Changes to Medicaid State Plan Personal Care Services Implementation: 2027

November 2026

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Agenda





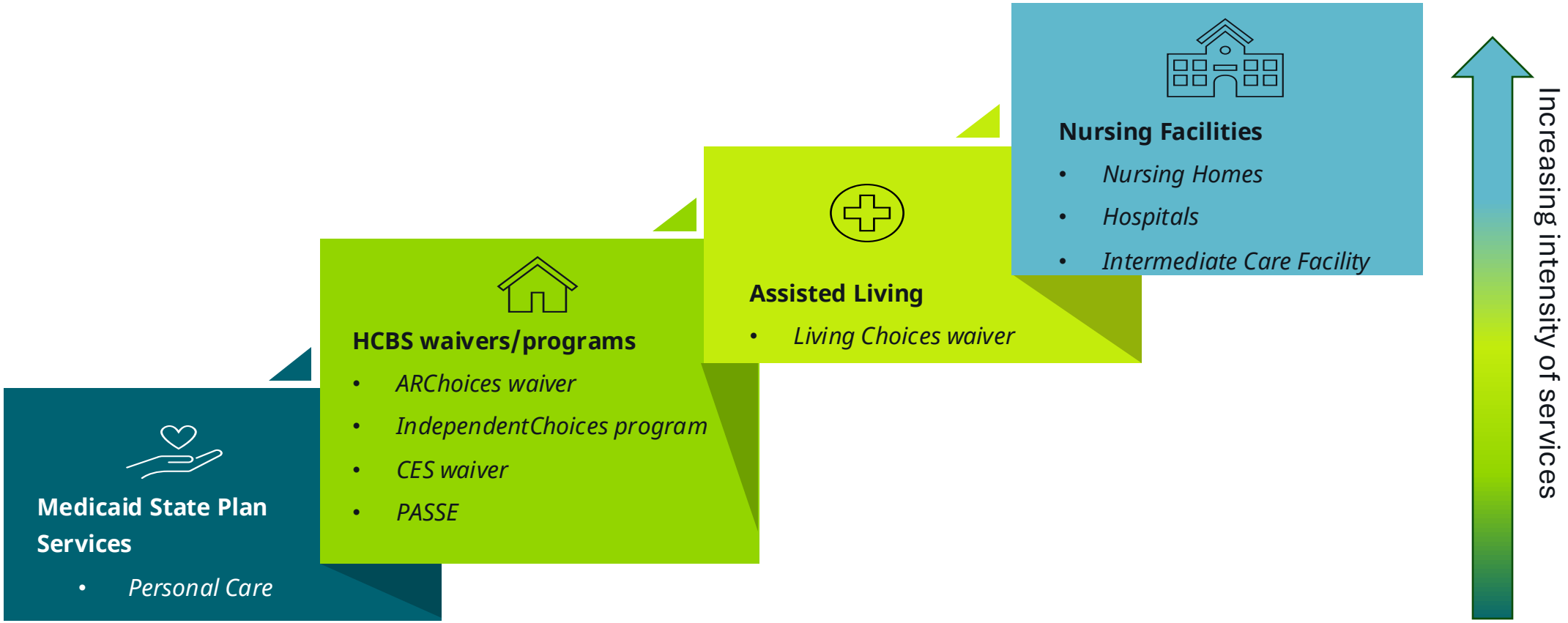
1. Medicaid Care Continuum Background
2. Defining Medicaid State Plan Personal Care Services
3. Clients Who Will Be Affected by Changes to Medicaid State Plan Personal Care Services
4. Explanation of Roles in State Plan Personal Care
5. New Process Walkthrough with forms
6. Provider expectations
7. Transfers to New Providers

Medicaid Care Continuum Background

Start with the Big Picture:

DHS' Medicaid Care Continuum

Care Continuum: DHS aims to support individuals along the care continuum to provide the right services, at the right time, in the right setting



Defining Medicaid State Plan Personal Care Services

What are Medicaid State Plan Personal Care Services?

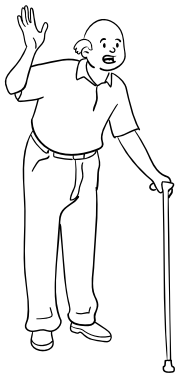
☑ What Personal Care Services are…	☒ What Personal Care Services are NOT…
Medically necessary services that assist a Medicaid beneficiary with assessed physical dependency needs in the performance of their routine activities of daily living (ADLs) and instrumental activities of daily living (IADLs)	Duplicative of other services available through outside resources, like private insurance, natural supports, or other generic sources
Limited to 64 hours per month, for adults. Under 21 can request an extension of benefits* if needed.	Stand-alone Housekeeping Services
	Stand-alone Respite Services*
	Replacement for childcare or behavioral services for children under 21 years old
	Comprehensive supported living services that offer assistance in socialization or adaptive skills.

*EOBs for under 21 years old, apply through Acentra.

Clients Affected by Changes to Medicaid State Plan Personal Care Services

Different Types of Clients You Might Serve

Non-waiver Beneficiaries



Mr. Smith is not receiving services through an HCBS waiver or in the PASSE. He just needs personal care to live independently at home.

He may access State Plan Personal Care Services by receiving a medical eligibility approval determination from Optum



Ms. Perez receives services through the ARChoices waiver since she has a physical disability and meets nursing home level of care.

She accesses State Plan Personal Care services in tandem with her waiver by getting a functional assessment (ARIA) and developing a person-centered service plan from her DAABHS RN .



Ms. Cherry receives services through the CES waiver and/or services in the PASSE.

She accesses State Plan Personal Care services in tandem with her waiver by getting a functional assessment (ARIA) and developing a person-centered service plan from her PASSE RN.

Waiver and/or PASSE Beneficiaries

Changes to State Plan Personal Care services in 2027 only apply to the non-waiver beneficiaries you serve.

Why? Personal Care as a stand-alone Medicaid State Plan 1905(a) service does not require the ARIA or a person-centered service plan. Going forward, non-waiver beneficiaries only require Medical Eligibility (a medical condition identified as causing ADL/IADL issues) and treatment plan based on a functional needs assessment.

For beneficiaries in a waiver/PASSE, a DHS RN uses the ARIA Independent Assessment to develop their person-centered service plan (which can include Personal Care services),

- ARChoices in Homecare Waiver
- Independent Choices program
- Community and Employment Support (CES) Waiver
- PASSE

Overview of New Process, After Implementation in 2027

High Level Process Overview

Step 1: Provider requests for **Medical Eligibility Review** of Medicaid Beneficiary and submits completed 618 Assessment and Treatment Plan to Acentra for Prior Authorization (PA). This all is sent by the provider to the Acentra Portal.

Step 2: Acentra sends data to Optum for Medical Eligibility Review.

Step 3: Optum conducts Medical Eligibility and sends decision letter to the Medicaid Beneficiary and electronic notice to Acentra and Provider.

Step 4 : If approved, Prior Authorization (PA) completed by Acentra.

Step 1: Request Medical Eligibility Review for First Time Services

A. Using the existing Acentra Portal, **Provider uploads request for Medical Eligibility review** with identifying information for new client. Optum conducts Medical Eligibility review. The 618 Assessment and treatment plan is submitted during this process.

B. Provider waits for return of Medical Eligibility Referral: it will either be “Approved,” “Needs more information,” or “Denied.”

Step 3: Optum's Medical Eligibility Referral

If…	Then…
(1) Client has historical Medicaid claims related to a diagnosis or condition causing physical impairment / deficits…	Optum will send notice of **Approval of Medical Eligibility Referral** to Acentra and Provider. • Optum will send decision letter to Beneficiary.
(2) Client does not have historical Medicaid claims related to a diagnosis or condition causing physical impairment / deficits…	Optum will email the Provider for **more information**. • Supplemental documentation or records showing a medical issue or condition causing ADL and IADL issues can be uploaded to Optum. • Or, the new client can go to their Primary Care Provider and obtain more documentation to be uploaded in order to meet Medical Eligibility.
(3) Client does not have historical Medicaid claims nor substantiating documentation related to a diagnosis or condition causing physical impairment / deficits…	Optum will send notice of **Denial of Medical Eligibility Referral** to Acentra and Provider. • Optum will send decision letter and appeals letter to beneficiary and Provider

Personal Care can only be delivered to clients with an Optum Approval of Medical Eligibility Referral

Step 4: Obtain Prior Authorization (PA) for Billing

A. Acentra will review submitted 618 Assessment & Treatment Plan for PA.

B. If/When Medical Eligibility is approved, **Acentra will issue the PA for 12 months.** Services can begin being billed.

Step 4a: A Word about PA Renewals

A. Sixty **(60) days prior to PA expiration**, Provider sends an updated Assessment & Treatment Plan through the Acentra portal.

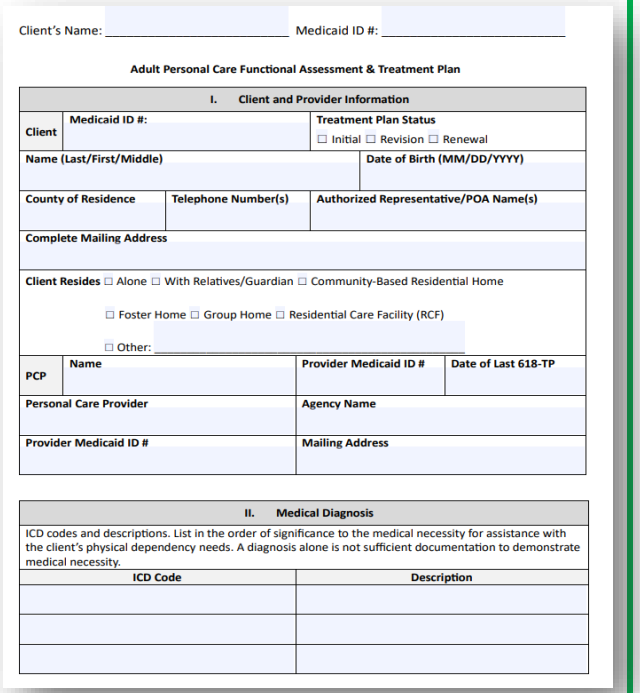
B. This triggers a new **Medical Eligibility review by Optum**.

- If client was deemed to have a **chronic condition affecting ADL/IADLs** in a previous review; Optum will automatically send notice of **Approval of Medical Eligibility Referral** to Acentra and Provider.
- Otherwise, the Medical Eligibility review takes place as usual (see slide 13).

C. After **Approval of Medical Eligibility Referral,** Acentra reviews/approves updated Assessment & Treatment Plan for PA as usual (see slide 22).

Step-by-Step Walk Through of New 618 Assessment And Treatment Plan

Assessment & Treatment Plan (Adult or Youth)



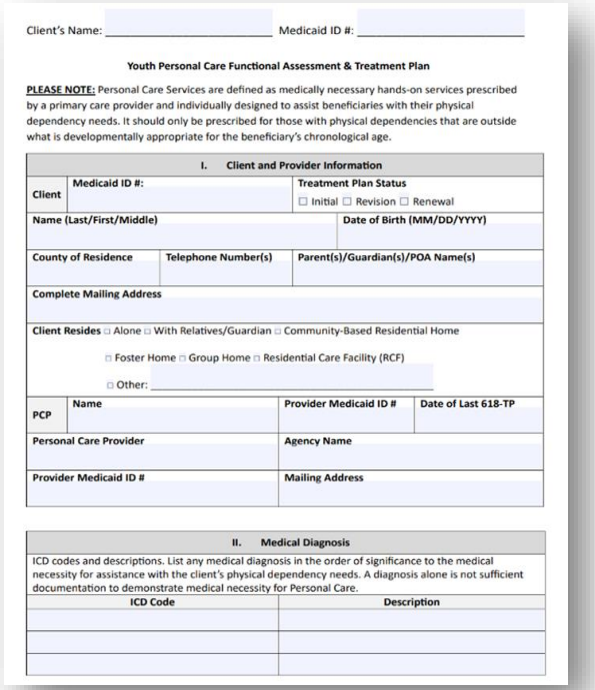
Client's Name: _____ Medicaid ID #: _____

Adult Personal Care Functional Assessment & Treatment Plan

I. Client and Provider Information			
Client	Medicaid ID #:	Treatment Plan Status ☐ Initial ☐ Revision ☐ Renewal	
Name (Last/First/Middle)		Date of Birth (MM/DD/YYYY)	
County of Residence	Telephone Number(s)	Authorized Representative/POA Name(s)	
Complete Mailing Address			
Client Resides ☐ Alone ☐ With Relatives/Guardian ☐ Community-Based Residential Home ☐ Foster Home ☐ Group Home ☐ Residential Care Facility (RCF) ☐ Other: _____			
PCP	Name	Provider Medicaid ID #	Date of Last 618-TP
Personal Care Provider		Agency Name	
Provider Medicaid ID #		Mailing Address	

II. Medical Diagnosis	
ICD codes and descriptions. List in the order of significance to the medical necessity for assistance with the client's physical dependency needs. A diagnosis alone is not sufficient documentation to demonstrate medical necessity.	
ICD Code	Description

- Must be completed by a Registered Nurse.
- RN signature should include credentials (i.e., RN, APRN, etc.)
- All sections must be completed as instructed within the document.
- Sections should not be left blank.



Client's Name: _____ Medicaid ID #: _____

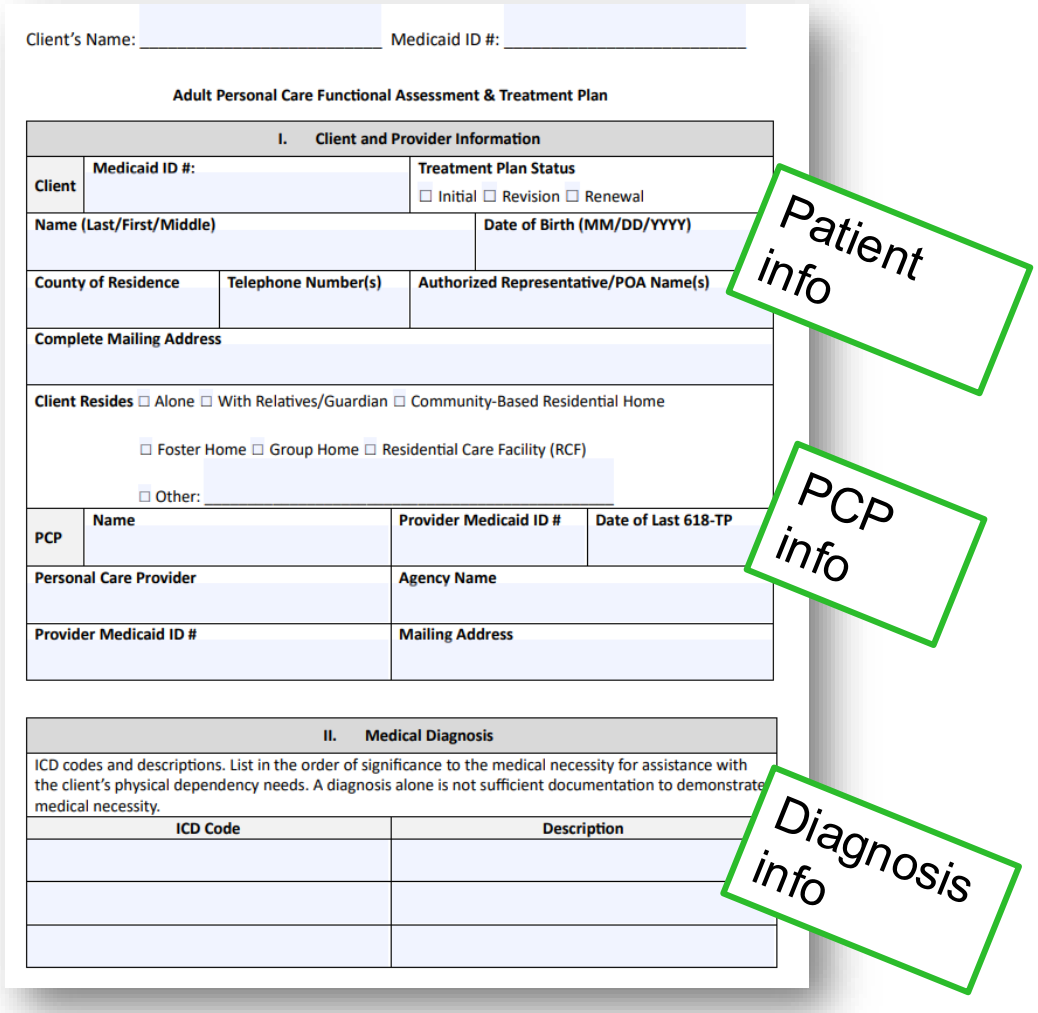
Youth Personal Care Functional Assessment & Treatment Plan

PLEASE NOTE: Personal Care Services are defined as medically necessary hands-on services prescribed by a primary care provider and individually designed to assist beneficiaries with their physical dependency needs. It should only be prescribed for those with physical dependencies that are outside what is developmentally appropriate for the beneficiary's chronological age.

I. Client and Provider Information			
Client	Medicaid ID #:	Treatment Plan Status ☐ Initial ☐ Revision ☐ Renewal	
Name (Last/First/Middle)		Date of Birth (MM/DD/YYYY)	
County of Residence	Telephone Number(s)	Parent(s)/Guardian(s)/POA Name(s)	
Complete Mailing Address			
Client Resides ☐ Alone ☐ With Relatives/Guardian ☐ Community-Based Residential Home ☐ Foster Home ☐ Group Home ☐ Residential Care Facility (RCF) ☐ Other: _____			
PCP	Name	Provider Medicaid ID #	Date of Last 618-TP
Personal Care Provider		Agency Name	
Provider Medicaid ID #		Mailing Address	

II. Medical Diagnosis	
ICD codes and descriptions. List any medical diagnosis in the order of significance to the medical necessity for assistance with the client's physical dependency needs. A diagnosis alone is not sufficient documentation to demonstrate medical necessity for Personal Care.	
ICD Code	Description

Visual: Assessment and Treatment Plan



Client's Name: _____ Medicaid ID #: _____

Adult Personal Care Functional Assessment & Treatment Plan

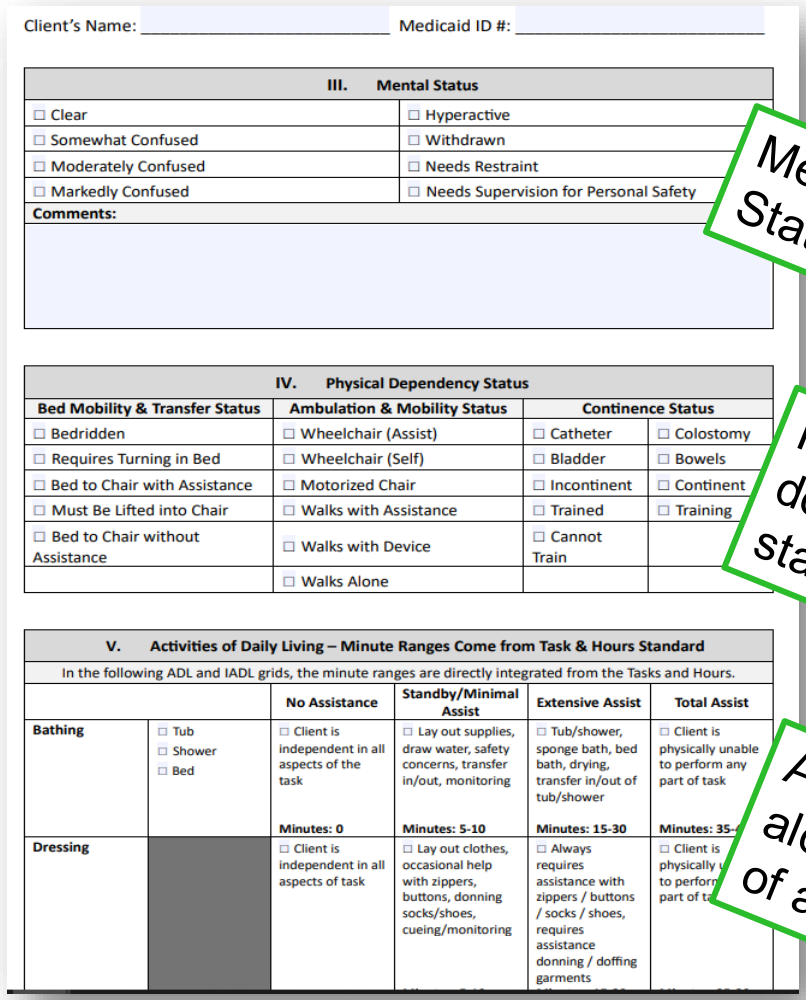
I. Client and Provider Information			
Client	**Medicaid ID #:**	**Treatment Plan Status** ☐ Initial ☐ Revision ☐ Renewal	
Name (Last/First/Middle)		**Date of Birth (MM/DD/YYYY)**	
County of Residence	**Telephone Number(s)**	**Authorized Representative/POA Name(s)**	
Complete Mailing Address			
Client Resides ☐ Alone ☐ With Relatives/Guardian ☐ Community-Based Residential Home ☐ Foster Home ☐ Group Home ☐ Residential Care Facility (RCF) ☐ Other: _____			
PCP	**Name**	**Provider Medicaid ID #**	**Date of Last 618-TP**
Personal Care Provider		**Agency Name**	
Provider Medicaid ID #		**Mailing Address**	

II. Medical Diagnosis	
ICD codes and descriptions. List in the order of significance to the medical necessity for assistance with the client's physical dependency needs. A diagnosis alone is not sufficient documentation to demonstrate medical necessity.	
ICD Code	**Description**

Patient info

PCP info

Diagnosis info



Client's Name: _____ Medicaid ID #: _____

III. Mental Status	
☐ Clear	☐ Hyperactive
☐ Somewhat Confused	☐ Withdrawn
☐ Moderately Confused	☐ Needs Restraint
☐ Markedly Confused	☐ Needs Supervision for Personal Safety
Comments:	

IV. Physical Dependency Status			
Bed Mobility & Transfer Status	**Ambulation & Mobility Status**	**Continence Status**	
☐ Bedridden	☐ Wheelchair (Assist)	☐ Catheter	☐ Colostomy
☐ Requires Turning in Bed	☐ Wheelchair (Self)	☐ Bladder	☐ Bowels
☐ Bed to Chair with Assistance	☐ Motorized Chair	☐ Incontinent	☐ Continent
☐ Must Be Lifted into Chair	☐ Walks with Assistance	☐ Trained	☐ Training
☐ Bed to Chair without Assistance	☐ Walks with Device	☐ Cannot Train	
	☐ Walks Alone		

V. Activities of Daily Living – Minute Ranges Come from Task & Hours Standard					
In the following ADL and IADL grids, the minute ranges are directly integrated from the Tasks and Hours.					
		No Assistance	**Standby/Minimal Assist**	**Extensive Assist**	**Total Assist**
Bathing	☐ Tub ☐ Shower ☐ Bed	☐ Client is independent in all aspects of the task **Minutes: 0**	☐ Lay out supplies, draw water, safety concerns, transfer in/out, monitoring **Minutes: 5-10**	☐ Tub/shower, sponge bath, bed bath, drying, transfer in/out of tub/shower **Minutes: 15-30**	☐ Client is physically unable to perform any part of task **Minutes: 35-**
Dressing		☐ Client is independent in all aspects of task	☐ Lay out clothes, occasional help with zippers, buttons, donning socks/shoes, cueing/monitoring	☐ Always requires assistance with zippers / buttons / socks / shoes, requires assistance donning / doffing garments	☐ Client is physically u… to perfor… part of t…

Mental Status

Physical dependency status

ADL grid along levels of assistance

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Visual: Assessment and Treatment Plan

		No Assistance	Standby/Minimal Assist	Extensive Assist	Total Assist
Feeding/Eating		☐ Client is independent in all aspects of task **Minutes: 0**	☐ Verbal cues / encouragement, donning adaptive devices Note: Feeding is calculated by # of meals per week, not # of days **Minutes: 5-10**	☐ Spoon feeding, bottle feeding, needs help to cut food, special diet **Minutes: 15-20**	☐ Client is physically unable to perform any part of task **Minutes: 25-30**
Grooming		☐ Client is independent in all aspects of task **Minutes: 0**	☐ Lay out supplies, verbal cues, comb/brush hair, apply non-prescription lotion **Minutes: 10-20**	☐ Shaving (face/legs/underarms), brush teeth, nail care, wash/dry/style hair, wash hands/face, apply makeup **Minutes: 30-50**	☐ Client is physically unable to perform any part of task **Minutes: 60-75**
Toileting	☐ Toilet ☐ Bedpan / urinal ☐ Bedside commode	☐ Client is independent in all aspects of task **Minutes: 0**	☐ Prepare supplies equipment, clothing assist during task, occasional help with perineal hygiene, occasional help with catheter / colostomy care **Minutes: 5-10**	☐ Assist on/off bedpan, assist with the use of urinal, assisting with perineal hygiene, assist with feminine hygiene needs, change incontinence briefs, change external catheter, emptying catheter bag, changing colostomy bag **Minutes: 15-20**	☐ Client is physically unable to perform any part of task **Minutes: 25-30**

ADL grid along levels of assistance

		No Assistance	Standby/Minimal Assist	Extensive Assist	Total Assist
Transferring		☐ Client is independent in all aspects of task **Minutes: 0**	☐ Help with positioning; minimal assistance rising **Minutes: 5-10**	☐ Non-ambulatory movement from 1 stationary position to another; hands-on assistance with rising from sitting to standing; extensive assistance with positioning or turning **Minutes: 15-20**	☐ Client requires total assistance with positioning or transferring from bed to chair **Minutes: 25-30**
Walking		☐ Client is independent in all aspects of task **Minutes: 0**	☐ Standby assistance with walking; assistance with putting on/removing leg braces **Minutes: 5-10**	☐ Steadying in walking/use of steps; assistance with wheelchair ambulation **Minutes: 15-20**	☐ Client requires total assistance with wheelchair ambulation **Minutes: 25-30**

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Visual: Assessment and Treatment Plan

VI. Instrumental Activities of Daily Living – Minute Ranges come from Task & Hours Standard					
Cleaning		☐ Client is independent in all aspects of task **Minutes: 0**	☐ Make bed, straightening areas **Minutes: 60-90**	☐ Cleaning after personal care tasks, cleaning floors of living area, dusting, cleaning bathroom, cleaning kitchen / appliances / dishes, changing bed linens, emptying / cleaning bedside commode, emptying trash, setting out garbage for pickup **Minutes: 95-235**	☐ Client is physically unable to perform any part of task **Minutes: 240-300**
Laundry		☐ Client is independent in all aspects of task **Minutes: 0**	☐ Individual requires at least minimal assistance but no special laundry needs **Minutes: 30-120**	☐ Individual has special laundry needs **Minutes: 120-240**	

IADL grid along levels of assistance

		No Assistance	Standby/Minimal Assist	Extensive Assist	Total Assist
Preparing Meals		☐ Client is independent in all aspects of task **Minutes: 0**		☐ Meal planning / prepping, cooking full meals, warming / cutting / serving prepared food, breakfast / lunch / supper, snacks, grinding and pureeing food *The maximum time per meal is 30 minutes. **Additional time for leftovers. Allow an extra 15 minutes per day to cook enough leftovers for the next meal. **Minutes: 10-90**	
Shopping		☐ Client is independent in all aspects of task **Minutes: 0**	☐ Preparing a shopping list, picking up extra items **Minutes: 10-30**	☐ Going to the store, shopping for all items, picking up medications, putting items away **Minutes: 35-90**	☐ Client is physically unable to perform any part of task **Minutes: 35-90**

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Visual: Assessment and Treatment Plan

VII. Assessment Narrative

Attach additional pages as needed to describe the client's physical dependency needs. These notes could include a summary of clinical observations, justifications, and a supportive description of th observed deficits and levels of needs noted above. Include any strengths the beneficiary currentl demonstrates, as well as challenges and/or risks. The assessing Registered Nurse (RN) must date initial all attachments.

Comments:

Assessment narrative

VIII. Alternate Resources for Assistance

List alternate resources for assistance with the client's physical dependency needs, beginning with other members of the client's household. Repeat as appropriate for other family and community resources, in accordance with instructions found in the Personal Care provider manual. Attach additional pages as necessary to give a full account.

□ I certify that the beneficiary's service plan will not duplicate any other in-home services of which provider is aware.

Comments:

Alternative resources and certification of non-duplication of services

IX. Certification of Service Need and Duration

I certify that personal care services are required to:

□ Be an effective treatment for the beneficiary's condition under accepted standards of practice.

□ Address the complexity of the beneficiary's condition through assistance with ADLs/IADLs.

□ Prevent the worsening of the beneficiary's condition.

Certification of need for services

X. Personal Care Treatment Plan

Attach additional pages as necessary. Using results from the assessment, document the plan to support the beneficiary in each needed ADL/IADL to prevent worsening of their current condition(s). The treatment plan must include written instructions for the personal care aide specifying how and when to execute or assist with the beneficiary's routines or activities.*

**Duration should come from the completed ADL/IADL grid above, not exceeding the minutes established.*

Treatment Plan

ADL/IADL	Frequency	*Duration	Staff Delivery Service	Notes/Comments
Ex. Bathing	3x/week	30 min	PC Aide, RN, LPN, etc.	Aide to assist with bathing, drying, and transferring in/out of tub

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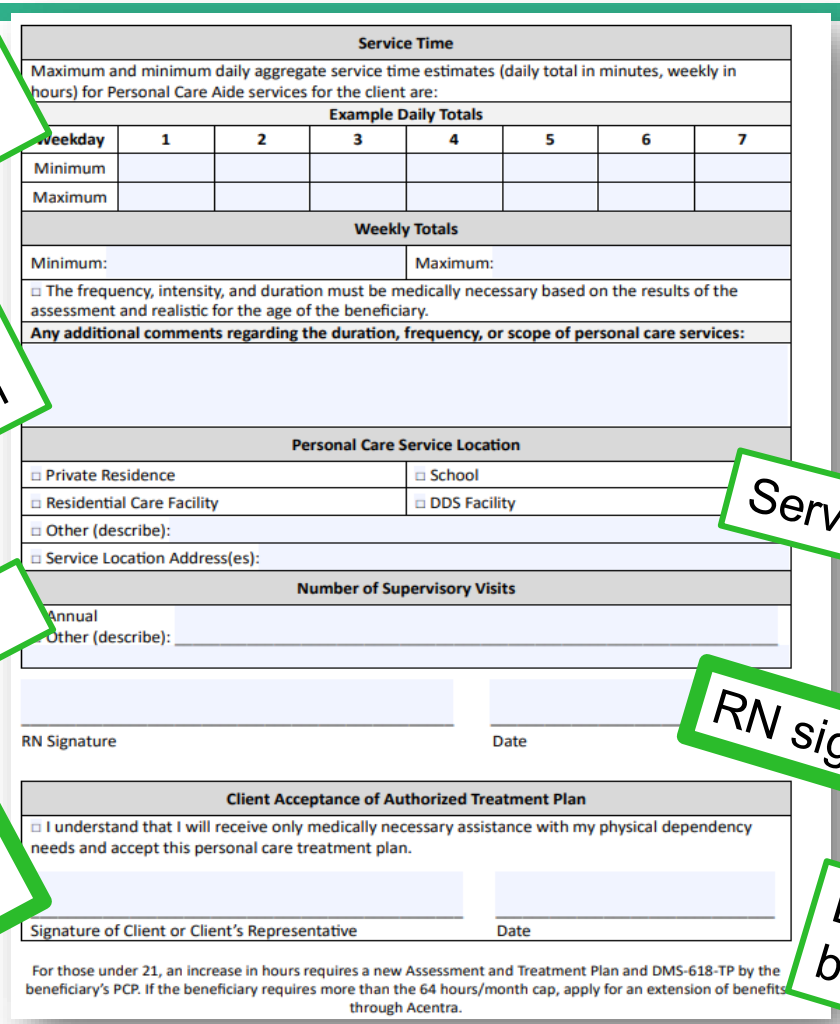
Visual: Assessment and Treatment Plan

Aggregate min-max for daily & weekly

Verification of medical necessity of frequency & duration

Supervisory visits

Client acceptance



Service Time

Maximum and minimum daily aggregate service time estimates (daily total in minutes, weekly in hours) for Personal Care Aide services for the client are:

Example Daily Totals

Weekday	1	2	3	4	5	6	7
Minimum							
Maximum							

Weekly Totals

Minimum: Maximum:

□ The frequency, intensity, and duration must be medically necessary based on the results of the assessment and realistic for the age of the beneficiary.

Any additional comments regarding the duration, frequency, or scope of personal care services:

Personal Care Service Location

□ Private Residence □ School

□ Residential Care Facility □ DDS Facility

□ Other (describe):

□ Service Location Address(es):

Number of Supervisory Visits

□ Annual

□ Other (describe): _____

RN Signature Date

Client Acceptance of Authorized Treatment Plan

□ I understand that I will receive only medically necessary assistance with my physical dependency needs and accept this personal care treatment plan.

Signature of Client or Client's Representative Date

For those under 21, an increase in hours requires a new Assessment and Treatment Plan and DMS-618-TP by the beneficiary's PCP. If the beneficiary requires more than the 64 hours/month cap, apply for an extension of benefits through Acentra.

Service location

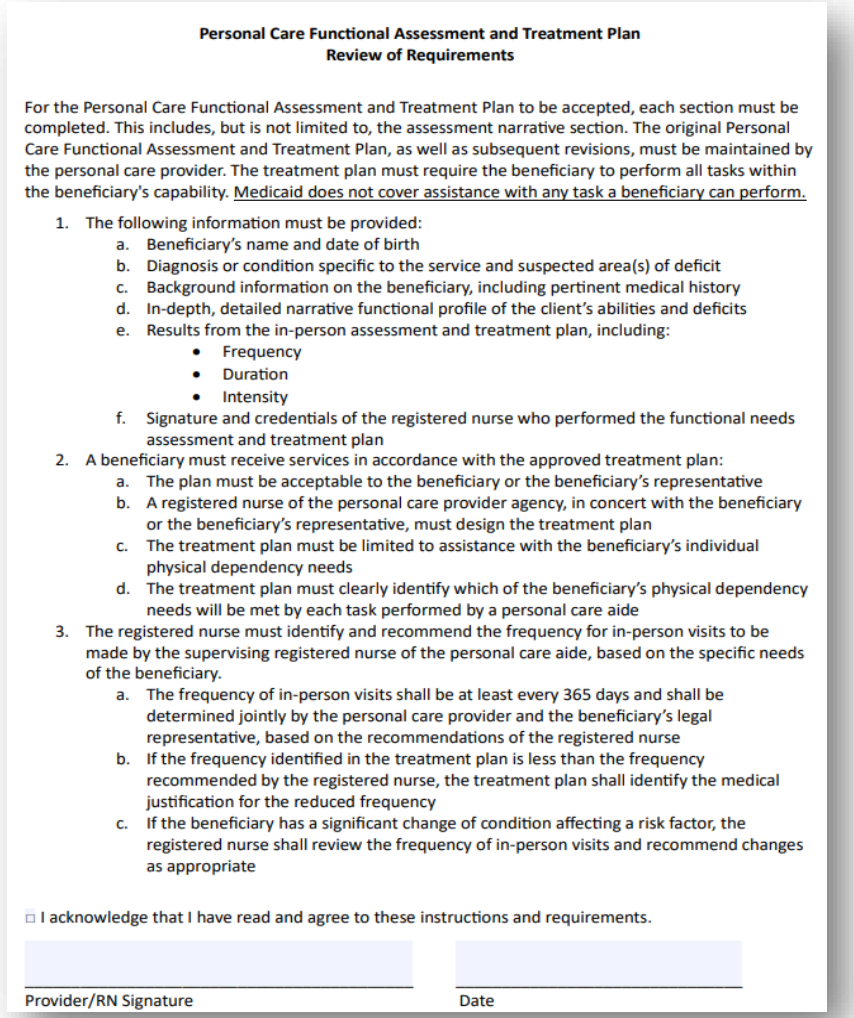
RN signature & date

Extension of benefits statement

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Assessment & Treatment Plan (Adult or Youth)

- Last page includes detailed instructions, rules, and policies.
- All of these requirements must be met for a Personal Care Assessment & Treatment Plan to be valid.
- Your signature is required to attest you have read and followed these requirements.



Personal Care Functional Assessment and Treatment Plan
Review of Requirements

For the Personal Care Functional Assessment and Treatment Plan to be accepted, each section must be completed. This includes, but is not limited to, the assessment narrative section. The original Personal Care Functional Assessment and Treatment Plan, as well as subsequent revisions, must be maintained by the personal care provider. The treatment plan must require the beneficiary to perform all tasks within the beneficiary's capability. Medicaid does not cover assistance with any task a beneficiary can perform.

1. The following information must be provided:
   a. Beneficiary's name and date of birth
   b. Diagnosis or condition specific to the service and suspected area(s) of deficit
   c. Background information on the beneficiary, including pertinent medical history
   d. In-depth, detailed narrative functional profile of the client's abilities and deficits
   e. Results from the in-person assessment and treatment plan, including:
      - Frequency
      - Duration
      - Intensity
   f. Signature and credentials of the registered nurse who performed the functional needs assessment and treatment plan
2. A beneficiary must receive services in accordance with the approved treatment plan:
   a. The plan must be acceptable to the beneficiary or the beneficiary's representative
   b. A registered nurse of the personal care provider agency, in concert with the beneficiary or the beneficiary's representative, must design the treatment plan
   c. The treatment plan must be limited to assistance with the beneficiary's individual physical dependency needs
   d. The treatment plan must clearly identify which of the beneficiary's physical dependency needs will be met by each task performed by a personal care aide
3. The registered nurse must identify and recommend the frequency for in-person visits to be made by the supervising registered nurse of the personal care aide, based on the specific needs of the beneficiary.
   a. The frequency of in-person visits shall be at least every 365 days and shall be determined jointly by the personal care provider and the beneficiary's legal representative, based on the recommendations of the registered nurse
   b. If the frequency identified in the treatment plan is less than the frequency recommended by the registered nurse, the treatment plan shall identify the medical justification for the reduced frequency
   c. If the beneficiary has a significant change of condition affecting a risk factor, the registered nurse shall review the frequency of in-person visits and recommend changes as appropriate

☐ I acknowledge that I have read and agree to these instructions and requirements.

Provider/RN Signature Date

Three (3) New Expectations

from the

Personal Care Provider Manual

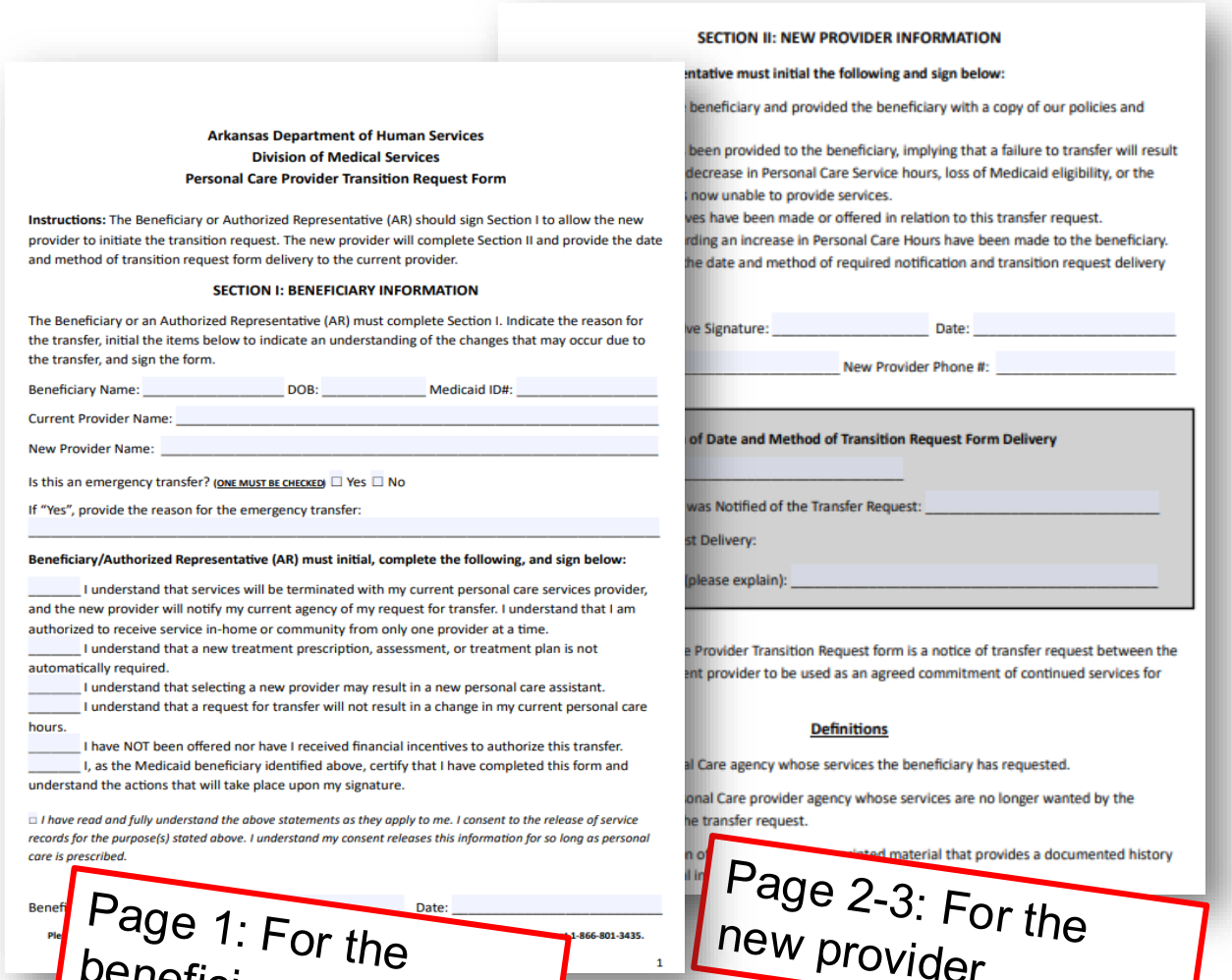
1. Personal Care Provider Transfers

Transition Request Policy

- The new manual includes a new system for when a beneficiary changes providers
- **A Personal Care Provider Transition Request**, is required to begin the process.
- This new process is a result of our conversations with providers during a series of webinars.

Personal Care Provider Transfers

Transition Request Policy (226.000)



Arkansas Department of Human Services
Division of Medical Services
Personal Care Provider Transition Request Form

Instructions: The Beneficiary or Authorized Representative (AR) should sign Section I to allow the new provider to initiate the transition request. The new provider will complete Section II and provide the date and method of transition request form delivery to the current provider.

SECTION I: BENEFICIARY INFORMATION

The Beneficiary or an Authorized Representative (AR) must complete Section I. Indicate the reason for the transfer, initial the items below to indicate an understanding of the changes that may occur due to the transfer, and sign the form.

Beneficiary Name: _____ DOB: _____ Medicaid ID#: _____

Current Provider Name: _____

New Provider Name: _____

Is this an emergency transfer? (ONE MUST BE CHECKED) ☐ Yes ☐ No

If "Yes", provide the reason for the emergency transfer:

_____

Beneficiary/Authorized Representative (AR) must initial, complete the following, and sign below:

_____ I understand that services will be terminated with my current personal care services provider, and the new provider will notify my current agency of my request for transfer. I understand that I am authorized to receive service in-home or community from only one provider at a time.

_____ I understand that a new treatment prescription, assessment, or treatment plan is not automatically required.

_____ I understand that selecting a new provider may result in a new personal care assistant.

_____ I understand that a request for transfer will not result in a change in my current personal care hours.

_____ I have NOT been offered nor have I received financial incentives to authorize this transfer.

_____ I, as the Medicaid beneficiary identified above, certify that I have completed this form and understand the actions that will take place upon my signature.

☐ *I have read and fully understand the above statements as they apply to me. I consent to the release of service records for the purpose(s) stated above. I understand my consent releases this information for so long as personal care is prescribed.*

Benef… Date: _____

Ple… …1-866-801-3435.

1

SECTION II: NEW PROVIDER INFORMATION

…ntative must initial the following and sign below:

…beneficiary and provided the beneficiary with a copy of our policies and

…been provided to the beneficiary, implying that a failure to transfer will result …decrease in Personal Care Service hours, loss of Medicaid eligibility, or the …now unable to provide services.

…ves have been made or offered in relation to this transfer request.

…rding an increase in Personal Care Hours have been made to the beneficiary.

…he date and method of required notification and transition request delivery

…ve Signature: _____ Date: _____

_____ New Provider Phone #: _____

…of Date and Method of Transition Request Form Delivery

_____

…was Notified of the Transfer Request: _____

…st Delivery:

…please explain): _____

…e Provider Transition Request form is a notice of transfer request between the …ent provider to be used as an agreed commitment of continued services for

Definitions

…l Care agency whose services the beneficiary has requested.

…onal Care provider agency whose services are no longer wanted by the …he transfer request.

…ated material that provides a documented history

Page 1: For the beneficiary

Page 2-3: For the new provider

When a beneficiary elects to transition from one provider to another:

1. The beneficiary or, if applicable, the beneficiary's parent or legal guardian, must complete page 1 of the Personal Care Provider Transition Request form.

2. The newly selected personal care provider must:
   a. Complete p. 2-3 of the Personal Care Provider Transition Request form.
   b. Notify the current provider of the beneficiary's decision to switch personal care providers; and
   c. Deliver the current/outgoing provider a copy of the completed Personal Care Provider Transition Request form.

The new provider must maintain verifiable proof of the date and method of its required notification and transition request form delivery.

Personal Care Provider Transfers

Transition Request Policy (226.000)

The Current (Outgoing) Personal Care Provider Must:

- Continue to provide services to the beneficiary in accordance with Medicaid Policy <u>until the first day of the 2nd month after the new provider completes the notification</u> and delivery requirements listed on the Personal Care Provider Transition Request Form
  - **Example:** if notified on May 11th, then the current provider would continue providing personal care services until July 1st.

- Forward the beneficiary's complete service record to the newly selected personal care provider <u>before the current provider's last day of service</u>, as described above.

- The beneficiary's complete service record includes, at minimum:
  - The beneficiary's signed 618-ER;
  - the beneficiary's active, current Assessment and Treatment Plan;
  - the beneficiary's active, signed 618-TP.





The New (Incoming) Personal Care Provider Must:

- Notify the current provider of the beneficiary's decision to switch personal care providers
- Deliver the current provider a copy of the completed "Personal Care Provider Transition Request form"
- Upload the "Personal Care Provider Transition Request form" to Acentra to accompany a new PA request

- Begin services to the beneficiary in accordance with Medicaid Policy <u>starting the first day of the 2nd month after the new provider completed the notification</u> and delivery requirements listed on the "Personal Care Provider Transition Request Form"
  - **Example:** if notified on May 11th, then the current provider would continue providing personal care services until July 1st. New provider takes over July 1st.

Personal Care Provider Transfer Timeline

Illustration of Transition Request Policy (226.000)

Beneficiary

Completes the Provider Transition Request form

Newly Selected Provider

Delivers copy of form to current/outgoing provider & Acentra

Current/outgoing Provider

Continues to deliver services until the first day of the 2nd month after notification

Current/outgoing Provider

Forwards the beneficiary's complete service record to newly selected provider before last date of service

Newly Selected Provider

Completes set-up of beneficiary in their system & Acentra using documents from service record

Provider Transfer Complete

Newly Selected Provider can deliver services and bill.

2. Use of Qualified Supervisor / Supervising RN



The personal care service delivery of each beneficiary must be supervised by a **qualified supervisor** who is responsible for the quality of services rendered:

1. The qualified supervisor must complete the following **at least monthly**:
    a. Review the beneficiary's service delivery logs and documentation;
    b. Document the time and date of their service documentation review;
    c. Actively train or assist assigned personal care aide with personal care service delivery, when necessary;
    d. Document any training or assistance provided to an assigned personal care aide.

2. A **supervising Registered Nurse** must conduct an on-site evaluation of a day's service delivery to a beneficiary as required in the treatment plan, but **no less often than annually**. On each on-site evaluation, the supervising registered nurse must:
    a. Observe and document;
        i. The condition of the beneficiary;
        ii. The type and quality of the personal care aide's service provision;
        iii. The interaction and relationship between the beneficiary and the personal care aide; and
        iv. Any changes or additions to any risk factors relevant to the needed frequency of in-person supervisory visits.

3. DHS Medical Justification Form

What is the DHS Medical Justification Form for?

- Providers may use this DHS Medical Justification Form to submit a medical justification for a day when personal care services have been delivered outside the service time authorized in the member's approved Personal Care Treatment Plan.

Why is this needed?

- Personal Care providers may bill Medicaid only up to the aggregate daily maximum service time authorized in the member's approved Personal Care Treatment Plan.
- Service time authorized for delivery across distinct days may not be combined and billed as a single visit. Providers are prohibited from exceeding the daily aggregate maximum to compensate for missed visits or to front-load services (e.g., billing six (6) hours in one day when the Treatment Plan authorizes a four (4) hour daily maximum.
- Any billing in excess of the aggregate daily maximum authorized in the Treatment Plan without supplemental medical paperwork is subject to post-payment review, audit, and recoupment of Medicaid funds.



Link to form online:

https://forms.cloud.microsoft/g/hFE4PgpqUD

* Required

1. Personal Care Agency name:
*

Enter your answer

2. Personal Care Agency Medicaid ID #:
*

Example: 1111112232

The value must be a number

3. Full name of individual completing this form, on behalf of agency:
*

Enter your answer

4. Full name of primary contact at agency, should DHS need to discuss:
*

Enter your answer

5. Phone number of primary contact, should DHS need to discuss:
*

Please enter at most 10 characters

6. Email of primary contact, should DHS need to discuss:
*

Please enter an email

Numbers 1-6 pertains to the current Agency: Agency's name, Medicaid ID number, name & information of Agency Personnel completing form, etc.

7. Full name of client
*

Enter your answer

8. Client's Medicaid #: *

Example: 1111112232

The value must be a number

9. Service location: *

Please include street, city, state, and ZIP code

Enter your answer

10. Date of service delivered outside of service plan:
*

Please input date (M/d/yyyy)

11. Number of hours delivered outside of service plan *

The value must be a number

12. Medical justification.
*

Please provide specific details on why the client requires hours beyond regular service hours.

Enter your answer

13. Has this Information been updated in the client's file?
*

- Yes
- No

Numbers 7 & 8 pertain to the client

Numbers 9-11 pertain to services and location

Number 12 is where the medical justification is indicated.



ARKANSAS DEPARTMENT OF HUMAN SERVICES

Reminders



- The maximum allowable hours to be billed for Medicaid State Plan Personal Care Services are 256 units/ 64 hours a month.
- Bill according to the established Service Plan/Task and Hours. (If outside of plan medical justification required.)
- Billing a large number of hours daily is a red flag to Medicaid.
- The EVV compliance benchmark is 90%, consistent with state and CMS expectations. Manual entries are considered non-compliant EVV methods.

Reminders Continued



- Act 853 revised the Arkansas code § 20-10-2301(b), by only requiring providers to obtain a private care agency license from the Arkansas Department of Health (ADH)
- Effective August 5th, 2025, the Arkansas Department of Human Services (DHS), Division of Provider Services and Quality Assurance (DPSQA) no longer certifies State Plan Personal Care, ARChoices Attendant Care or ARChoices Respite Care.

DHS Personal Care Program Contacts

Personal Care Provider Inbox for Questions
Personal.Care.Prov@dhs.arkansas.gov

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