providers, complete an APS-0001 (Authorization for Adult Maltreatment Central Registry) at the time the providers submit a DAAS certification/Medicaid information packet or DAAS recertification packet. Upon receipt program staff will forward the APS-0001 to APS unit. After which APS will check the Adult Maltreatment Central Registry and return to program staff the APS-0001 indicating that the provider was or was not found on the Adult Maltreatment Central Registry.

D. In-services and provider trainings will be held quarterly, or as needed, to ensure program staff, APS staff and providers have access to information

about programs, processes and issues related to the welfare of waiver participants.

E. APS upon completion and closure of an investigation involving a program participant will advise the program reporter of the incident whether (a) legal action was taken; (b) services were provided; or (c) no action was taken.

F. APS investigates all impaired adult abuse and neglect reported to the Adult Maltreatment Hotline according to Arkansas State law governing APS activity.

G. DAAS staff will meet at least on a semi-annual basis to discuss problems, evaluate the programs and initiate appropriate changes in policy as it relates to protecting the health and welfare of program participants.

H. CMS requires reporting regarding quality assurance measures taken by the State to protect the health and safety of participants. APS will confirm reports made by program staff were investigated when a case is closed by letter that the situation required (a) legal action; (b) referral for services; or (c) no action was necessary.

I. Participant Reporting Guidelines: Each participant will receive a brochure specific to protections from abuse, neglect and exploitation and shall receive verbal explanation regarding the process to notify appropriate authorities when the participant may feel subjected to abuse, neglect or exploitation. Each Intense Transition Manager, DD Specialist, and DHS RN will be responsible to ensure the participant remains aware of the reporting guidelines and receives a new brochure, at each review and re-assessment. A signed copy of the brochure will be maintained in the participant file while a copy is provided to the participant.

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 200d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the DAAS assures no individual shall be subjected to discrimination under this plan on the grounds of race, color, national origin or handicap.

Developmentally Disabled:

Potential participants will be identified primarily through the DDS (Division of Developmental Disabilities) application team managing the wait list DDS Adult Services Intake and Referral unit. DDS Waiver staff anticipates (1) to (2) applications(s) per month, which will be submitted to the team from participants residing in ICF/MR settings that meet the institutional stay Medicaid eligibility criteria. In addition, participants will be identified through the annual review process, at the facility level currently in place. The ACS Waiver was implemented September 1, 1989 and network providers are well aware of the services and procedures for making application. DDS has a unit dedicated to the application process. In addition, a DDS Intake service Specialist will gladly help with completion of the initial paperwork/packet and will submit that packet on participant's behalf. If determined eligible, the person will be placed on the request for services list. A psychological team will determine eligibility in regard to disability and the Medicaid unit determines financial eligibility. The state employs qualified staff by designing functional job descriptions which outline minimum educational and experience requirements.

DDS Central Office mails an information packet to any referral or direct inquiry copy including inquiry contact information is sent to the DDS Intake Specialist assigned to process Pre-Admission Screening and Annual Resident Review (PASRR) referrals. A DDS Intake Specialist will arrange contact and explain the program, obtain informed consent, offer choice, and answer any questions that the person or family may have. After compiling any relative forms, the DDS Intake Specialist submits packet to DDS Waiver Application unit for further processing. This information is logged electronically. An Interim Plan of Care will be selected and issued, dependent upon the individuals' unique situation;

DDS Intake and Referral manager and specialists will be trained in areas relating to informed consent and other program specific areas. Designated staff person(s), Intake Manager, will be responsible for developing a working relationship with facilities' social workers, and setting regularly scheduled meetings to discuss potential participants for the MFP program. In addition, a DDS representative will act as liaison with the MFP Review Team to establish program eligibility and provide specified data specific to the developmental disability target population.

Indirect Recruitment Sources:

A marketing campaign will be executed throughout the state during each year of the grant period. The educational forums will be tailored to the target audiences to include state agencies, personnel, advocacy groups, consumers, facility administrators, affordable and supported housing networks, policy makers, HCBS providers and others identified as interested stakeholders. Each presentation will have a consistent message regarding the process to obtain additional information or to make application, and will include the toll free telephone number for the Choices in Living Resource Center. Trainers will include the Program Administrator, Program Coordinator and those persons trained to address specific groups. For example, Ombudsmen will be trained to provide presentations to facility resident and family councils in nursing facilities and the AHC (Arkansas Health Center of the Division of Behavioral Health). DHS Options Counselors will be trained to discuss the MFP program with individual consumers, families, DHS county office personnel and other similar entities. The Divisions of Developmental Disabilities and Behavioral Health will designate staff to be trained for the purposes of providing MFP information.

Printed materials providing MFP specific information will be available. An MFP Brochure and Question and Answer Sheet will be provided to specific stakeholders for further distribution to potential participants and/or families. Additionally, they will be available to be mailed out upon request for information. MFP Website address will be provided to stakeholders and included on all publications.

As with any program, an increase in self referrals is anticipated once the MFP program has proven successes that can be highlighted in such presentations. Word of mouth, is anticipated, to be the primary referral source, following the first full year of operation.

Access to Facilities and Residents:

Nursing Homes and AHC:

MFP program staff began introducing themselves and the MFP concept to facility administrators during 2007. A Power Point presentation, specific to Arkansas's MFP, was presented through various forums, including the annual Aging conference, which

was approved for Continuing Education Unit's we will continue to make presentations in the next year in advance of the implementation. A meeting was held during the Aging conference which was attended by the Executive Vice President of the Arkansas Health Care Association (AHCA). Prior to that date, the Operational Protocol was emailed to various persons in the association and was since made available to anyone interested. "Access to Facilities" was discussed and it was determined that initial introduction would be made through the AHCA once the protocol is approved by CMS and implementation date is set. A work plan is scheduled for the second quarter of 2008 for the Transition Coordinators and other program staff to visit facilities for further introductions and to try and alleviate any fears or concerns regarding MFP and the potential impact to their facility. Thereafter, when a resident requests an on-site visit or assessment for MFP be conducted, a letter will be faxed to the facility administrator and a copy mailed to the resident or guardian or responsible family member as notification of a Request for Visit. During the initial visit, a consent form will be obtained by the local Ombudsman, acting on behalf of MFP staff, to gather information to be used for eligibility determination as well as to set the stage for future visits in which the transitional plan and resulting programs and services referrals will be generated.

ICF/MR:

DDS staff will first personally introduce the program to facility directors in the coming months. MFP staff will present program information at public meetings and other forums as appropriate. Thereafter, when a resident requests an on-site visit or assessment for MFP to be conducted, a letter will be faxed to the facility administrator and a copy mailed to the resident and/or guardian or responsible family member as notification of a Request for Visit.

Information and Dissemination of MFP Information

Information	Dissemination
Direct Recruitment Letter Describes the MFP program in general terms and invites him/her to request additional information or to make	Mailed to persons identified through a direct data source

application.	
Brochures Tri-fold brochure describing the program in general and process to request additional information or to make application.	Handouts: Presentations, Personally delivered: Options Counseling Mailed: Personal request Stock supply to advocacy and provider agencies
Website: Provides program specific information (including previously mentioned documents) and provides a comment/questions box.	Internet: www.mfp.ar.gov
Q & A Sheet Fact Sheet to more fully describe the transition process and to identify other available HCBS options to the consumer.	Handouts: Presentations Personally delivered: Options Counseling Mailed: Personal requests Stock supply to advocacy and provider agencies

2011-2012 Marketing Plans

Marketing Type	**Audience**	**Budget**
Gap Analysis		
Educational DVD Options for HCBS	**Consumers**	**$15,000.00**
Collateral Materials Options Counseling,		**$12,500.00**
Presentations/Outreach	**Consumers, providers, stakeholders**	

Recruitment Screening Process:

Persons residing in Nursing Facilities or Arkansas Health Center (AHC):

Every inquiry by a potential MFP participant will be pre-screened for appropriateness of referral and potential for enrollment to MFP. Local Ombudsmen will be trained to conduct the initial level pre-screen assessments for persons residing in nursing homes and the AHC. Training, conducted by the MFP Coordinator, will occur during the spring of 2008 Ombudsman meeting and ongoing thereafter in order to provide consistent and

timely information. The training will also include a competency evaluation and role play training techniques to ensure competency and confidence in the execution of the assessments. The tool combines sections of tools used in other states' transition programs and addresses critical indicators for nursing home placement, including medical condition and professional care needs information, functional status (Activities of Dailey Living specific), emotional and behavioral issues, informal resource availability, personal history, preliminary risk assessment, and housing and other supportive services needs. The Ombudsman conducting the pre-screen assessment will be responsible for obtaining the resident's Release of Information. The pre-screening tool has a section for professional recommendation in which the local facility administrator, Ombudsman or DD Intake Specialist conducting the screen may provide information specific to enrollment considerations.

Once initial eligibility (90 day institutional stay and 1 day on Medicaid) is determined by the Transition Coordinator, the pre-screen will be reviewed by the MFP Review Team, consisting of the Transition Coordinator, MFP Coordinator/Administrator, and DHS RN or waiver representative. Provisional approval is granted based on the initial eligibility and pre-screen data provided by the Ombudsman.

Every person residing in a nursing facility or AHC approved for MFP participation will then be referred to an ITM MFP demonstration service to work with the participant and responsible parties to complete the Informed Consent process, to complete a Transition Assessment to be used to develop the Transition Plan, to develop the transition plan (including consumer back-up plan and risk mitigation plan) and to execute the plan (including making appropriate referrals). The ITM discusses the options of services available through the qualified programs. The participant is then referred to the waiver of his or her choice. The ITM will provide the waiver assessment specialist with a copy of the transition plan and updates throughout the transition process. Each waiver has a primary case manager entity. The ITM will coordinate specific MFP functions with the ongoing activities of the primary case manager. The specific waiver assessment specialist shall prepare an individualized plan of care (POC), based on assessment findings and information presented by the ITM, and make initial referrals to service

providers of waiver, State Plan and/or demonstration services. The waiver assessment specialist is responsible to provide the Department of County Operations the necessary documentation to initiate the status changes (from LTC to HCB category) into the Medicaid system. A copy of the POC will be provided to the MFP Transition Coordinator.

Upon approval of each MFP case, a copy of the documents will be presented to the facility (nursing facility, AHC or ICF/MR) discharge coordinator for incorporation into the official discharge planning process. The transition plan will outline potential discharge date, based on housing availability. The ITM is the primary case manager for transition purposes and is responsible for coordinating all case specific activities with the waiver assessment specialist, facility d/c planner, and Transition Coordinator. Once the participant is successfully transitioned into the residential setting chosen by the participant, the waiver primary case manager assumes the primary daily case management role. This case manager will continue to coordinate with the ITM any MFP specific activities, including but not limited to risk mitigation oversight, critical incident management, demonstration services evaluation, and post MFP transition planning process.

Informed Consent and Guardianship

B. Informed Consent and Guardianship

Informed consent should be clearly explained completely understood and absolutely voluntary. More than just a form or a signature, *Informed Consent* is a process of information exchange that discloses the intent and elements about the program, including the services and supports provided both during and after the demonstration year; the aspects of the transition process; participant rights and responsibilities; criteria for who can provide consent as well as the requirements for someone to "represent" an individual in this matter; and a question and answer opportunity. The Consent Form serves as a written summary of the information that is presented to a potential participant and/or responsible party. The form can be made available in large print for the visually impaired and Spanish for Hispanic participants upon request. An interpreter will be used to translate information for the hearing impaired and Spanish participants when needed**.** The Transition Coordinator (TC) is responsible for ensuring that informed consent is obtained from each participant or responsible party before any transition activities begin.

Elements of Consent

Informed consent should stipulate basic required elements of consent in as clear and concise. The format shall satisfy federal and departmental informed consent requirements.

Obtaining Consent

Consent considerations are how, when, and by whom consent will be obtained. Considerations regarding any necessary accommodations for communication barriers should be addressed, as well. Alternative formats of the consent process and form shall be available.

Arkansas is a public guardian state for adults at this time. The state may assume a custodial role for endangered children and impaired adults.

Informed consent may be obtained from a program applicant and/or a person acting in the interest of the applicant, including a court-appointed legal guardian, or other representative such as appointed by a power of attorney, or a representative decision-

maker. A representative will be a legal guardian, other legally appointed representative such as an income payee or may be a family member or friend. A representative cannot serve as a paid caregiver to the participant.

A representative may be requested by the MFP applicant. Additionally, the MFP Review Team may require a representative as a condition of participation. Circumstances indicating a need for representation include:

- Inability to understand or make decisions about the program benefits and potential risks; or
- Inability to understand the impact of decisions made and assume the responsibility for the results of those decision; or
- Special needs due to medical, physical or social circumstances are identified during the assessment process.

All representatives, regardless of legal status, will be required to complete Representative Screening Questionnaire and sign a Designation for Authorized Representative Form.

The Representative must:

- Be at least 18 years of age.
- Obtain approval from the applicant or a consensus from other family members to serve in this capacity.
- Submit to a criminal background checks.
- Show a strong personal commitment to the applicant and be knowledgeable about the applicant's preferences.
- Agree to visit the participant at a frequency, established during the transition plan development and indicated by the needs and circumstances of the individual case, but no less than once per month.
- Be willing and able to meet and uphold program requirements listed for the participant, including self-directed activities.

The representative may NOT:

- Be paid for this service.
- Be employed by the applicant.
- Have any reported history of physical, mental or financial abuse.
- Be known to abuse alcohol or drugs.

Representative decision-maker for Money Follows the Person

If you are interested in participating in Money Follows the Person and have a court-appointed legal-guardian, other representation (such as appointed by a Power of Attorney), or an established payee of income you will need to have that person be your representative decision-maker. A representative will also need to be required when circumstances indicate a change in ability to self-direct or if you are unable to:

- Understand or make decisions about your own personal assistant service needs.
- Organize your lifestyle and environment by making these choices.
- A representative may be requested by the potential enrollee, a Money Follow the
- Persons' staff member, a representative staff member of the Department of Human Services or the fiscal agent.

A representative will be a legal guardian if court-approved and if not court-approved may be other legally appointed representative such as income payee or maybe family member or friend. A representative cannot serve as the paid caregiver.

All representatives will be required to complete and sign a Designation for Authorization Representative Form.

Statement of Rights of MFP Participants

1. To live as independently, actively and fully as desired.
2. To have personal information treated confidentially.
3. To be treated in a courteous and respectful manner and to be free from mental, physical, and financial abuse.

4. To live safely in a healthy environment.
5. To be dealt with in a manner that recognizes your individuality and that responds to your needs and preferences. This includes preferences based on ethnic, spiritual, linguistic, familial and cultural factors.
6. To have information about community services provided to you and to choose the manner in which the services will be provided**.**
7. To participate in the assessment and review of your requirements, development of your service plan, review of your requirements, evaluation and revision of your service plan.
8. To give or refuse consent to the provision of any community service.
9. To raise concerns or recommend changes in connection with the community services provided to you and in connection with policies and decisions that affect your interests, to your service provider, government officials or any other person, without fear of retaliation, interference, coercion, discrimination or reprisal .
10. To know of any changes to the Money Follows the Person (MFP) Program in a timely manner.
11. To appeal the "Money Follows the Person Notice of Decision" to DAAS by calling 1-888-682-0044 or by formally writing to DAAS to appeal decisions received in writing from Money Follows the Person within 10 business days.

Statements of Responsibilities of MFP Participants

1. To know about your rights, and to understand what each right means and how it applies to you.
2. To make your needs and expectations known.
3. To give your consent only when you understand fully what you are agreeing to.
4. To be honest and respectful toward the people who provide your services.
5. To participate in planning and reviewing your services.
6. To let your service provider know if you are having problems with your service or if you feel that your rights are not being respected.

7. To provide true and complete information to any person, associated with the Money Follows the Person (MFP) program, specific to the assessment process, transition planning and implementation and ongoing care, through an authorized plan of care.
8. To ask questions or request the information in an alternative format to ensure full understanding of the process and information being presented.
9. To follow the plan of care and rules governing the programs and services you are enrolled in.
10. To notify your primary care medical provider of any health or medical changes or concerns, in a timely manner.
11. To know and review you're Back-up Plan, in the event of need, to ensure service is not interrupted, and to notify the appropriate personnel when the need to implement the Back-up Plan occurred.

Statement of Rights to a Hearing

Your Right to a Hearing

If you disagree with the action we plan to take, you may request a hearing. You must make your request no later than 30 days from the date of the notice to receive a hearing. If you wish to discuss your case with the MFP transition coordinator before deciding whether to file for a hearing, you should contact the person who signed "Money Follows the Person Notice of Decision."

How to File for a Hearing

If you are not satisfied with the decision on your case, you may request a hearing by completing a DHS-1200, Appeal for a Hearing, which can be obtained from your local DHS County Office or by making the request by letter to the Appeals and Hearings Office, P.O. Box 1437, Slot N401, Little Rock, Arkansas, 72203-1437.

Your Right to Representation

If you request a hearing, you have the right to appear in person and to be represented by a lawyer or by another person you have selected. You may contact the HelpLine Center for

Arkansas Legal Services at 1-800-952-9243 to request free legal aid. (In Pulaski County, you should call 501-376-3423.) You may also log onto their website at www.arlegalservices.org and click on the HelpLine icon.

Prior to the hearing, you and/or your representative have the right to review your record and any other evidence that is to be presented at the hearing. You have the right to present evidence in your own behalf, to bring witnesses, and to question any person who is presented as a witness against you.

Management of Critical Incidents and Compliant Policies:

This information is detailed in the Participant Enrollment and Consumer Supports sections.

Outreach and Marketing

C. Outreach and Marketing

2.2 MFP put together a new Educational DVD highlighting all HCBS and MFP that the Division of Aging Services does in the state, this DVD was completed October 2009. We will be working to put together some companion literature. The ARCHOICES website, https://dhs.arkansas.gov/daas/ARChoices/index.html, website is statewide and allows consumers and care professionals to locate providers of various HCBS in specific local communities. It is a critical piece of technology for transition plan development (including the most critical barriers – housing and transportation).

A. Description of MFP Information: Information will be tailored to the specific audience being addressed, as follows:

Enrollees: Information will be written in a reader friendly style and presented in either a standalone format or included together into a Participant Information Packet. Dissemination of printed materials will be statewide to targeted groups for distribution at the community level, and to individuals based on personal requests. In addition to printed materials, professional educational outreach presentations will be provided to targeted audiences, including resident and family councils in institutions, community support groups, and advocacy groups. Outreach to Stakeholder organizations will begin in early spring 2008 while specific outreach to potential participants is estimated to begin in June 2008. The Local Ombudsman and DD Intake Specialist will primarily be responsible for reviewing the MFP information with the potential participants.

Information	Type of Media	Dissemination Process
1. Brief history of the events leading up to the legislation and initiatives	Print Professional Presentation Website	Statewide: Brochure included in Participant Information Packet Handout at presentations
2. Frequently Asked Question (FAQ) Sheet	Print Professional Presentation	Statewide Handouts at presentations

	Website	Included in Participant Information Packet
3. MFP Eligibility: Enrollment Process	Print Professional Presentation Website	Statewide: Included in Participant Information Packet
4. Program specific elements, including informed consent, participant safeguards, self-direction, benefits and services, quality and evaluation	Print Professional Presentation Website	Statewide: Information packet for participants

Participating Providers: The Arkansas MFP will utilize the existing provider networks currently enrolled in the HCBS programs, as well as any other qualified providers of services as measured by state certification, licensure and/or other established standards. HCBS waiver and Medicaid providers will be given information more procedural in nature, such as internal communication process, reporting and billing changes, participant safeguards, emergency back-up procedures, program specific forms and so forth. Demonstration services, while new to the state, will vary with regard to provider participation. Intense Transitional Management and Transition Services will be open for enrollment by existing waiver providers as well as providers new to the Medicaid and/or waiver programs, so long as they satisfy MFP and Medicaid provider certification standards; Tele-Homecare will be considered technical contracts and be subject to the state procurement procedures.

Existing HCBS Providers

Information	Type of Media	Dissemination
1. Overview of MFP	Print Professional Presentation at Provider Network meetings and conferences Provider website	Statewide Mail out Handout at presentation
2. Procedures specific to MFP, including internal communication process,	Print Professional Presentation at Provider Network meetings	Statewide Mail out Handout at presentation

reporting and billing changes, MFP forms etc	and conferences DHS Memorandums Provider website	www.mfp.ar.gov
3. Emergency back-up plan requirements	Print Professional Presentation at Provider Network meetings and conferences DHS Memorandums Provider website	Statewide Mail out Handout at presentation
4. Program quality and evaluation requirements	Print Professional Presentation at Provider Network meetings and conferences DHS Memorandums Provider website	Statewide Mail out Handout at presentation

Demonstration HCBS Providers

Information	Type of Media	Dissemination
1. Overview of MFP	Print Professional Presentation at Provider Network meetings and conferences Provider website	Mail out Handout at presentation Website
2. DAAS MFP Technical contract procedures	Print	Per procurement guidelines Website
3. Medicaid enrollment procedures	Print Professional Presentation at Provider Network meetings and conferences DHS Memorandums Provider website	Mail out Handout at presentation Website
4. MFP specific procedures, including internal communication process, reporting and billing requirements, MFP specific forms etc	Print Professional Presentation at Provider Network meetings and conferences DHS Memorandums Provider website	Mail out Handout at presentation Website
5. Emergency back-up plan requirements	Print Professional Presentation at Provider Network meetings and conferences DHS Memorandums Provider website	Mail out Handout at presentation Website

6. Program quality and evaluation requirements	Print Professional Presentation at Provider Network meetings and conferences DHS Memorandums Provider website	Mail out Handout at presentation Website

State outreach/education/intake staff: MFP will encompass several target populations. Thus, a wide spectrum of state personnel associated with the provision of information and assistance will be utilized. State personnel will include Division of County Operations eligibility workers, in the local DHS county offices, assessment professionals such as Developmental Disabilities Specialist and DHS RNs, and Arkansas Disabilities Resource Center (ADRC) Social Service Workers. In addition to "state" staff, the Ombudsmen program staff will assist in local outreach efforts, Intense Transitional Manager (ITM), will be actively involved in assessments and transition activities specific to MFP. It will be critical for all staff persons to be confident in every aspect of the MFP program. There will be a series of training sessions around the state targeted at this particular type of audience. MFP administrative staff will utilize video-conferencing capabilities and local on-site trainings at the Department of Human Services (DHS) County Offices.

Listed below are identified training and/or educational opportunities.

State Level Annual Conference Audience	Frequency
Long Term Care Summit	Annual
Developmental Disabilities Annual Conference	Annual
Arkansas Nurses Association	Annual
Arkansas Health Care Association (AHCA)	Bi-Annual
Arkansas Foundation for Medical Care (AFMC)	Annual
Arkansas Chapter of American Case Management Association (ACMA)	Annual
Arkansas Gerontological Society (AGS)	Annual
Mental Health	Annual
Arkansas Waiver Association	Annual

Arkansas Traumatic Brain Injury Board of Directors	Annual
Governor's Integrated Services Taskforce (GIST)	Annual
Governor's Taskforce on Supported Housing	Annual

Outreach/Education/Intake training	Frequency	Details
Arkansas Ombudsmen	Annual	MFP Protocol Detailed Training: Case Scenarios, Transition team roles and responsibilities, informed consent, enrollment process, participant safeguards, quality assurance measures, post-demonstration continuity of care.
State Employees Intense Transition Managers	Semi-Annual	MFP Protocol Detailed Training: Eligibility determination; MFP enrollment procedures, flowchart and timelines; roles and responsibilities; informed consent, internal communication procedures; consumer supports, self-direction intent and procedures, housing inventory management access, complaint resolution, participant safeguards, post-demonstration continuity of care, evaluation.
Developmental Disabilities (DD) Intake and Waiver Specialists DD Providers of Case Management	Quarterly	MFP Protocol Detailed Training: Case Scenarios, Transition team roles and responsibilities, informed consent, enrollment process, quality assurance measures, MFP enrollment procedures, flowchart and timelines; roles and responsibilities; internal

		communication procedures; consumer supports, self-direction intent and procedures, housing inventory management access, complaint resolution, participant safeguards, post-demonstration continuity of care, evaluation.

B: Type of Media: Outreach/marketing/educational will be conducted primarily through presentations directed at targeted audiences. Target groups are identified as stakeholder individuals and entities having a direct interest in the MFP program and the potential impact of the program throughout Arkansas. Print media will be the primary media source. Division DVD, highlighting the MFP program.

C: Geographic Areas: Statewide

D. Locations to Disseminate Information: DHS County Offices, provider agencies (Area Agencies on Aging, Independent Living Centers) advocacy organizations (Arkansas Disabilities Rights Center). The Division of Developmental Disabilities will disseminate information throughout their provider network. Information will also be provided to the AHC for distribution through their network.

E. Seminars, Training and Educational Schedules: See above chart

F. Availability of interpretation services and services for individuals with special needs: Information will be available in alternative formats by contacting the Americans with Disabilities Act (ADA) Coordinator. DHS maintains a department wide contract with a company that provides translation services. Services are provided in a very time efficient manner and will be utilized for MFP should the need present itself.

G. Information on Cost Sharing Responsibilities: This section is not applicable to AR MFP as there is no cost sharing responsibilities.

Stakeholder Involvement

D. Stakeholder Involvement

Long Term Care Balancing Advisory Group Membership - This Advisory Group was convened in September to serve as an advisory capacity with representatives from the groups below. This group meets on a monthly basis and is provided with any problems, challenges or updates on the program. This group that was brought together once GIST was disbanded. The members and their affiliations are:

Name	Representation Category
Larry Brewster	Retired/Consumer
Brenda Stinebuck	Advocate
Herb Sanderson	AARP
Jennifer Dillaha, M.D.	Health Department, Geriatrician
Jim Moreland	Arkansas Rehab Services
Billie Dougherty	Parent, Retired
Eugene Gessow	DHS, Division of Medical Services
Elaine Eubank	AAA
The Honorable Joyce Elliott	Legislator
Liz Blankenship	Assisted Living
Don Hindman	GACA
Phyllis Watkins	Alzheimer's Arkansas
Nancy Elphingstone	Home Care Association, Home Health
Joey Wiggins	NH, Convacare
Joni Jones	DHS, Division of County Operations
Krista Hughes	DHS, Division of Aging & Adult Services
Carol Shockley	DHS, Office of Long-Term Care
David Norsworthy	AHCA

- An Advisory capacity to the MFP Program Evaluation Process, providing feedback in areas of concern, including but not limited to:
    - A. Transition Experience
    - B. Quality of Life indicators
    - C. Demonstration Services efficacy and value

Travel expenses will be reimbursed to encourage participation in consumer involvement on an as needed basis. Additionally, consumers can participate through telecommunication methods.

2. Advocates/Providers: Involvement by advocates' and providers' greatly impacts enrollment, policy and procedures, services and housing access and availability, and quality of the program (including the health and welfare of the participants). Their involvement will be critical in:

- Monitoring Benchmark progress;
- Recruiting Housing support and Inventory Management;
- Identifying and Recruiting of MFP participants; and
- Participating in Continuous Quality Improvement;

3. Nursing Facility Operators: Operators are vital in creating a positive environment in which the culture change to consumer choice is embraced. MFP Administrative staff will conduct training sessions on the MFP process, consumer choice and empowerment philosophies, effective transitioning strategies and building bridges of cooperation. MFP staff will coordinate with the Arkansas Foundation for Medical Care for outreach, through the six training sites in Arkansas, the local nursing facility administration. In addition, staff will present training sessions at state conferences generally attended by nursing facility operators. Their primary involvement during the demonstration will be:
    - Participant Identification and Referral;
    - Transition plan resource;
    - Evaluation and recommendation specific to benchmarks;
4. Inter-DHS offices/divisions: Partnering division staff and waiver program staff work cooperatively to ensure seamless assessment, transitioning and continuity of care before, during and after MFP; and,
5. Government Agencies:

Department of Health (DOH): The DOH Center of Health Statistics will provide documentation specific to hospitalization stays necessary to verify the institutional stay eligibility requirement.

Housing and Urban Development (HUD): HUD will continue to partner with DHS in encouraging local Public Housing Authorities (PHAs) to lend support and priority to the program as well as participate in activities relating to the state's supported housing task force.

Arkansas Development Finance Authority (ADFA): ADFA will continue an active role in the supported housing taskforce. For example, ADFA 2007 recommendations included 26 Low Income Housing Tax Credits (LIHTC/Home Funding) projects throughout the state and an increase Assisted Living Set Asides from $400,000 to $1,085,899 thus demonstrating a commitment to expanding affordable supported housing options in the state.

U.S. Department of Workforce, Arkansas Rehabilitation Services (ARS): ARS partners include the Independent Living Council network and Increasing Capabilities Access Network (ICAN), both of which provide advocacy, training and other resources to participants from each of the targeted populations.

Consumers' and Institutional Providers' Roles and Responsibilities:

The purpose of consumers and institutional providers' participation in Arkansas's MFP is:

A: To participate in the design of the operational protocol, a process taking approximately one year and which required a significant commitment by all involved;

B: To monitor implementation of the MFP Demonstration throughout the remaining implementation period;

i. provide advice and share experiences on specific subject matter related to MFP and MFP initiatives/objectives;

ii. review actions and progress relating to benchmarks, demonstration services, consumer back- up plans, transition plans, housing and quality assurance; and

iii. Commit to participate, within abilities, either directly or through alternative modes, in forums as scheduled to review/discuss program activity reports and make recommendations as appropriate.

Long Term Care Balancing Advisory Group Membership - The Advisory Group was convened in September 2009 to serve in an Advisory capacity as well as stakeholders in the community.

Benefits and Services

E. Benefits and Services

Elderly, Adults with Physical Disabilities and Developmental Disabilities:
With prospective planning in mind for the post MFP period, each participant will be referred to and enrolled in a Medicaid Waiver program of his or her choice, or a State Plan service(s) (such as personal care), which will begin on the first day of the demonstration program and/or demonstration service that the participant elects to choose, if appropriate. This decision will be made during the planning process with the participant and the ITM. A waiver referral is appropriate as it provides a process for the participant to receive all needed services (State Plan, waiver and demonstration) in a coordinated manner by one ultimate authority, the DHS RN or Self Directed waiver Counselor or Prepaid Ambulatory Health Plan Counselor, (Counseling Support Manager, hereafter referred to as Counselor), depending on the waiver. Moreover, this places the participant in the waiver rotation schedule for ongoing re-assessments and seamless continuity of care post MFP demonstration, and ensures a slot in the specific waiver in which the participant will continue. The ITM coordinates a post demonstration continuity plan with the waiver case manager (or Counselor) and ensures the plan is submitted for approval by MFP Transition Coordinator and executed as approved. This plan, required no later than three months prior to the end of the participant's demonstration period will become an official part of the participant file. Once approved, the ITM will initiate appropriate referrals and actions within timelines specified in the plan. Monitoring the continuity plan will be a required Quality Management Systems (QMS) activity of the Transition Coordinator. Referral and enrollment in HCBS waivers is voluntary and the decision to apply for waiver services ultimately rests with the participant. If the participant chooses to not apply for waiver services the ITM is obligated to create the continuity plan with appropriate resources as identified during the 365 demonstration period.

MI/DD participants:
Institutionalized persons with MI/DD, who have requested DDS Waiver Service, will be offered the choice to participate in MFP. If this choice is elected, the DDS Intake Specialist will notify the DDS Waiver Unit once an individual has been determined

eligible to participate in the MFP Demonstration Program, and DDS Waiver slot will be placed in reserve for the individual(s) and will be utilized at the end of MFP Demonstration Program. Participants with MI/DD are enrolled on day 1 of the waiver program.

The service delivery mechanism for existing services is "fee for service". In addition, self-directed option is available in varying degrees, as described below. The Medicaid mechanism, provided at the termination of the demonstration period.

Qualified HCB Services via waivers:

MFP will include four (4) existing waivers and a State Plan Service:

Persons who are aged:

- ElderChoices (EC): Aged 65 and Older.
- Living Choices (LC) Assisted Living: Licensed Level II Assisted Living Facility for ages 21 and older.

Adults and Children with MI/DD:

- Alternative Community Services (ACS): Ages birth until death, provided the diagnosis determines age of onset to be prior to age 22, Developmentally Delayed and Mentally Retardation, Cerebral Palsy, Epilepsy, Autism, or any other condition that results in same level of functioning, as if the previous condition exists. Self-directed care option is exercised through the Independent Choices state plan service implemented April 1, 2008.

Persons with Physical Disabilities:

- IndependentChoices (IC): Ages 18 or older, (self-directed care program).
- Note: This waiver was transitioned to a regular State Plan service April 1, 2008. Companion service through Elder Choices and State Plan personal care service can be self-directed through this program.
- Living Choices (LC) Assisted Living: is available to persons aged 21 and older.
- Alternatives for Persons with Physical Disabilities (APD): Ages 21 through 64 declared physically disabled by SSA or MRT. (Significant self directed care focus).

Qualified HCB Services via State Plan: Participants may also choose to receive various State Plan HCB services as deemed appropriate, including:

1. Targeted Case Management (TCM);
2. Personal Care (PC);
3. Home Health Services;
4. Private Duty Nursing;
5. Non emergency transportation
6. Independent Choices (IC) effective 4/08.

Qualified HCB Service Package: The following charts depict the qualified HCB services available to each population, served by the demonstration, through existing Medicaid waivers and the State Plan.

		Elderly and Adults with Physical Disabilities					MR/DD
WAIVER SERVICES	EC	IC	APD	LC			ACS
Adaptive Equipment			x				x
Adult Day Care	x						
Adult Day Health Care	x						
Adult Family/Foster Care	x						
Assisted Living (II)							
Case Management			x				x
Chore service	x						
Companion Service	x	x					
Community Experiences							x
Community Transition							
Consultative Service		x					x
Counseling service							
Crisis Center							x
Crisis Intervention							x
Environmental Accessibility Adaptations/Modifications			x				x
Fiscal Support		x	x				
Homemaker	x						

Home Delivered Meals	x						
Individual Directed Goods and Services		x					
Limited Nursing Services				x			
Medication Assistance				x			
Non medical Transportation				x			x
Periodic Nurse Evaluation				x			
Personal Emergency Response System	x						x
Personal Attendant		x	x	x			
Pharmacy Consultation				x			
Respite service	x						x
Specialized medical equipment and supplies							x
Skilled medical service							
Supplemental Support							x
Supported Employment							x
Supportive Living							x
Therapeutic Social and Recreational programming				x			

State Plan Services		Elderly and Adults with Physical Disabilities					MR/DD
Targeted Case Management		x					
Personal Care		x	x				x
Home Health		x	x	x			x
Independent Choices (effective 4/09)		x	x				x
Private Duty Nursing		x	x	x			x
Non-Emergency Transportation		x	x	x			x

Qualified State Plan services may be received separately or concurrently with existing waiver programs.

Demonstration HCB Service package

Specific rate information referenced throughout this section has been removed from the narrative description of the services. The specific rate information is included on a chart in Appendix. Rates will be updated annually to reflect changes.

In Home Monitoring

24/7 personal monitoring system that identifies developing health problems and alerts for potential emergencies by detecting changes in key behaviors. These changes are tracked through a patented technology. It detects prolonged inactivity, extreme temperatures, and other activity and captures this to a web-based program that is monitored around the clock by emergency response operators. Additionally, family members and other authorized users are able to view the activity any time of the day or night. The system uses sensors that are strategically placed throughout the home. No cameras are used, preserving privacy. No action is required on the part of the participant. The sensors detect information and feed it to the computer, which develops key patterns of behavior. The data is tracked over time so that the information can be shared with physicians or other health professionals as needed. It has even been used to verify the arrival and departure of personal attendants. Because of the sensitive nature of this equipment, it is best suited for frail elderly or person with disability, living alone.

Medication Monitoring Device

Stores dosages of medication and provides reminders to take the medicine. Technology allows the monitoring company to receive signal 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 medication too close to the next dosage time) and will call to notify a specified contact of the need to make contact with the participant.

Tele-medicine

"Tele-medicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Tele-medicine is not a consultation provided by telephone or facsimile machine.

1. Tele-health: Tele-health is the incorporation of telecommunications technology within the Provider(s) Case Management Delivery Model for the provision of patient care. In this model, home visits and care coordination are paired with telemonitors placed in the

patient's home. These monitors will collect clinical information from the patient, such as vital signs or reported symptoms, which will be transmitted to the patient's home health agency daily via their telephone line for clinical review. The combination of trended vital sign data with clinical judgment enables the home health nurse to make informed decisions which will drive clinical action. Signs and symptoms of declining health status in patients are recognized early and appropriate adjustments to therapy or care are made in a timely basis. Additionally care is coordinated with the patients Primary Care Physician (PCP) or specialist to ensure treatment orders remain appropriate. The overall result will be an improved quality of care and reduction in health care costs. Tele-health can be tailored to any target population. Home Health agency nurses will teach family members or caregivers to assist in the gathering of the health data and its transmission.

2. Tele-Rehabilitation:

Access to rehabilitative services for rural patients remains a critical challenge, especially with the increasing numbers of individuals needing health care services as more and more aging baby boomers develop chronic diseases and disabilities. There is currently a shortage in health care professionals as well, and availability of therapists in rural areas is even more acute. Over the past decade, computer and information technologies have become increasingly accessible and cost-effective as a means of providing health care services and education. Tele-rehabilitation is the clinical application of consultative, preventative, diagnostic, and therapeutic services via two-way interactive telecommunications technology.

Tele-rehabilitation Plan: An interventional evaluation of Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST), utilizing a tele-rehabilitation approach will be conducted with MFP participant volunteers who require traditional therapy. "Volunteer" simply refers to the fact that participants choose whether or not to participate in the tele-rehabilitation program (participation is voluntary). Outcomes from interventional volunteers will be compared to those from a reference group of participants receiving in-home therapy services in the traditional manner. The length of this evaluation will be one year.

Participants: Individuals participating in the MFP Medicaid program, requiring standard rehabilitation for progressive exercise, assistive technology strategies, environmental modifications and/or improvement in functional capacity, will be invited to participate. In particular, individuals who have recently been prescribed a walker, those exhibiting functional decline, those at high risk for falls identified via a fall risk assessment, and those needing bathroom safety equipment will be targeted. The project goal will be to enroll ten individuals in the interventional group per year. Individuals in the interventional group will be paired to a reference group. Persons from this reference group will be matched to the intervention group by their scores on routine home health start of care Outcome Assessment Information Set (OASIS) assessment.

The functional independence of both groups will be assessed utilizing home health OASIS data set questions. Only individuals with a good prognosis for improvement and the improvement is believed to be realized in 3 months time or less, will be included due to the one year time limit of MFP.

Therapeutic Interventions

MFP participants require a minimum of ninety days institutionalization for eligibility. MFP administration considers these participants to be vulnerable and needing additional medical/health oversight immediately upon transitioning to a community setting. The interventions include an array of therapeutic activities designed to assess potential risks and identify therapeutic plans of care for risk mitigation and optimal participant care. Areas of Interest might include: Medication Adherence: Some studies have suggested that 28% of elderly patient admissions to the hospital are due to medication noncompliance or adverse drug events. The FDA says that medication errors cause approximately one death per day. Other adverse medication effects can lead to falls and injuries – one study suggested that 14% of hip fractures in the elderly can be attributed to At the start of care, provider case managers, under the direction of a licensed pharmacist, will review the patient's prescribed medications as well as over the counter medications the patient is taking for risk associated with polypharmacy and other side effects, and will assess the patient's ability to properly self administer medications.

Nutrition/Dietary Needs A person's food intake affects behavior, mood and brain function. The human brain requires a high amount of energy and nutritional resources. Additionally, alcoholism is often responsible for nutritional deficiencies affecting mental functioning. Nutrition status is relevant to every person in every target population served by MFP. Ongoing nutrition assessments will help identify serious risk indicators such as unwanted weight loss or gain, uncontrolled blood sugar levels, severe confusion, dehydration, and urinary tract infections indicating a need for intervention. Assessment findings will identify needs for special diet considerations, changes that are needed, and counseling or educational needs.

Other Assessments as Identified by Therapeutic Management Director - Depending on diagnosis, additional assessments might be indicated. For example, a person who has a developmental disability might be referred for specific assessments that might differ from those mentioned above. Interventions include but are not limited to life skills training; behavior management services; medication assistance and nursing assistance beyond what is authorized in the Medicaid program or to persons not meeting home health "home bound" or other admission criteria. Annual maximum benefit is $5,000.

Community Transition Services

Community Transition Services include items, goods or services necessary to allow an institutionalized individual to transfer into a community setting. These services may be provided throughout the individual demonstration period**.** Billing for services may begin the day the individual transitions into the community. These services include:

- Environmental modifications;
- Assistive Devices;
- Security Deposits;
- Rental and Utility Deposits;
- Initial pantry set up with food, if needed;
- Essential Furniture, Appliances and Household Items; and,
- Other items, goods or services approved by DAAS and deemed necessary for the health and welfare of the participant.

Community Transition Services do not include monthly rental or mortgage expenses, regular utility charges or recreational items. Maximum annual benefit is $5,000 per transition from nursing home and a lifetime maximum of $10,000 under MFP.

Recreational items that have a therapeutic intent are acceptable but must be justified as having a specific goal or intent beyond recreational purposes.

Supported Living Services

Supportive living services are an array of individually tailored services and activities provided to enable eligible persons to reside successfully in their own homes, or in an alternative living setting. Services are delivered over a 24 hour period in a protected supervised environment to persons needing this level of supervision on a short term basis. The need might be prior to transitioning as the residence receives final preparations, after discharge from a hospital or institutional inpatient stay, or during a period of repair or, renovation to an existing residence. Supportive services include nutritional management, meals, personal care services, supervision, medication supervision and/or assistance, social integration and transportation coordination. Nursing facilities provide a similar service now through private arrangements with families. Additionally, many facilities are enrolled as Facility Respite Providers and are accustomed to short stay arrangements. Qualifications of Providers: Licensed Nursing Facilities, Licensed Assisted Living Facilities and Certified Adult Family Homes will be accepted as providers of Supported Living Services. Maximum annual benefit not to exceed $5,000 per person per state fiscal year.

24 Hour Attendant Care

Although each waiver participant has access to personal care through either or attendant care self-directed or agency directed sources, the maximum benefit is approximately 10-12 hours of care per day. There are circumstances that might place the participant at need for 24 hour care on a temporary basis. For example, a person who has a serious episode of pneumonia and upon discharge from the hospital simply needs more assistance until he/she is physically stronger. This person might not have an informal caregiver and thus will need to rely on purchased services. The purpose of this ***service*** is to supplement existing waiver and/or Medicaid State Plan services to allow additional hours, on a time

limited basis. Personal Attendant Care is the provision of assistance to a medically stable and/or physically disabled person to accomplish those tasks of daily living that the person is unable to complete independently.

Intense Transition Management

ITM is the provision of assistance in obtaining services or benefits, beyond the scope of existing case management activities, (currently reimbursed by Medicaid). This includes acting on behalf of participants to resolve identified barriers to needed services or resources. Activities may include completion of applications and paperwork, attending meetings/hearings on behalf of the participant, inspection of services or goods acquiring or obtaining in addition to inspection (such as furniture, appliances, ramps), crisis intervention, setting up banking services and other related activities identified as determination of need (utilities, phone and other necessary home services, arranging for housing durable medical equipment) necessary on the official plan of care.

ITM will be available to all participants. There is no medically necessary criteria. This service exists to provide additional oversight and assistance during the initial 12 months of a person's transition out of an institution. Lessons learned from previous experience taught that many of these people will lack informal or familial support and thus need someone conducting those functions normally carried out by this support system. In addition, persons who have been in an institutional setting for six months or longer have a learned dependency due to the nature of institutional schedules. More intense management will be necessary to assist the person to acclimate to a more independent level of functioning.

Qualifications of Providers: For persons transitioning from nursing facilities or the AHC, providers will meet the same criteria of existing Targeted Case Management services for persons 60 years of age and older. Additionally, persons serving the Developmentally Disabled population, service providers' qualifications are: DDS Service Providers are required to be certified and/or licensed by DDS and meet the qualifications outlined in DDS Certification Policy 1091 and DDS Licensing Policy 1090.

It is acceptable for an ITM agency to utilize a transition assistant to fulfill non-skilled duty areas critical to the transition of an individual. The assistant must be directly supervised by the assigned Intense Transition Manager, time records maintained by both, and perform only those tasks related to securing home furnishings and other necessary purchased goods. The assistance will allow the ITM to devote more time to the more critical activities associated with plan development and oversight of participant(s) health and welfare. The agency must develop a position description for this position and submit to DAAS for approval. There must be a direct supervisory pathway between the ITM and the Transition Assistant.

Goods and Services

Goods and services are goods, services, assistive technology and/or adaptations/modifications to equipment or environment to improve the quality of life or potential for greater independence in a home and community setting. These goods and services are not provided through the waivers or through the Medicaid State Plan and address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community). The item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in their environment; and, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Goods and Services are approved only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the individual is unable to meet such expenses through other sources. MFP executes the initial plan of care for transitioning purposes and would include Goods and Services on that POC. The POC is provided to the Waiver authority (be it a DHS RN, Counselor, or DD Specialist). Goods and services are available in the Independent Choices (now a state plan option), but not in the waivers per say. MFP participants are enrolled into appropriate waivers on day 1. Therefore, even if the person chooses to self direct through the Independent Choices venue, the waiver authority will be in receipt of the MFP POC which specifies the goods and services approved and reimbursed through the MFP program.

Providers: Open enrollment will be offered to existing and new providers of Medicaid waiver, state plan or MFP services. A limit of $5,000 per person per state fiscal year. Rates will be increased at the time Medicaid increases rates to reflect the current rate for related services.

Geographic Restrictions of Services: Qualified HCB waiver and State Plan services, and demonstration services will be available on a statewide basis; the service area will expanded over the initial approval period with CMS approval.

Consumer Support

F. Consumer Support

Each MFP participant will be enrolled into an existing HCBS waiver or State Plan service of the participant's choice, based on considerations of desires and needs, if appropriate. Agency directed providers of waiver HCBS are required to maintain emergency access and back-up plans specific to their service.

- ElderChoices Provider Assurances section 102 Staffing (AAS 9514) outlines specific requirements for agency level back-up plans.
- DDS Licensure Standards for ACS Waiver sections 508.1 and 802 outlines requirements for back-up plan for staff and transportation services.
- Self directed (SD) care options empower the participant as the direct provider/employer with the associated responsibilities of that role, including the development of back-up plans, such as the Alternatives, Self Directed Services Agreement (form AAS 9512):

The following chart reflects the service delivery mechanism for each waiver and concomitant responsibilities.

HCBS Waiver Program	Service Delivery Mechanism	Consumer Support Responsibility	Primary Monitoring Responsibility
Alternatives	**1. Traditional** **2. Agency/Participant Co-Employer Directed** **3. Self Directed**	**1. Direct Providers** **2. Participant/Direct Provider** **3. Counseling Support Manager**	**1. DAAS Program Staff** **2. Counseling Support Manager**
ElderChoices	**1. Agency Directed**	**1. Direct Providers**	**1. DAAS Program Staff** **2. Targeted Case Manager**
Assisted Living	**1. Agency Directed**	**1. Direct Providers**	**1.DAAS Program staff**
DD ACS	**1. Traditional** **2. Self Direction through personal care**	**1.Direct Providers** **2.Counseling support** **3.Financial Management services**	**1.DAAS Program staff** **2.Counselor**

Assisted Living Waiver was effective 12/01/2010 for five years and the unduplicated count for 5 years is 800 slots for each year.

The AAPD waiver renewal was approved effective 7/1/2010. The maximum unduplicated counts are Year 1 (this year) – 2,600, Year 2 – 2,800, Year 3 – 3,000, Year 4 – 3,200 and Year 5 – 3,400.

Consumer Support Educational Materials

Information regarding consumer supports will be provided in a participant specific back-up plan as part of the official Plan of Care, on the website, and through the various professionals working on the individual case (such as the Intense Transition Coordinator, DHS RN, DDS Specialist, transition coordinator, HCBS Ombudsman and MFP Administrative staff).

A.1. Organizations providing pre-transition and transition services to MFP participants

Pre-Transition services

Local Ombudsmen will conduct MFP Pre-Admission Screening to assist in the enrollment determination process. Ombudsmen are employees of the Area Agencies on Aging. The State Ombudsman, employee of the DAAS, has some administrative and technical assistance responsibilities and is actively involved in training and development activities with the local Ombudsman programs. Qualifications require certification by the state long-term care Ombudsman.

DHS RNs and DD Specialists are employees of the Arkansas Division of Aging and Adult Services and the Division of Developmental Disabilities respectively. These staff is responsible for assessment and coordination activities associated with specific waivers and will be actively involved in the MFP assessment, enrollment and care plan development processes of the program.

Transition Coordinators (TC) are employees of the Arkansas DAAS and are assigned to the MFP program. There will be 2 TC assigned to MFP and will be assigned to specific counties of coverage. These staff will work specific with Ombudsmen and ITM's within their designated counties to oversee the transition process as well as other specified duties. Qualifications are similar to those of non-medical case management and do not require licensure. The position will require a bachelor degree and experience in case management related activities. The degree requirement may be optional depending on level of experience.

Back-up systems for MFP participants:

Transportation:

Transportation needs of the constituents vary and include medical appointments, employment services and personal services. The DAAS' Committee representative and the Assistant Director were instrumental in encouraging providers to participate by submitting their information in the statewide directory of services ARGETCARE. The ARGETCARE website (www.ARGETCARE.org) is a database of information that contains hundreds of resources, covers the entire state of Arkansas, makes it easy to find the information someone needs, helps hospital discharge planners, case managers, and other professionals to better serve someone, as well as, helping individuals find the resources they need to continue to live independently. The ARGETCARE statewide directory of services includes information on location, hours, cost, availability, and how to contact each provider. During a query conducted Sept 20, 2007, a total of 176 transportation providers from across the state were represented on the website.

Another back-up option is the Medicaid Non-Emergency Transportation (NET) Program. NET is an option for participants to secure transportation to and from doctor appointments or other covered Medicaid services. Participants do not have to pay anything and there is no limit on the number of trips or miles traveled. However, NET will only transport to and from Medicaid-covered services. NET is available to anyone who is on Medicaid and has no other way to get to the Medicaid covered appointment. Other resources must be exhausted before NET is authorized. Emergency or specialized transportation may also be provided by local emergency transport through hospital or contract entities.

Transportation will be addressed on the individual participant's transitional plan of care, completed by the Intense Transitional Manager, and submitted to the DHS RN or DD Specialist for the official Plan of Care.

Direct Service Workers

CMS has asked the National Balancing Indicator Contractor (NBIC) and the National Direct Service Workforce Resource Center (DSW RC) to prepare a strategy for developing and collecting DSW indicators for a selected number of states and Arkansas

is one of those states. Arkansas was one of the states that were selected, we had the NBIC, DSW RC, and the MFP program. The overall goal of the project is to increase the number of direct service workers available to people in home and community settings.

Repair and Replacement of durable medical and other equipment

Durable medical companies enrolled as a Medicare provider are subjected to a multitude of quality assurance standards through CMS, The Joint Commission and other accrediting entities. CMS has recently implemented Quality Standards specific to this industry. In addition, there are a series of 21 supplier standards, some of which apply to warranty coverage, repair or replacement expectations, substandard item returns, and complaint resolution and record maintenance. Arkansas Division of Medical Services requires all Medicaid enrolled providers to submit evidence of accreditation. The Joint Commission currently examines 514 Elements of Performance, 122 Home Medical Equipment Standards, 19 Accreditation Preparation Requirements and 9 National Patient Safety Goals. DME companies in Arkansas provide stickers on their equipment containing company name and contact information. They provide 24 hour emergency access to service in the event of faulty or broken equipment.

In the event the participant is unable to get assistance from a DME provider, depending on the nature of the equipment and its impact on health and safety, the participant can contact emergency medical assistance through the 911 system, or notify their Attendant Care Agency for guidance in appropriate action, up to and including contacting APS. This will generate a critical incident report and be recorded into the database for quality improvement review and remediation.

Arkansas' Assistive Technology (AT) Program is called Increasing Capabilities Access Network (ICAN) will be considered another, although non-emergency, support to the participant. ICAN is one of nine programs in the Special Programs division which is one of seven divisions in the overall structure in ARS. ICAN operates a statewide AT equipment loan program. By offering individuals with disabilities, service providers, and employers the opportunity to borrow and try out a number of different types of devices prior to making a purchase, equipment loan programs extend immediate short-term loans of assistive technology without the costly investment in a device that may prove unsuitable for the consumer. Loan programs permit hands-on-experience and enhance

the facilitation of training associated with assistive technology devices and services through AT Act project personnel. In addition to aiding in the selection process, the loan programs provide temporary replacement equipment to consumers when a personal device is on order or in need of repair.

Access to Medical Care

Participants and their case manager, a provider based service, will discuss medical care access during the transition planning meetings and the decisions will be reflected on the transitional plan of care. If the participant needs and/or requests assistance in this area, the case manager will make initial arrangements for the medical appointment(s). In addition, the case manager will provide basic training to the participant on steps to making and changing an appointment, and how to identify and communicate problems with the medical staff. The participant will have access into medical services via home health, if the participant is so referred. The use of the tele-home monitoring unit and skilled in-home oversight visits will ensure a significant level of access and monitoring. Local providers, home health agencies, are required to provide 24 hour emergency access for participants.

Emergency Basis Procedure

An emergency safety situation is defined as unanticipated behavior that places the person served or others at serious threat of violence or risk of injury if no intervention occurs. The organization **providing services to a MFP participant** shall establish policies/procedures for emergency intervention that must be undertaken in the event of emergency circumstances for a consumer that has no behavior management plan in place. The policies/procedures must identify the circumstances under which emergency intervention procedures will be used as a protective measure in a life- or safety-threatening situation only when de-escalation has failed or is not possible.

Emergency basis procedure may not be repeated more than 3 times within six months without the interdisciplinary team meeting to revise the plan of care. Each incident consists of: a behavior was exhibited, a procedure was used, the individual was no longer thought to be dangerous, and the procedure was discontinued.

Note: The number three 3 means 3 distinct incidents. The 3 distinct occurrences could take place in 1 day.

Complaint and resolution process for elderly, and adult disabled target populations:

HCBS Waiver Process:

MFP participants will be enrolled in the existing HCBS waiver of the participant's choice and will continue, based upon the eligibility determination process, post demonstration. Each HCBS waiver program has an established complaint and resolution process, beginning at the direct provider level and progressing to the Programmatic Administrators and finally through the DHS Appeals Process. Complaint and resolution process specific to MFP Demonstration services will be the responsibility of the MFP Program Administrator. MFP participants will be provided with a brochure describing the Demonstration Complaint and Resolution Process, included in the Participant Information Packet along with a letter letting them know that if they move of the facility before they are enrolled in the Money Follows the Person Program they will lose program eligibility. It will provide instruction in the steps to be taken in order to report a complaint and how resolution attempts will be made at each level of the process. (Note: Previous reference to the HCBS Ombudsman have been removed as this was a grant funded position which has recently expired. The activities of the HCBS Ombudsman were additional to the existing policy and procedures and its removal in no way compromises the integrity of the complaint and resolution process).

Complaint and resolution process for the MR/DD target population:

This policy provides the administrative procedure for reporting and gathering information about complaints regarding services/supports provided by private organizations licensed and persons certified by Division of Developmental Disabilities Services (DDS), i.e., Early Intervention Voucher Providers, Certified Case Managers, etc. and to bring resolution to complaints. This is all covered in the DDS waiver information.

Data Tracking:

MFP staff is responsible for maintaining a data system that will monitor critical incidents specific to consumer supports and back-up systems, including:

- type of participant requesting back-up calls;

- type of incident;
- responsiveness of all entities involved; and
- quality management remediation recommendations.

Data is entered into an IRIS database by key staff assigned to the various programs. This data can be accessed by the MFP Coordinator so that cumulative data to specific programs can be gathered into a report. The MFP Review team consisting of the Transition Coordinator, MFP Coordinator, MFP Administrator and division(s) program representative will review the data and identify resolution recommendations. Recommendations will be shared with program QA designees and remediation status reports will be obtained by MFP Coordinator to monitor resolution status. Copies of recommendations will be provided to DMS QMS staff so that they can monitor success of resolution process.

Self-Direction

G. Self-Direction

Money Follows the Person (MFP) program will offer many choices of existing Medicaid waiver, State Plan and new demonstration services. Participants will have the opportunity to self–directed services, choose agency-based services or receive a blend of both. The, Self-direction philosophy begins with a participant-directed community transition plan and a participant-centered plan of care.

Once the MFP participation is elected, the participant, whomever he/she chooses to include, and the TCM, Counselor or DD Specialist work together to develop a participant-directed detailed plan of transitioning to a qualified residence within established time frames. The transition plan will consider living preferences, informal supports identified by the participant, resources available in the community and health and safety needs. The assessment tool will identify strengths, weaknesses, and special needs or accommodations required for a safe transition. Every participant will be referred to an existing waiver program or State Plan service.

Monitoring for Success

Each waiver, which includes self-direction includes back-up supports as required by CMS. In addition, MFP will implement specific services and procedures to ensure the participant has the necessary support for successful transition and community re-entry in order to achieve maximum independence. These services will also support self-direction through additional oversight and evaluation. These include: Intense Transition Coordination – a demonstration service available during the 12 month demonstration period will provide assistance with complex non-medical support needs.

Consumer Supports

Participants consumer-directing their care will be required to have a back-up worker, either formally or informally, to provide care in the absence of the primary attendant. The need for and effectiveness of the back-up plan, will be reported by the Intense Transitional Manager, Counselors, DHS RNs and DD Specialists to the Transition Coordinator, and will identify any needs for modifications to the self-directed

arrangements. The MFP Administrator will notify specific waiver program administrators of any concerns regarding the participant's ability to self-direct and/or any significant findings on the reports on self-direction.

Each waiver will fully delineate the responsibilities of every individual with a role in the participant's self-direction plan of care, including program participants and their representatives if applicable, the state including Medicaid and the operating agency, DAAS and the various employees assigned to work with the program, the Pre-Paid Ambulatory Health Plan (PAHP), including Support Service Coordinators and the Financial Management entity and all service providers. Monitoring by all persons involved will identify situations that have potential negative consequences. Together, this team will identify and implement necessary corrective actions.

Despite the efforts to ensure successful consumer-directed care, there will be times when the participant is better served by a more traditional agency-directed system of care. Termination of self-directed services may be initiated by the participant or by the waiver program team.

7. a. Voluntary Termination of Self-direction

When an MFP participant voluntarily elects to discontinue participation, the MFP staff will notify the waiver program staff of the request or vice versa depending on which staff receives initial notification by the participant. Waiver program staff/designee will discuss with the individual the reason for termination and assist the individual in resolving any barriers or problems that may exist in preventing continuation. If the participant wishes to continue with the option to terminate, the staff/designee will assist the participant by informing of traditional agency providers in the participant's area. Once the participant selects an agency provider, the staff/designee will make the referral to establish agency services. Self directed services can continue until agency services are established or the participant may elect to use informal supports until agency services are established.

7. b. Involuntary Termination of the use of Self-Direction

Health, Safety and Well-being: At any time the health, safety and well-being of the participant is compromised by continued participation in a self directed option, the participant may be returned to the traditional agency provider managed program. MFP staff will communicate any concerns regarding health, safety and well-being to the specific waiver staff who will in turn work with the participant to make alternative arrangements. In addition, waiver or program staff, counselor or DHS RN (depending on program) responsible for the self-direction oversight may determine that continuing in self-direction would compromise the health, safety and well-being of the participant, he/she make take actions to transition the participant to agency directed services, and will take appropriate action to update the POC and participant file, and to notify all entities involved in the case. Updates file copies will be provided to MFP transition coordinator.

Change in Condition: Should the participant's ability to direct his or her own care diminish to a point where he/she can no longer do so and there is no responsible representative available to direct the care, the waiver self-direction staff (counselor) will notify MFP staff of any action taken to terminate self-direction status. Action to transition a participant from self-direction to agency based services is the responsibility of the waiver self-direction Counselor.

Misuse of Allowance: Specific procedures for each waiver.

Underutilization of Allowance: Specific procedures for each waiver.

Each waiver has specific procedures for involuntary termination from self-direction. Appendix A includes the Self-direction procedures for each waiver included in MFP.

7.c. State's goal for unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

Many of the existing Waiver programs available to MFP participants have varying degrees of self-direction options. Therefore, it is a reasonable expectation to have *50%* of the MFP program participants electing the self-direction care option, by year 4, starting lower and increasing as the ACS waiver participants request and enroll in self- directed services as well as implementation of the ARHome waiver. Please see Benchmark specific to increasing self direction. Self Directed services will have unique procedure

codes and can thereby be tracked, in terms of numbers of users, through the Medicaid Management Information Systems (MMIS) system.

Quality

H. Quality

Roles and Responsibilities

The Arkansas Department of Human Services (DHS) is the State Medicaid Agency and its Division of Medical Services (DMS) is the Medical Assistance Unit. DMS retains responsibility for the administration and oversight of all Medicaid waivers, including those operated by other Divisions. To facilitate this responsibility, DMS added a Waiver Quality Assurance Administrator to its staff in 2005. The Waiver Quality Assurance Administrator plays a major role for DMS in QMS development, implementation, and monitoring for each 1915(c) HCBS waiver. The Waiver QA Administrator works closely with the operating agencies and serves as primary liaison with CMS regarding the waivers. This position serves to centralize responsibility and accountability for the waiver with DMS, and also provides leadership in promoting and improving waiver quality in 1915(c) HCBS waivers. The Waiver QA Administrator reports to the DMS Assistant Director, and together they keep the DMS Director informed of waiver concerns and activities**.** The DMS Program Integrity Unit will review a valid sample of participant records on a quarterly schedule. This unit will review for compliance with key assurances including level of care, plans of care, qualified providers, health and welfare, administrative authority, and financial accountability. The DMS Program Integrity Unit will report findings to the MFP Program Administrator. The MFP Program Administrator will share review results with the DMS QMS Administrator, and will advise on and track any necessary remediation and improvement.

DAAS is the designated operating unit for the MFP demonstration. This demonstration program will receive quality oversight identical to existing waivers, to be conducted according to the Quality Management plan established per waiver. DMS QA Administrator has designated a DMS QA staff person to the MFP program. DMS QA staff has determined that adequate resources exist presently to achieve a 100% participant review**.** The MFP Program Administrator will work closely with the DMS Quality Assurance Administrator during the discovery, remediation and improvement processes of the Continuous Quality Improvement (CQI) plan. During the MFP demonstration period, the two will meet quarterly to discuss the findings of the reports and any issues or concerns. During these meetings, priorities will be established and strategies developed

for any remediation and improvement results and report findings to their Assistant Directors. When the DMS Program Integrity reviews and reports are added to the discovery process, the quarterly results will inform of prioritization as well as needed remediation and improvement. DMS and DAAS Assistant Directors and Directors will be informed of major issues that impact one or more of the assurances and their input requested into prioritization and remediation. Remediation and quality systems changes are the responsibility of the MFP Program Administrator. Corrective action plans will be developed by the Administrator, approved by DMS QA, and the director of Division of Aging and Adult Services, Director of Division of Aging, immediate supervisor of the Administrator.

The DMS QA Administrator will compile a QMS report regarding MFP annually and will be based on discovery findings from DAAS and DMS Program Integrity as well as the CMS-372s report. The annual QMS report will include key information relevant to each assurance, information about participation in and cost of the program based on the CMS-372s reports, and information on any key findings, including status of remediation and improvement activities. The DMS QA Administrator will make the report available to DAAS and DMS administration as well as key stakeholders and/or advisory groups.

The QMS report will be placed on the agenda of the MFP Advisory groups; starting with the Long Term Care Balancing Advisory Group Membership - This Advisory Group was convened in September to serve in an Advisory capacity as well as Stakeholders in the community. The Advisory group(s) may provide input and recommendations to assist in quality systems changes.

Assurances

Arkansas plans to integrate the MFP demonstration into existing 1915 (c) waivers and HCB State Plan services. For the qualified HCBS offered under existing Medicaid waivers, the State assures:

- The MFP demonstration will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing

1915 (c) HCBS waiver application during the transition and during the 12 month demonstration period in the community.

- The quality management systems currently employed in the existing 1915 (c) waivers will be employed under the demonstration, to include all demonstration services.
- The quality management system will address:
    1. Level of Care Determinations;
    2. Individual Plan of Care;
    3. Identification of qualified HCBS providers for those participants being transitioned;
    4. Health and welfare;
    5. Administrative authority; and
    6. Financial accountability

The agency will gather quality management data on a monthly basis and will conduct a quality management review on a quarterly basis, specific to the six QMS assurances.

Below is a chart depicting the Quality Management Process schedule provided by the QMS Program Administrator.

Additional Quality Management Strategies:

In addition to the existing DMS quality management process, DAAS will incorporate additional quality indicators during the participant's transition period, as well as program quality indicators specified by CMS for the web-based semi-annual program evaluation. Data for the quality indicators will be gathered on a monthly basis, reviewed quarterly, and reported semi-annually based on criteria stipulated by CMS.

The Alternative Community Services (ACS) waiver for persons with Developmental Disabilities has recently completed the development of their QMS plan document, in cooperation with DMS QMS. Please reference MFP Operational Protocol Appendix D1 for this document. It will be submitted to CMS during the upcoming waiver renewal process.

Individual Risk Assessment and Mitigation

Identifying Participant Risks - Assessment: Potential risks will be identified through the pre-transition screen, transition assessment process, waiver specific assessment process, therapeutic assessment process, and the case management/DD Specialist assessment process. Ultimately, the Transition Coordinator with the assistance of the Intense Transition Manager or DD Specialist, and with input from the Therapeutic Management Director, will identify a specific Risk Assessment and Mitigation Plan which will be added to the official Plan of Care for each MFP participant. The Risk Assessment will be a critical process to establish effective back-up plans and shall address at a minimum:

- Health
- Fall Risk
- Risk of institutionalization
- Behavioral health
- Fragility of informal caregiver system

Risk Mitigation:

The ITM and DD Specialist will be required to submit monthly progress reports for the first 6 months of the participants' transition, and quarterly thereafter. Anything identified as a concern will necessitate a review of the POC and provider assignment/selection for needed revisions and/or actions.

Housing

I. Housing

Arkansas will enroll a participant in the MFP Demonstration to a "qualified residence" as defined in Section 6071 (b) (6) of the Deficit Reduction Act. Qualified residences, their definitions, projected usage and regulatory information is described as follows:

Type of Qualified Residence	No of Qualified Residences *= projections	State Definition of Housing Settings	Number of Available Units * = projections	How Regulated
Home owned or leased by individual or individual's family member	Unknown *	home leased by individual or family home owned by individual or family	7* 8*	lease with landlord N/A
Apartment with an individual lease, lockable access and egress, & which includes living, sleeping, bathing & cooking areas over which the individual or the individual's family has domain & control.	26 361	**Assisted Living** Any building or buildings, section or distinct part of a building, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide assisted living services for a period exceeding twenty-four(24) hours to more than three (3) adult residents of the facility who are not relatives of the owner or administrator; includes those facilities which provide assisted living services either directly or through contractual arrangements or which facilitate contracting in the name of residents; housing, meals, laundry, socialization, transportation, one or more personal services, and limited nursing services. **USDA Rural Dev.**	180	Office of Long Term Care

		The Rural Community Development Initiative (RCDI) program provides technical assistance and training funds to qualified intermediary organizations to develop their capacity to undertake housing, community facilities, and community and economic development projects in rural areas. RCDI grant funds are available to intermediaries and have a dollar for dollar matching fund requirement, intended to double the impact of the grants. Qualified organizations can be public or private (including tribal organizations) that have been legally organized for at least three years and have experience working with eligible recipients. Recipients of assistance from the intermediary can be non-profit organizations, low-income communities, or federally recognized tribes.		
	109	**HUD properties** Public housing is limited to low-income families and individuals. An HA determines your eligibility based on: 1) annual gross income; 2) whether you qualify as elderly, a person with a disability, or as a family; and 3) U.S. citizenship or eligible immigration status.		
Residence, in a community-	5*	* **Adult Family Care** A private single-family	20 (targeted	Certified by DAAS, Medicaid

based setting, in which no more than 3 unrelated individuals reside.		home, certified by DAAS may provide in-home services to a waiver participant, who is unrelated to the provider. AFC allows the participant skillful, one-on-one consideration. Services customarily provided include personal care, homemaking, attendant care, medication oversight, and transportation. The services are provided in a home-like environment that includes a private bedroom, semi-private bathroom, home-cooked meals, a common living area, and assistance with activities of daily living.	for 2009)	provider enrolled. Not subject to additional regulatory oversight at this time.

Type of Residence Documentation:

MFP staff will maintain data specific to the type of residence in which each participant chooses to transition. This information will be included in the transition plan and will be entered into the MFP database. In addition, the data will be updated if the participant's housing changes during the course of their demonstration period, along with a reason for housing changes. Housing changes will be communicated to the Transition Coordinators by TCM, Counselors or DD Specialists using a Change in Status communication form.

Assisted Living properties meeting statutory requirements of Section 6071 of the DRA defining a "Qualified Residence":

Assisted Living in Arkansas meets criteria (B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.

Arkansas Assisted Living Level II Regulations, Section 200 Purpose:

> **"The purpose of these rules and regulations is to establish standards for Level II assisted living facilities that provide services in a homelike environment for elderly and disabled persons. Level II assisted living facilities ensure that residents receive supportive health and social services as they are needed to enable them to maintain their individuality, privacy, dignity, and independence, in the highest degree possible in an apartment-style living unit. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation.**

The environment promotes resident self-direction and personal decision making while protecting resident's health and safety."

Section 300 Definitions:

"Choice: Viable options available to a resident that enables the resident to exercise greater control over his or her life. Choice is supported by resident's self-directed care (including methods and scheduling) established through the care planning process, and the provision of sufficient private and common space within the facility to provide opportunities for residents to select when and how to spend time, and when and how to receive personal and assisted living services."

Level II assisted living facilities provide private and semi-private (semi-private units are available for those who choose this arrangement) apartment style units that have separate bathroom and kitchenette areas. Residents are provided with keys to their apartment units; have unlimited access into and from the facility (residents are free to come and go as they please); have private mail boxes; have the right to have pets; have the right to eat meals at the facility dining room, eat meals prepared by the facility in their apartment, to prepare their own meal in their apartment, have meals delivered into the facility or to dine out; have the right to choose private health care providers if needed; and, have the right to unrestricted visitation.

Assisted Living Facilities have the authority, and are required through regulation, to terminate individual lease agreements based on level of care exceeding their license. Facilities' administrators (or designees) assist residents and families in developing discharge plans. Regulations require 30 day notice of termination of the agreement to allow for post discharge plans to be implemented.

Assisted Living Facilities have the authority, and are directed through governing regulation, to terminate lease agreements in cases where the medical level of care exceed the level granted under the facility license. Notice of termination is required and the facility administrator or designee assists the resident and/or family in making appropriate post discharge plans.

The AR Housing Registry became operational March 2009. This site was initiated under Affordable Housing and Long-Term Care Support. It is currently managed by RTZ Associates. Funding for this site is currently provided by Systems' Transformation Grant; however, this grant is scheduled to end June 2010. Significant marketing activities were executed to secure participation by providers. However, to date there has been only marginal success. MFP requested funds to assume this website. It will require retooling. DAAS is currently considering dedicating a position for website maintenance to ensure adequate resources are given such critical elements of our operations.

State's approach to addressing identified housing shortages for persons transitioning under the MFP demonstration grant, including:

Arkansas' Development Finance Authority, as well as the state association of housing authorities, and for-profit and non-profit housing developers are taking active roles in developing and implementing a campaign to identify and secure a permanent, ongoing public source of funds for the state's Housing Trust Fund. Some partners are helping to defray the costs of the campaign while others will help with the grassroots effort to disseminate the messages to gain public and legislative support. Once funded, Housing Trust Fund moneys will be available, through a competitive process, to housing authorities, CAP agencies, and developers, among others, to use toward building new or rehabilitating existing housing. A range of Universal Design standards—from full-access and to visitability—will be a highly valued component of a successful application, as will connectivity with existing community services and supports.

MFP staff has coordinated networking activities with the state HUD office, USDA Rural Development state office, and local housing providers. MFP staff:

- are scheduled to present to the state NAHRO (National Association of Housing and Redevelopment Officials – Arkansas Chapter) spring workshop;
- act as liaison to Supported Housing taskforce;
- coordinate MFP referrals with TBRA (Tenant B Rental Assistance) based grantees (described below) for immediate assistance for participants within their service area(s).

ii. Address how the State Medicaid Agency and other MFP stakeholders will work with the Housing Finance Agency, Public Housing Authorities and other housing programs they fund to meet these needs; and MFP Coordinator served on the Governor's Supported Housing Task Force. This group was successful in securing enabling legislation for a Housing Trust Fund, deemed critical to address identified housing shortages in our state. This group is currently working on strategies to achieve a dedicated funding source.

iii. Identify strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants.

<u>Increase in ADFA 2008 Housing Credit Allocation Standards:</u>

- Amount: Increase the maximum amount of credits allowed for assisted living developments to $425,000. This represents a 100% increase.
- Assisted Living Set-Aside. Increase the set-aside amount for assisted living developments to $850,000. This represents a 100% increase.

Adult Family Home (AFH) Development:

The Governor approved a 1 time stimulus grant of a $100,000 on November 1, 2009, for the Division of Aging and Adult Services to dedicate more resources to the expansion of this Adult Family Home program. The division did upgrade a current position inside the division to a higher level, so that we may hire a full time coordinator for Adult Family Homes. This position has been approved to be paid at 100% Federal Match Rate by Money Follows the Person

As an objective under the 2006 Housing grant, Arkansas will certify and enroll five (5) AFH providers into the ElderChoices waiver program.

Assisted Living Facility (ALF) Growth:

The Department entered into a Memorandum of Understanding with ADFA to administer a newly approved stimulus project of $5 million to increase the development of affordable assisted living units throughout the state. Policies and procedures are expected to be promulgated no later than August 2010.

Arkansas currently has 1,614 ALF beds licensed. In addition, there are 1,970 beds either approved under the Permit of Approval (POA) process or under construction. Once a POA is issued, the company has 9 months to secure a construction contract. Once signed, another 6 months is allowed for foundation to be laid. Once construction is completed, the facility has 15 months to get licensed.

Universal Design Standards

Livable Communities Workgroup of Arkansas's Partners in Planning has secured funding to build a model interactive bathroom into a trailer that will be driven around the state for educational/awareness opportunities.

Continuity of Care

J. Continuity of Care

HCBS Waiver and State Plan & State Plan Amendment(s)

Continuity of Care Post Demonstration Evidence

Waiver or State HCBS	Renewal Date	Number of Occupied Slots (6/07)	Maximum Number of Slots	**Mechanism to Accommodate MFP Participants AND Continuity of Care Evidence Post Demonstration**
ElderChoices (EC) 1915 (c)	2009 2014	5,324 active cases	7,950	Records indicate that there has been an approximate -1% growth rate over the last 3 years, indicating adequate capacity to accommodate projected new growth associated with MFP. **1.3 4% capacity is correct number of growth rate**
Developmentally Disabled (ACS) 1915 (c)	2009 2014	3495 active cases 7/07: 240 new slots, releasing 20 per month	3838 1.3 Max slots approved 3988	MFP participants will be occupying a waiver slot upon acceptance to the MFP program. The participant will retain this slot beyond the demonstration period.
IndependentChoices (IC) 1115 (a) / 1915 (j) State Plan service	N/A	1,800 active cases	7,500 effective 2/1/08	Effective 3/1/08, IC will transition from an 1115 demonstration waiver to a 1915(j) State Plan service.
Adults with Physical Disabilities (APD) 1915 (c)	6/2010	1,725 active cases	2008 = 2100 slots approved 2009 = 2200 slots approved	Growth rate was 8% over the last 3 years, indicating adequate capacity to accommodate projected new growth associated with MFP. Growth rate was 28% over the last 3 years, from Oct 06 – 09.
Assisted Living. Living Choices Waiver	11/2010	263 active participants	12/05-11/06=215 12/06-11/07=315 12/07-11/08=415 12/08-11/09=515 12/09-11/10=615	Records indicate that there has been an approximate 16% growth rate over the last year, indicating adequate capacity to accommodate projected new growth associated with MFP.
TBI 1915 Waiver	N/A	N/A	N/A	This will be addressed in the combined waiver.
State Plan Personal Care.	N/A	N/A	N/A	N/A
State Plan Targeted Case Management	N/A	N/A	N/A	N/A

Continuity of Care Post the Demonstration

HCBS Waiver and State Plan & State Plan Amendment(s)

DHS will convene a Waiver Executive Review Committee. This group will review slot availability, amendment requests and other critical decisions in order to establish a departmental strategic approach to the further development of the waiver programs to meet the needs of the recipients.

MFP participants are enrolled in the waiver of their choice during their 365 day demonstration period, as determined through participant choice and waiver capacity. If a waiver is not selected, an alternative plan will be documented by the ITM and approved by the MFP TC. If a waiver is selected, the process is as follows: Waiver assessments are conducted by the entity as specified in each waiver. In the Developmental Disabilities ACS Waiver, initial assessment is initiated by a DD Intake Specialist (employee of the Division of Developmental Disabilities) and completed by the DD Waiver Specialist (employee of the Division of Developmental Disabilities). In the ElderChoices, Alternatives for Persons with Physical Disabilities, Independent Choices, Living Choices, Assisted Living the assessment process is completed by a DHS RN's (employees of the Division of Aging and Adult Services).

MFP requires a post demonstration transition plan for each participant to be submitted for approval. The Post demonstration transition plan, developed similarly to the initial transition plan, will be completed by the Intense Transition Manager (ITM) in cooperation with the waiver care manager or self directed Counselors or DD case managers (depending on the participant's choice of waiver and/or services) three (3) months prior to the end of the participant's demonstration period. The Transition Coordinator will be monitoring the participant 365 day clock and will issue a notice reminder of the post demonstration transition plan due date. The transition plan must address ongoing services and programs to which the participant is referred, projected dates of re-assessments and who will be completing the assessments, and who will be assuming primary responsibility for the participant's case once MFP demonstration period concludes. MFP program administrators will have internal procedures to track the number of days in the demonstration program and will notify the participant, providers, DHS personnel (specific Waiver program staff, Division of Medical Services, Division of County Operations), and other appropriate entities of the official MFP end date and submit data to the management information system to make the appropriate changes in the data systems. The post

demonstration transition plan will ensure referrals for services and assessments are scheduled in advance of the demonstration end date to ensure against the disruption of services.

Organization and Administration

III. Organization and Administration

The Operational Protocol is submitted by the state Medicaid agency, the Division of Medical Services (DMS) in partnership with the Division of Aging and Adult Services (DAAS), Behavioral Health Services (DBHS), and Developmental Disabilities (DDS). All Divisions are part of the Arkansas Department of Human Services (DHS) and serve under the same Department Deputy Director. The DAAS will serve as the operating agency for MFP, but will involve all previously mentioned divisions of DHS. Also included in DHS is the Division of County Operations (DCO). DCO is the local DHS presence in counties throughout Arkansas, and is the point of entry into most Medicaid services, determining eligibility for Medicaid, Food Stamps, Transitional Employment Assistance, and administering certain community programs. The DHS Office of Long Term Care (OLTC) is the designated entity for medical level of care, for nursing facility admission, determination.

Roles and Responsibilities

MFP Administrative/Program services: To include program planning, development, and management; contracts and grants development and management; program data management; inter departmental activities and stakeholder involvement coordination; and overall program quality and evaluation monitoring. MFP administrative staff include one (1) Program Administrator, (1) Program Coordinator, (1) Program Assistant and (2) and Housing Specialist (1) Transition Coordinators budgeted to the DAAS. Resumes are attached. Data integration will be managed by the MFP Coordinator, and overseen by the MFP Administrator. Each Division has assigned staff to coordinate data access and delivery to the MFP Coordinator.

MFP Eligibility Determination services To require all divisions included in the aforementioned paragraph. A MFP review team will require a designated staff person from DDS, DBHS, and DAAS. In addition, DCO is the designated entity to determine Medicaid eligibility and the OLTC is the designated entity to determine medical level of care. Divisions participating in the MFP demonstration have designated staff to be responsible for the activities associated with the program operations related to MFP.

MFP Transition Management services To include participant screening, explaining program specifics in order to obtain informed consent, development of the initial transition plan, referral to waiver and/or

other services as directed by participant, assistance during the transition, and coordinating care during the institutional transition. Intense Transition management services will proceed through the entire 365 day demonstration period for each participant and will culminate in the development and implementation of the post demonstration transition plan. Transition Management services may be provided through existing Medicaid TCM and case management services of Developmental Disabilities providers, both of which are local service providers. Transition Management services will be monitored by the MFP Transition Coordinators.

Coordination and Communication Process

Department of Human Services (DHS) Internal Process

- Both divisions' directors are on the executive staff of DHS- reporting to the same supervisor in the Director's office.
- All divisions participating in MFP have designated staff persons in respective program areas to work directly with MFP Program Administrator.
- DMS and DAAS designated staff meet on a regular basis with DHS supervisor to clearly identify areas and issues requiring internal coordination, prioritization, tasks assignments and review and approval procedures.
- MFP Program Administrator submits monthly program report to DAAS director which in turn is incorporated into an internal report to the DHS Director's office.

External Process

- DHS Director is a member of the Governor's cabinet.
- The Governor's office has a designated liaison assigned to DHS.
- The DMS and DAAS directors meet periodically with the Governor.

Staffing Plan:

Full time Program Administrator: Arkansas assures that the Project Director for the MFP Demonstration is a full time position. This position is held by Marico Howe. She will be building an IT system to track progress in the state's LTC balancing initiative, including building data bases, developing evidence based evaluations and reporting capacity for real time program management; and training field and central office staff in the new data systems, and automated assessments/care planning and outcome measurements. This includes planning and administering grant initiatives, benchmark tracking, provider development, quality assurance, meeting all federal and state reporting

requirements, ensuring the MFP database is current and accurate and other duties as assigned. Development and revision of project work plans and timelines and supervision of MFP staff.

The number and title of dedicated positions paid for by the grant. Please indicate the key staff assigned to the grant: In addition to the MFP Program Director, Marico Howe, there are five (5) positions, each assigned full time to MFP. They are: MFP Coordinator: Julie Kaplan this position serves as the MFP Program Coordinator is responsible for the day to day management of the grant. Activities and functions also include grant and contract development and administration; and responding to inquiries from providers, other agencies, the public, etc. regarding data, program, and statistical analysis pertinent to populations served by the grants, programs, and reports.

iv. Transition Coordinators (TC): Two positions, similar to social service workers with experience in case management. We moved the location of the Transitional Coordinators to be housed with the rest of the MFP staff._will be the lead for all MFP referral/intake activities; will have specific counties assigned to work with Intense Transition Coordinator and Ombudsmen, to facilitate effective participant selection and transition planning activities; will be the lead facilitator to the MFP Review Committee in making determinations specific to eligibility and pre-transition plan approval; will ensure appropriate risk management assessment and oversight is ongoing; will work with housing network stakeholders to ensure the inventory is updated and current; and will document participant specific data, identify potential problem areas and recommend remediation activities. The TC will be liaison between DCO, DDS, AAS, DMH (the four key partnering divisions in MFP) at the participant service level. Dionne Saih, will be responsible for entering participant and other program specific data into software program; responding to informational inquiries; drafting correspondence; coordinating presentation schedule and materials, travel and other office management duties; management of the housing inventory; drafting technical contract requirements for demonstration services; coordination of stakeholders ongoing meetings and other related duties.

Percentage of time dedicated to grant:

Each position listed above is dedicated full time to the MFP demonstration.

Identify positions providing in-kind support to the grant.

There are no positions providing in-kind support for the MFP demonstration.

Tele-home care services, and the UAMS School of Public Policy selected to perform evaluation of the MFP demonstration**.**

	Name of Person Hired

Position	
MFP Program Administrator	**Marico Howe**
MFP Program Coordinator	Julie Kaplan
MFP Program Assistant	Dionne Saih
Transition Coordinators (x2)	Latonya Robinson Paula Gentry

Entity responsible for performance assessment of MFP staff:

The Program Administrator will be assessed by Director of Division of Aging, Director of the Division of Aging and Adult Services (DAAS); all other MFP positions will ultimately be assessed by Marico Howe, MFP Program Administrator, with final approval authority by Director of Division of Aging, Director of DAAS. DAAS is one of the divisions under the umbrella of the Arkansas Department of Human Services (DHS), as are the other partnering divisions in the MFP demonstration. The operational activities of the MFP demonstration have been delegated to DAAS.

Evaluation

IV. Evaluation

The Evaluation of Money Follows the Person has been put on hold until we have a larger pool of participants.

The local evaluation will give primary emphasis and attention to the ARHome 1915 (a) (c) Waiver component of the larger MFP program, because it represents a unique and innovative approach to long-term care re-design that has not been tested or studied extensively in Arkansas or other states. By placing emphasis on this particular component of the state's MFP program, the local evaluation will complement the national MFP evaluation in offering a more detailed view of the operation and impact of ARHome in transitioning eligible nursing home residents to consumer-directed, home and community-based services. Moreover, implementation of ARHome initially will be restricted geographically to a 12-county region of the state, thereby allowing the local evaluation to employ a delayed-treatment comparison group methodology to assess the program's impact. This design feature represents another unique facet of the local evaluation that will complement the activities of the national MFP evaluation.

A second major area of focus for the local evaluation will be the demonstration home and community-based services that Arkansas will offer as part of its MFP demonstration. These services include a 24-hour help line, in-home monitoring services, telemedicine services, enhanced therapeutic services, community transition services, supported living services, and 24-hour attendant care. The local evaluation will offer a detailed examination of the patient subgroups that receive this care, their patterns of service use (duration and intensity), and the outcomes of these services.

The local evaluation will rely primarily on Arkansas data sources that are already being collected and reported as part of the national MFP evaluation, in order to avoid any duplication in data collection. These data elements will include those collected through the national MFP Quality of Life assessment instrument.

V. ADRC/MFP Budget

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. ADRC Nursing Home Transition and Diversion Programs	$	$	$	$ 0.00
9.				0.00
10.				0.00
11.				0.00
12. TOTAL *(sum of lines 8-11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 0.00	$	$	$	$
14. Non-Federal	0.00				
15. TOTAL *(sum of lines 13 and 14)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.ADRC Nursing Home Transition and Diversion Programs	$ 200,000.00	$ 200,000.00	$	$
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$ 200,000.00	$ 200,000.00	$ 0.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:

23. Remarks:

Authorized for Local Reproduction

Standard Form 424A (Rev. 7-97) Page 2

Final Budget

VI. Final Budget

Money Follows the Person Demonstration
Worksheet for Proposed Budget (revised Dec 2011)

Instructions: Please fill in only the cells highlighted in YELLOW. All other cells will auto populate and are locked.
Please note: The enhance rate for FFY2009 thru FFY2011 is based on the increased FMAP rate related to the implementation of the Recovery Act of 2009 & the Education, Jobs and Medicaid Assistance Act of 2010. Budget calculations for the last quarter of CY2008 thru the first two quarters of CY2011 use these rates.

Date of Report:	**1/30/2012**	**Preparer Name:**	**Georgia McNabb**
State:	**Arkansas**	**Preparer Phone:**	**(501) 320-6547**
Award Number:	**1LICMS300145**	**Preparer Email:**	georgia.mcnabb@arkansas.gov

Original and ARRA Increased Federal Medicaid Assistance Percentages (FMAP) are provided in the State FMAPs worksheet tab.

FMAP Table	Column 1		Column 2	Column 3	Column 4	Column 5			
Please express FMAP as a decimal (example: 68.32%=.6832)	Original State FMAP		State Enhanced FMAP (1.00 - Reg FMAP / 2 + Reg FMAP)	ARRA Increased FMAP (Oct 2008 - Jun 2011)	ALLOWED Enhanced FMAP Not to Exceed 90%	Calculated Enhanced FMAP (Oct 2008 - Dec 2010)			
	FFY 2007	0.73370	0.8669		0.8669				
	FFY 2008	0.72940	0.8647		0.8647				
Oct-Dec 2008	FFY 2009 Q1	0.79140	0.8957	0.83405	0.9000	0.9170			
Jan-Mar 2009	FFY 2009 Q2	0.79140	0.8957	0.83405	0.9000	0.9170			
Apr-Jun 2009	FFY 2009 Q3	0.80460	0.9023	0.83405	0.9000	0.9170			
Jul-Sept 2009	FFY 2009 Q4	0.80460	0.9023	0.83405	0.9000	0.9170			
Oct-Dec 2009	FFY 2010 Q1	0.80460	0.9023	0.80950	0.9000	0.9048			
Jan-Mar 2010	FFY 2010 Q2	0.81180	0.9059	0.80950	0.9000	0.9048			
Apr-Jun 2010	FFY 2010 Q3	0.81180	0.9059	0.80950	0.9000	0.9048			
Jul-Sept 2010	FFY 2010 Q4	0.81180	0.9059	0.80950	0.9000	0.9048			
Oct-Dec 2010	FFY 2011 Q1	0.81180	0.9059	0.80950	0.9000	0.9048			
Jan-Mar 2011	FFY 2011 Q2	0.78300	0.8915	0.79960	0.8998	0.8998	0.21700	0.1085	0.89150
Apr-Jun 2011	FFY 2011 Q3	0.76390	0.8820	0.79960	0.8998	0.8998	0.23610	0.11805	0.88195
Jul-Dec 2011	FFY 2011 Q4	0.71370	0.8569		0.8569		0.28630	0.14315	0.85685
	FFY 2012	0.70710	0.8536		0.8536		0.29290	0.14645	0.85355
	FFY 2013	0.70710	0.8536		0.8536				
	FFY 2014	0.70710	0.8536		0.8536				
	FFY 2015	0.70710	0.8536		0.8536				
	FFY 2016	0.70710	0.8536		0.8536				

Populations Transitions Chart (unduplicated count)
Unduplicated Count - Each individual is only counted once in the year that they physically transition.
All population counts and budget estimates are based on the *Calendar Year (CY)*.
The State is held accountable for the current year populations to be transitioned and actual numbers should be consistent with semi-annual reports submitted in Jan/Feb for the previous calendar year.

	Elderly	I/DDD	Physical Disability	Mental Illness	Other	Total per CY
CY 2007 (**actuals**)	0	0	0	0		**0**
CY 2008 (**actuals**)	5	14	2	0		**21**
CY 2009 (**actuals**)	13	12	16	2		**43**
CY 2010 (**actuals**)	20	15	29	2		**66**
CY 2011 (**actuals**)	22	26	25	5		**78**
CY 2012 (**projected**)	25	30	28	0		**83**
CY 2013 (**projected**)	29	35	32	0		**96**
CY 2014 (**projected**)	33	40	37	0		**110**
CY 2015 (**projected**)	30	24	39	0		**93**
CY 2016 (**projected**)	32	24	40	0		**96**
Total Count	**209**	**220**	**248**	**9**	**0**	**686**

Demonstration Budget Summary-All Years
* *Qualified HCBS Services, Demonstration HCBS Services* and *Supplemental Services* are defined in the MFP Solicitation.
* *Administration - Normal* - costs that adhere to CFR Title 42, Section 433(b)(7);
* *Administrative - 75% - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10);*
* *Administrative - 90% - costs that adhere to CFR Title 42 Section 433(b)(3)*
* *Federal Evaluation Supports* - costs related to administering the Quality of Life Survey (reimbursed @ $100 per survey).
* *Rebalancing Fund* - is a calculation devised by CMS to estimate the amount of State savings attributed to the Enhanced FMAP Rate that could be reinvested into rebalancing benchmarks.
* *Other* - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2016)	**Total Costs** (Fed & State)	**Federal**	**State**
Qualified HCBS	$ 35,076,737	$ 30,128,933	$ 4,947,804
Demonstration HCBS	$ 4,057,505	$ 3,500,577	$ 556,928
Supplemental	$ -	$ -	$ -
Administrative - Normal	$ 962,655	$ 481,328	$ 481,328
Administrative - 75%	$ -	$ -	$ -
Administrative - 90%	$ 68,380	$ 61,542	$ 6,838
Federal Evaluation Supports	$ 66,744	$ 66,744	$ -
Administrative (Other) - 100%	$ 4,039,462	$ 4,039,462	$ -
State Evaluation	$ 385,133	$ 192,567	$ 192,567
ADRC Funding	$ -	$ -	$ -
Total	$ 44,656,616	$ 38,471,152	$ 6,185,464

Administrative 20% Cap Calculation	
Total Costs (Fed & State less Fed Eval & ADRC)	$ 44,589,872
Total Administrative Costs (Fed & State)	$ 5,070,497
Admin. to Services Percentage (20% Max)	**11%**
	Within budget

Total Costs (Fed & State) Per Capita	
Service Costs	$ 57,047
Admin Costs	$ 7,391

Estimated Rebalancing Fund Calculation	
CY 2007	$ -
CY 2008	$ 15,281
CY 2009	$ 114,566
CY 2010	$ 123,528
CY 2011	$ 710,234
CY 2012	$ 801,353
CY 2013	$ 921,556
CY 2014	$ 1,059,790
CY 2015	$ 900,821
CY 2016	$ 900,821
Rebalancing Fund Total	**$ 5,547,950**

If necessary, please update actual expenditures for all past years. — **Enter CY 2007 Comments Here**

2007 Federal Award			$ 139,513	
CY 2007	**Rate**	**Total Costs** (actual expenditures)	**Federal** (actual expenditures)	**State** (actual expenditures)
Qualified HCBS	0.8669		$ -	$ -
Demonstration HCBS	0.8669		$ -	$ -
Supplemental	0.7337		$ -	$ -
Administrative - Normal	0.5000	$ 89,938	$ 44,969	$ 44,969
Administrative - 75%	0.7500		$ -	$ -
Administrative - 90%	0.9000		$ -	$ -
Federal Evaluation Supports	1.0000		$ -	$ -
Administrative (Other) - 100%	1.0000		$ -	$ -
State Evaluation (if approved)	0.5000		$ -	$ -
ADRC Funding	1.0000	$ -	$ -	$ -
CY 2007 Actual Total		**$ 89,938**	**$ 44,969**	**$ 44,969**
CY 2007 FEDERAL Unobligated Balance			**$ 94,544**	

Enter CY 2008 Comments Here

2007 Federal Unobligated Balance			$ 94,544	
2008 Federal Award			$ 2,378,149	
Total 2008 Federal Budget (2007 unobligated balance plus 2008 Fed award)			$ 2,472,693	
CY 2008 (including Partial Year Increased FMAP)	**Rate**	**Total Costs** (actual expenditures)	**Federal** (actual expenditures)	**State** (actual expenditures)
Qualified HCBS (Jan - Sept)	0.8647	$ 7,969	$ 6,891	$ 1,078
Qualified HCBS (Oct - Dec increased FMAP)	0.9000	$ 86,259	$ 77,633	$ 8,626
Demonstration HCBS (Jan - Sept)	0.8647	$ -	$ -	$ -
Demonstration HCBS (Oct - Dec increased FMAP)	0.9000	$ 44,525	$ 40,073	$ 4,453
Supplemental (Jan - Sept)	0.7294	$ -	$ -	$ -
Supplemental (Oct - Dec increased FMAP)	0.8341	$ -	$ -	$ -
Administrative - Normal	0.5000	$ 282,292	$ 141,146	$ 141,146
Administrative - 75%	0.7500	$ -	$ -	$ -
Administrative - 90%	0.9000	$ -	$ -	$ -
Federal Evaluation Supports	1.0000	$ 1,100	$ 1,100	$ -
Administrative (Other) - 100%	1.0000	$ -	$ -	$ -
State Evaluation (if approved)	0.5000	$ 123,624	$ 61,812	$ 61,812
ADRC Funding	1.0000	$ -	$ -	$ -
CY 2008 Actual Total		**$ 545,769**	**$ 328,654**	**$ 217,115**
CY 2008 FEDERAL Unobligated Balance			**$ 2,144,039**	

Enter CY 2009 Comments Here

2008 Federal Unobligated Balance			$ 2,144,039	
2009 Federal Award			$ 3,691,722	
Total 2009 Federal Budget (2008 Unobligated balance plus 2009 Fed award)			$ 5,835,761	
CY 2009 (using Increased FMAP)	**Rate**	**Total Costs** (actual expenditures)	**Federal** (actual expenditures)	**State** (actual expenditures)
Qualified HCBS (Jan-Mar increased FMAP)	0.9000	$ 147,938	$ 133,144	$ 14,794
Qualified HCBS (Apr-Jun increased FMAP)	0.9000	$ 249,155	$ 224,240	$ 24,916
Qualified HCBS (Jul- Sep increased FMAP)	0.9000	$ 254,387	$ 228,948	$ 25,439
Qualified HCBS (Oct - Dec increased FMAP)	0.9000	$ 244,768	$ 220,291	$ 24,477
Demonstration HCBS (Jan-Mar increased FMAP)	0.9000	$ 32,096	$ 28,886	$ 3,210
Demonstration HCBS (Apr-Jun increased FMAP)	0.9000	$ 85,408	$ 76,867	$ 8,541
Demonstration HCBS (Jul- Sep increased FMAP)	0.9000	$ 63,175	$ 56,858	$ 6,318
Demonstration HCBS (Oct - Dec increased FMAP)	0.9000	$ 52,770	$ 47,493	$ 5,277
Supplemental (Jan-Mar increased FMAP)	0.8341	$ -	$ -	$ -
Supplemental (Apr-Jun increased FMAP)	0.8341	$ -	$ -	$ -
Supplemental (Jul- Sep increased FMAP)	0.8341	$ -	$ -	$ -
Supplemental (Oct - Dec increased FMAP)	0.8095	$ -	$ -	$ -
Administrative - Normal	0.5000	$ 295,823	$ 147,912	$ 147,912
Administrative - 75%	0.7500	$ -	$ -	$ -
Administrative - 90%	0.9000	$ 480	$ 432	$ 48
Federal Evaluation Supports	1.0000	$ 1,800	$ 1,800	$ -
Administrative (Other) - 100%	1.0000	$ 4,446	$ 4,446	$ -
State Evaluation (if approved)	0.5000	$ 57,152	$ 28,576	$ 28,576
ADRC Funding	1.0000		$ -	$ -
CY 2009 Actual Total		**$ 1,489,398**	**$ 1,199,893**	**$ 289,505**
CY 2009 FEDERAL Unobligated Balance			**$ 4,635,868**	

Enter CY 2010 Comments Here

2009 Federal Unobligated Balance			$ 4,635,868	
2010 Federal Award			$ -	
Total 2010 Federal Budget (2009 Unobligated balance plus 2010 Fed award)			$ 4,635,868	
CY 2010 (using increased FMAP)	**Rate**	**Total Costs** (actual expenditures)	**Federal** (actual expenditures)	**State** (actual expenditures)
Qualified HCBS (Jan-Mar increased FMAP)	0.9000	$ 204,405	$ 183,965	$ 20,441
Qualified HCBS (Apr-Jun increased FMAP)	0.9000	$ 220,441	$ 198,397	$ 22,044
Qualified HCBS (Jul- Sep increased FMAP)	0.9000	$ 291,813	$ 262,631	$ 29,181
Qualified HCBS (Oct - Dec increased FMAP)	0.9000	$ 416,839	$ 375,155	$ 41,684
Demonstration HCBS (Jan-Mar increased FMAP)	0.9000	$ 42,424	$ 38,182	$ 4,242
Demonstration HCBS (Apr-Jun increased FMAP)	0.9000	$ 60,533	$ 54,480	$ 6,053
Demonstration HCBS (Jul- Sep increased FMAP)	0.9000	$ 81,660	$ 73,494	$ 8,166
Demonstration HCBS (Oct - Dec increased FMAP)	0.9000	$ 82,435	$ 74,191	$ 8,243
Supplemental (Jan-Mar increased FMAP)	0.8095	$ -	$ -	$ -
Supplemental (Apr-Jun increased FMAP)	0.8095	$ -	$ -	$ -
Supplemental (Jul- Sep increased FMAP)	0.8095	$ -	$ -	$ -
Supplemental (Oct - Dec increased FMAP)	0.8095	$ -	$ -	$ -
Administrative - Normal	0.5000	$ 137,264	$ 68,632	$ 68,632
Administrative - 75%	0.7500	$ -	$ -	$ -
Administrative - 90%	0.9000	$ 67,900	$ 61,110	$ 6,790
Federal Evaluation Supports	1.0000	$ 3,800	$ 3,800	$ -
Administrative (Other) - 100%	1.0000	$ 757,991	$ 757,991	$ -
State Evaluation (if approved)	0.5000	$ 49,647	$ 24,824	$ 24,824
ADRC Funding	1.0000	$ -	$ -	$ -
CY 2010 Actual Total		**$ 2,417,151**	**$ 2,176,851**	**$ 240,300**
CY 2010 FEDERAL Unobligated Balance			**$ 2,459,017**	

Please refer to the most recent ABCD Forms for Actual Expenditures. Totals may be "provisional" for last quarter (Oct-Dec) pending receipt and payment of all claims. — **Enter CY 2011 Comments Here**

2010 Federal Remaining Balance			$ 2,459,017	
2011 Federal Award			$ 6,708,235	
Total 2011 Federal Budget (2010 remaining balance plus 2011 Fed award)			$ 9,167,252	
CY 2011 (using partial year increased FMAP)	**Rate**	**Total Costs** (actual expenditures)	**Federal** (actual expenditures)	**State** (actual expenditures)
Qualified HCBS (Jan-Mar increased FMAP)	0.8998	$ 633,472	$ 569,998	$ 63,474
Qualified HCBS (Apr-Jun increased FMAP)	0.8998	$ 1,122,351	$ 1,009,892	$ 112,460
Qualified HCBS (Jul- Dec)	0.8569	$ 2,909,067	$ 2,492,634	$ 416,433
Demonstration HCBS (Jan-Mar increased FMAP)	0.8998	$ 112,621	$ 101,337	$ 11,285
Demonstration HCBS (Apr-Jun increased FMAP)	0.8998	$ 128,043	$ 115,213	$ 12,830
Demonstration HCBS (Jul- Dec)	0.8569	$ 256,573	$ 219,845	$ 36,728
Supplemental (Jan-Mar increased FMAP)	0.7996	$ -	$ -	$ -
Supplemental (Apr-Jun increased FMAP)	0.7996	$ -	$ -	$ -

VII. Billing and Reimbursement Procedures

Arkansas uses the MMIS claims processing system to verify that the participant was Medicaid-eligible on the date of service specified in the request for reimbursement and allows payment only on claims for services provided within the eligibility period. Waiver services are delivered in accordance with the service plan including type, scope, amount, duration and frequency specified in the program plan.

Prior to processing the waiver claims, the automated claims management system edits claims for the validity of the information and compliance with the business rules for the service/program, and calculates the payment amount and applicable reductions for the claims approved for payment.

Demonstration services will be preauthorized by MFP staff and will be manually tracked in an Access database by the MFP Project Coordinator. Once invoices are authorized they will be sent to Accounts Payable for payments. The demonstration services can then be tracked in AASIS by the internal order assigned to each service.

The methods used in the fiscal review process will include: examination of financial and service records as well as plans of care and other records; comparison of provider billings to service delivery and other supported documentation.

Arkansas has a new waiver Quality Assurance Unit that will provide on-site fiscal reviews to examine the provider agency's service and delivery and financial records and verify that all payments made to the provider agency have supported documentation. We are expecting a quarterly review process that will look at assessment documents, service delivery documents and complaints.

Arkansas verifies that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services. There is an initial review, follow-up review prior to the end of provisional license – every six months, the annual thereafter. This includes a paper and on site review of records.

A. Billing and Payment Processing

Payment processing will be based on a tiered level payment system associated with medical need criteria as shown below. For example, a Provider wishes to transition a participant meeting Degree or Incapacity Criteria Level 1. Prior to transition the Provider shall submit documentation supporting the Medical Need for Level 1. Upon approval, the Provider shall submit an estimate of the Demonstrations Services that will be utilized under MFP Tiered Level Payment System I; however, receipts will not be required to receive payment. The Provider shall be paid the amount specified in Payment Level 1 regardless of funds expended. If the Provider can show a medical need for other Demonstration Services those funds can also be paid out with prior approval. However, the Provider can only bill a maximum of (5) times per client in a 365 day period and there is no maximum dollar amount associated with these 5 requests.

Completion of the following procedures is required for the provider to request payment on the Tier Level Payment System.

1. The pre-transition process requires completion of all of the following documents:

- Health Disclosure
- Pre-Screen & MFP Assessment
- Personal History
- Professional Recommendation & Facility Letter
- Provider Freedom of Choice
- Demonstration Service Freedom of Choice
- State of Rights and Responsibilities
- Checklist for Clients Rights
- Informed Consent
- Medical Assessment (Elderly and AAPD Only)
- Copy of Prescriptions (Elderly and AAPD Only)
- QoL Survey
- Verification of Waiver Approval

No client will receive approval to participate in the MFP Program unless each form is submitted as an Assessment Packet.

2. Upon approval to participate in the MFP Program:

10 days prior to transition from qualified residence to new housing the following forms must be submitted and receipt verified

- Transition Risk Plan
- Demonstration Services Plan of Care
- Transition Services (Must be pre-approved in order to receive payment)
- Goods and Services (Must be pre-approved in order to receive payment)

3. After transition:

a. Start Service Plan (Due on date of transition)
b. Risk Mitigation Monthly Report (Due on the 15th of each month beginning 30 Days after transition date)
c. Client Satisfaction Survey (Due 30 days after transition; and, on the 15th of each quarter, thereafter)

Supplemental Document(s):

- Critical Incident Report: Within 2 business days of a critical incident such as a hospital stay or police called to residence

- Resolution/follow-up Critical Incident Report must be submitted 5 business days after the critical incident

Note: If client residence changes after transition, a revised Plan of Care must be submitted within 5 business days.

Additionally, detailed description and estimates for the following categories of transition services must be approved by MFP:

- Community Transition/Goods and Services
- Therapeutic Interventions/Intense Transition Management
- In Home Monitoring Technology
- Telemedicine
- Supported Living /24 Hour Attendant Care
- Emergency and Dental

MFP case managers will conduct random and scheduled home visits for MFP participants to ensure successful community transition and to verify that transition services and demonstration services have and/or will be provided to the participant within the 365-day participation timeframe for MFP. In the event that a there is a complaint or allegation(s) that the provider has/is not providing services as detailed in the pre-transition process and/or the transition services documentation, MFP will conduct a thorough investigation with 10 business days. If the allegations are found to be true, the provider will be given 30 calendar days to remedy the situation. If the provider does not remedy the situation within the allocated time, the case will be turned over to the Arkansas Department of Human Services, Medicaid Program Integrity Unit. The goal of this Unit is the identification, investigation, and referral of suspected fraud and abuse cases. Program Integrity will report fraud and abuse information to the Department; and have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients. Program Integrity to make the determination on remedying the case.

a. To be determined a functionally disabled individual, the individual must meet at least one of the following three criteria as determined by a licensed medical professional:

1. The individual is unable to perform either of the following:

A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or,

B. At least two (2) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without limited assistance from another person; or,

2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,
3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.
4. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.

b. When determining eligibility for payments, if an individual requires a skilled level of care as defined below, eligibility for MFP will be denied unless there is documented verification that the individual has adequate support for the skilled level of care.

c. Definitions

1. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.

2. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.

3. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.

4. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.

5. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.

6. MENTAL RETARDATION means a level of retardation as described in the American Association on Mental Retardation's Manual on Classification on Mental Retardation. For further clarification, see 42 C.F.R. § 483.100 - 102, Subpart C - Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals.

7. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice, and in terms of duration and amount.

- Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.
- Intravenous injections and hypodermoclysis or intravenous feedings.
- Levin tubes and nasogastric tubes.
- Nasopharyngeal and tracheostomy aspiration.
- Application of dressings involving prescription medication and aseptic techniques.
- Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.
- Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.
- Initial phases of a regimen involving administration of medical gases.
- Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies, that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.
- Ventilator care and maintenance.
- The insertion, removal and maintenance of gastrostomy feeding tubes.

9. SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.

10. TOILETING means the act of voiding of the individual's bowels or bladder, and includes the use of a toilet, commode, bedpan or urinal, transfers on and off a toilet, commode, bedpan or urinal, the cleansing of the individual after the act, changes of incontinence devices such as pads or diapers, management of ostomy or catheters and adjustment to clothing.
11. TOTAL DEPENDENCE means the individual needs another person to completely and totally perform the task for the individual.
12. TRANSFERRING means the act of an individual in moving from one surface to another, and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids, and chairs.

Medical Need/ Degree or Incapacity Criteria

Level I	Level II	Level III	Level IV
Services when delivered by licensed medical personnel in accordance with a plan of care requiring continuing assessment and monitoring on a daily basis and expected to last more than twenty-one (21) days. These services are: ➢ Intrarmuscular or subcutaneous injections if the use of licensed medical professional personnel are necessary to teach an individual or the individual's caregiver the procedure. ➢ Intravenous injections and hypodermoclysis or intravenous feedings. ➢ Levin tubes and nasogastric tubes ➢ Nasopharyngeal and tracheostomy aspiration. ➢ Application of dressings involving prescription medication and aseptic techniques. ➢ Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders which are in Stage III or Stage IV. ➢ Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress. ➢ Initial phases of a regimen involving administration of medical gases. ➢ Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies, that are part of active treatment, to obtain a specific goal and not as maintenance of existing function	Must require total dependence or extensive assistance from another person in all three areas of: ➢ ADL Maximum assistance ***Mobility*** ➢ Transferring to or from bed or chair with weight bearing assistance from another person. ➢ Must be lifted to or from bed or chair. ➢ Weight bearing assist from another person to ambulate. ➢ Wheelchair push. ➢ Requires turning in bed by another person. ***Feeding*** ➢ Spoon fed. ***Toileting*** ➢ Transferring on or off commode or bedpan with weight bearing assistance from another person ➢ Dependent upon another person for cleansing after the act, changing diapers, pads, or clothing. ➢ Management of ostomy, catheter, or colostomy.	Must require total dependence or extensive assistance from another person in two of the following areas: ➢ ADL Moderate assistance ***Mobility*** ➢ Transferring to or from bed or chair with weight bearing assistance from another person. ➢ Must be lifted to or from bed or chair. ➢ Weight bearing assist from another person to ambulate. ➢ Wheelchair push. ➢ Requires turning in bed by another person. ***Feeding*** ➢ Spoon fed. ***Toileting*** ➢ Transferring on or off commode or bedpan with weight bearing assistance from another person. ➢ Dependent upon another person for cleansing after the act, changing diapers, pads, or clothing. ➢ Management of ostomy, catheter, or colostomy.	Must require total dependence or extensive assistance in one area or limited assistance in two areas or have a diagnosis of Alzheimer's or related dementia and require substantial supervision from another person: ➢ ADL Minimum assistance three or more times per week. ➢ Emphasis on supervision, protection, and assistance if has diagnosis of Alzheimer's or related dementia. ➢ Has a diagnosed medical condition that requires monitoring or assessment on a daily basis by a licensed medical professional and the condition, if untreated, would be life threatening. **Mobility** ➢ Limited assistance from another person for transferring to or from bed or chair and/or with ambulation. ➢ Supervision due to wandering if has dementia diagnosis. **A. Feeding** ➢ Supervision, cueing, encouragement due to dementia. ➢ Assistance from another person to guide utensil to mouth due to blindness or tremors. **B. Toileting** ➢ Reminding or assisted to bathroom prn. ➢ Limited assistance to get on or off commode. ➢ Assistance with adjusting clothing. ➢ Assistance with changing pads or diapers. ➢ Assistance with cleansing after the act

➢ Ventilator care and maintenance. ➢ The insertion, removal and maintenance of gastrostomy feeding tubes.			

MFP Tiered Level Payment System

	Tier Level I	Tier Level II	Tier Level III	Tier Level IV
Community Transition/Goods and Services	$ 10,000.00	$ 9,000.00	$ 8,000.00	$ 7,000.00
Therapeutic Interventions/Intense Transitional Management	$ 10,000.00	$ 8,000.00	$ 7,000.00	$ 5,000.00
In Home Monitoring Technology	$ -	$ -	$ -	$ -
Telemedicine	$ -	$ -	$ -	$ -
Supported Living/24 Hour Attendant Care	$ 5,000.00	$ 4,000.00	$ 3,000.00	$ 2,000.00
Dental and Emergency	$ -	$ -	$ -	$ -
Total	$ 25,000.00	$ 21,000.00	$ 18,000.00	$ 14,000.00

Table 1: Crosswalk between State Procedures Codes and Type of MFP Services

CROSSWALK BETWEEN STATE PROCEDURE CODES AND TYPE OF MFP SERVICES

FOR MFP FINANCIAL REPORTING FORMS A AND B

[STATE]

Instructions:

1. Include codes for *all* services approved in your MFP Operational Protocol
2. Use a single line for each procedure code
3. Add lines to each type of service if necessary
4. Update and submit this crosswalk with each MFP Services File your state submits

Type of Service by Category	State Procedure Code	Label for State Procedure Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
State Plan Services			
Clinic Services NA			
Targeted Case Management for Long Term Care NA			
PACE (Program for All Inclusive Care for the Elderly)			

NA			
Rehabilitation Services NA			
Home Health Services NA			
Hospice NA			
Personal Care Services NA			
Optional Medicaid Plan Services			

NA			
Waiver Services			
Case Management DD Alternative Community Service (ACS)	T2022	Case Management	Provider ID
Adults with Physical Disabilities (APD)	T 2022U1	Case Management	Provider ID
Homemaker Services Elderchoices	S5150	Homemaker Services	Provider ID
Personal Care (Attendant Care)			
Adults with Physical Disabilities (APD)	S5125	Personal Care	Provider ID
Adults with Physical Disabilities (APD)	S5125U1	Personal Care - Co-Employer	Provider ID
Adults with Physical Disabilities (APD)	S5125U2	Personal Care - Traditional Care	Provider ID
Living Choices	S5125SU	Personal Care	Provider ID
Living Choices	T2031U1	Personal Care - Tier 1	Provider ID
Living Choices	T20231U3	Personal Care - Tier 3	Provider ID
Living Choices	T2031U4	Personal Care - Tier 4	Provider ID
Adult Day Health Elderchoices	S5100T2	Adult Day Health	Provider ID

Habilitation **a. Residential Habilitation** DD Alternative Community Service (ACS)	H2016	Residential Habilitation - Individual	Provider ID
DD Alternative Community Service (ACS)	H2016UB	Residential Habilitation - Group	Provider ID
b. Day Habilitation NA			
Expanded Habilitation Services **a. Prevocational Services** NA			
b. Supported Employment			
DD Alternative Community Service (ACS)	H2023	Supported Employment	Provider ID

c. Education NA			
Respite Care Elderchoices	S5150	Respite Care - In Home	Provider ID
Elderchoices	S5135	Respite Care - Facility	Provider ID
Elderchoices	T1005	Respite Care - Respite Long-term Facility bases	Provider ID
DD Alternative Community Service (ACS)	S5151	Respite Care	Provider ID
Day Treatment NA			
Partial Hospitalization NA			
Psychosocial Rehabilitation NA			
Clinic Services			

NA			
Live-In Caregiver NA			
Capitated Payments for Long Term Care Services NA			
Other Elderchoices	S5100	Adult Day Care 6-8 hours of care	Provider ID
Elderchoices	S5100U1	Adult Day Care 4-5 hours of care	Provider ID
Elderchoices	S5100TD	Adult Day Health Care 6-8 per date	Provider ID
Elderchoices	S5140	Adult Foster Care	Provider ID
Elderchoices	S5120	Chore Services	Provider ID
Elderchoices	S5135 U1	Companion Services	Provider ID
Living Choices	S5135 U1	Companion Services	Provider ID
DD Alternative Community Service (ACS)	T2034	Crisis Center	Provider ID
DD Alternative Community Service (ACS)	T2034 U1, UA	Crisis Intervention	Provider ID
Independent Choices	Z3009	Financial Management Services	Provider ID
Elderchoices	S5170	Home Delivered Meals - Frozen	Provider ID

Elderchoices	S5170 U1	Emergency Home Delivered Meals	Provider ID
Elderchoices	S5170U2	Home Delivered Meals	Provider ID
Living Choices	T2031 U1	Limited Nursing Services - Tier 1	Provider ID
Living Choices	T2031 U3	Limited Nursing Services - Tier 3	Provider ID
Living Choices	T2031 U4	Limited Nursing Services - Tier 4	Provider ID
DD Alternative Community Service (ACS)	A0080	Non Medical Transportation	Provider ID
Living Choices	T2031 U1	Non Medical Transportation - Tier 1	Provider ID
Living Choices	T2031 U3	Non Medical Transportation - Tier 3	Provider ID
Living Choices	T2031 U4	Non Medical Transportation - Tier 4	Provider ID
Living Choices	T2031 U1	Periodic Nurse Evaluation - Tier 1	Provider ID
Living Choices	T2031 U3	Periodic Nurse Evaluation - Tier 3	Provider ID
Living Choices	T2031 U1	Periodic Nurse Evaluation - Tier 1	Provider ID
Living Choices	Z2789 (Paper Only)	Pharmacy Consult	Provider ID
DD Alternative Community Service (ACS)	T2028(3)	Specialized medical equipment supplies	Provider ID
DD Alternative Community Service (ACS)	T2020UA	Supplemental Support	Provider ID
DD Alternative Community Service (ACS)			
Independent Choices	Z2736	Counseling Initial Contact	Provider ID
Independent Choices	Z2737	Counseling Orientation	Provider ID
Independent Choices	Z2738	Counseling Management Fee	Provider ID
DD Alternative Community Service (ACS)	S5161	Adaptive Equipment	Provider ID
DD Alternative Community Service (ACS)	K0108	Environmental Accessibility Adaptations/Medications	Provider ID
DD Alternative Community Service (ACS)	T2020	Community Experience	Provider ID
Elderchoices	S5160	Personal Emergency Response Install	Provider ID
Elderchoices	S5161UA	Persona Emergency Response System	Provider ID

DD Alternative Community Service (ACS)	S5160	Personal Emergency Reponses Install	Provider ID
DD Alternative Community Service (ACS)	S5161UA	Persona Emergency Response System	Provider ID

Table 2: Demonstration Services Summary

Demonstration Services Summary

Service	Definition	Provider Description
Community Transition/Goods and Services **Maximum Benefit: $5,000 per transition from nursing home; lifetime maximum of $10,000 under MFP.**	**Community Transition/Goods and Services** Goods, services, assistive technology and/or adaptations/modifications to equipment or environment for the purpose to improve the quality of life or potential for greater independence in a home and community setting. (Requesting to remove "may be provided 60 days prior to discharge from NF up to 60 after discharge and may include:") Environmental Modifications; Assistive Devices; Security Deposits; Rental and Utility Deposits; Essential furniture, appliances and household items; other items, goods or services approved by DAAS as necessary for the health and welfare of the participant. Participant is allowed to purchase clothing such as shoes, coats, socks, underwear, pants, shirts, sleepwear, shorts, etc.	**Community Transition/Goods and Services** Open enrollment Certified Medicaid State Plan and/or Waiver providers
Therapeutic Interventions/Intense Transitional Management Billable Unit Rate: is One (1) contact. Unit rate is $100. **Intense Transitional Management** Unit = One (1) Fifteen minutes (15 minutes) Rate = $8.00 per unit	**Therapeutic Interventions/Intense Transitional Management** Therapeutic activities designed to assess potential risk and identify therapeutic plans of care for risk mitigation and optimal participant care. Areas of intervention may include Medication Adherence; Nutrition/Dietary; Other areas such as Behavioral/Life Training needs. **Intense Transitional Management** The provision of assistance in obtaining services or benefits, beyond the scope of existing case management activities, currently reimbursed by Medicaid. This includes acting on behalf of participants to resolve identified barriers to needed	**Therapeutic Interventions/Intense Transitional Management** Open Enrollment: Certified Medicaid State Plan and/or Waiver providers **Intense Transitional Management** Open enrollment: Typically will be Targeted Case Management Agency

Maximum benefit is 625 units. Unit = One (1) Fifteen minutes (15 minutes) Rate = $6 per unit **Maximum benefit is 200 units.** **Maximum Benefit: $11,200 per transition under MFP.**	services or resources. Activities may include completion of applications and paperwork, attending meetings/hearings on behalf of the participant, inspection of services or goods (such as furniture, appliances, ramps), crisis intervention, setting up banking services and other related activities that are identified as necessary on the official plan of care, but not reimbursed under Medicaid or other funding mechanism. ITM Assistant: to fulfill non-skilled duty areas critical to the transition of an individual.	(TCM) Providers; DD Network Providers of Case Management
In Home Monitoring Technology Billable Unit: One time Installation fee of $99 **Monthly Monitoring fee of $114 ($1368 annually) for annual maximum of $1,467 per person.** Medication Dispensing Unit: Billable Unit . One time Installation Fee of $50. Monthly Monitoring Fee of $75. **Annual maximum of $950.**	**In Home Monitoring Technology** 24/7 personal monitoring system that identifies developing health problems and alerts for potential emergencies by detecting changes in key behaviors. These changes are tracked through a patented technology. It detects 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. 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.	**In Home Monitoring Technology** Monitoring Technology Vendor Monitoring Technology Vendor Home Health Agency or Personal Emergency Response Agency
Telemedicine A. Tele-health B. Tele-	**Telemedicine** "telemedicine" means the practice of health care delivery, diagnosis,	**Telemedicine** Open enrollment:

rehabilitation Tele-health: Unit = One (1) day. Rate =$10.00 per day Maximum benefit is 365 units. **Maximum annual expenditure is $3,650 per person** Nursing: Unit = One (1) visit. Rate: $117.73 Maximum benefit is 24 visits Annually for a maximum expenditure of $2,825.52 per person. Tele-Rehab Billable Unit = One (1) visit Rate = $106.71 per visit. **Maximum benefit is 48 visits, or $5,122.08 with a onetime extension allowable for an additional 48 visits.**	consultation, treatment, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine is not a consultation provided by telephone or facsimile machine. Nursing service specific to tele-health includes patient education, medication assistance and supervision and crisis intervention. Rates have been revised to meet rate changes in the State of Arkansas.	Licensed Class A and Class B Home Health Agencies
Supported Living/24 Hour Attendant Care Billable Unit: Daily Rates AHC $364.70, Nursing Facilities, $145.30 ICFMR Under 16 Private Bed, $178.85 16 and Over Bed Private, $266.20 State Operated, $300.76 Assisted Living Tier 3, $66.58 **24 Hour Attendant Care** Billable Unit: One (1) 15 minutes Self Directed:	**Supported Living/24 Hour Attendant Care** Supportive living is an array of individually tailored services and activities provided to enable eligible persons to reside successfully in their own homes, or in an alternative living setting. Services are delivered over a 24 hour period delivered in a protected supervised environment to persons needed this level of supervision on a short term basis. Rates have been revised to meet rate changes in the State of Arkansas. **24 Hour Attendant Care** The provision of assistance to a medically stable and/or physically disabled person to accomplish those tasks of daily living that	**Supported Living/ 24 Hour Attendant Care** Enrollment: Licensed Nursing Facilities; Certified Adult Family Homes; Licensed Assisted Living Facilities **24 Hour Attendant Care** Certified provider of Personal Attendant Services provided

$2.43/unit Agency: $3.46/unit **Maximum Benefit: $10,000 per transition from under MFP.**	the person is unable to complete independently. Services may include companion services, transportation assistance, accompanying participant to assist with shopping and errands, and incidental housekeeping as necessary. This service is provided on a time limited basis, in conjunction with other waiver and State Plan services to provide around the clock coverage for persons with that level of need.	under an existing waiver program. Medicaid enrolled Personal Care Agency.
Emergency and Dental **Maximum Benefit: Maximum annual expenditure per participant is $7,500.**	**Emergency and Dental** Misc. Items to be purchased for participant on an emergency basis at the discretion of Intense Transition Managers Request, for items that would otherwise be denied. (Items which might be covered include food, utilities, medical needs, or payment for an item not covered in another category). Not to be used on Rent, Room/Board. **Dental** These services are to be paid after client has reached the maximum Medicaid Dental Service dollar amount.	**Emergency and Dental** Open Enrollment Certified Medicaid State Plan and/or Waiver Providers **Dental** Open Enrollment Certified Medicaid State Plan and/or Waiver Providers

Rates will be increased at the time Medicaid increases rates to reflect the current rate for related services.