

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: SPA #2020-0011; AR Choices Medicaid Provider Manual, Personal Care Medicaid Provider Manual, and Targeted Case Management Medicaid Provider Manual

DESCRIPTION:

Statement of Necessity

The Department of Human Services (DHS) proposes to amend the ARChoices and Personal Care Medicaid Provider Manuals to implement regulatory reform which will allow the Manuals to mirror the Arkansas Department of Health (ADH) requirements while at the same time reducing administrative costs for providers and eliminating duplicative requirements. These revisions will allow DHS to make needed technical changes and corrections while bringing DHS into compliance with new ADH rules.

Rule Summary

Revisions of the Personal Care Medicaid Provider Manual include the following:

- Section 220.100 of the Personal Care Manual requires an agency RN Supervisor to make an inhome visit for every beneficiary served by the agency at least once every 62 days. This requirement is based on an identical requirement contained in the Arkansas Department of Health (ADH) Rules and Regulations for Private Care Agencies in Arkansas. Act 811 of 2019 repealed the ADH requirement and replaced it with a requirement that each beneficiary be visited at least annually by a supervisor who may either be an RN or an individual with at least two years of fulltime study in an institution of higher education. DHS is proposing to eliminate the parallel requirement contained in Section 220.100 and replace it with language that mirrors the new requirements. The Act requires supervisory visits to be made at a frequency that is “based on the specific needs of the patient.”
- Section 215.200 has been updated to require that, before furnishing any personal care services to an individual, the provider must prepare a complete and accurate Individualized Service Plan with proposed hours and minutes and frequency of needed tasks consistent with the Task and Hour Standards. The service plan must be prepared, certified, and signed by a supervisor or registered nurse. Documentation of the service plan and all revisions must be kept by the personal care provider.
- Section 215.320 has been inserted to require in-person supervisory visits at least annually but at a frequency determined by a registered nurse, the personal care provider, and the beneficiary or the beneficiary’s legal representative. The section states that the risk factors identified by the service plan must include any relevant medical diagnoses; the beneficiary’s mental status; the presence of family or other residents in the beneficiary’s home, and the frequency of their presence; and the beneficiary’s physical dependency needs, including the activities of daily living (ADL) with which the beneficiary needs assistance. 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. Parts of sections 215.330, 216.000, and 220.100 were revised to provide clarity for certain requirements. The revisions include updates to monthly hours provided, qualifications and restrictions for supervisory individuals, and specifications of annual visits. The revisions include a duty to observe, document, and report. The manual requires documentation of consultation in the beneficiary's records, and includes a new subsection regarding early recognition and reporting of changes in a client's condition.

- Changes are made throughout the rule to remove the requirement that a supervisor must be an RN. (Sections 216.000, 220.100, 221.000, 222.110, 222.120)
- DHS is reducing the amount of information required to be submitted by providers to request authorization to provide personal care services. DHS proposes to require only the following information:
 - Beneficiary and provider information;
 - Identification of alternative sources of personal assistance available to the beneficiary (family or friends, AAA, VA, Medicare, or other insurance, etc.);
 - Certification that the beneficiary's service plan will not duplicate any other in-home services of which the provider is aware;
 - The total number of hours per month which the provider seeks to offer for the beneficiary;
 - The frequency of in-person supervisory visits to be made by an agency supervisor, including information on the risk factors specific to the beneficiary and a justification for the frequency; and
 - The signed approval of the beneficiary or beneficiary's representative. (Section 215.200)

DHS is also proposing changes to the Personal Care Manual regarding beneficiaries' individualized service plans:

- Revising the Manual to clarify that a service plan is effective for one year from the date of the client's last Independent Assessment;
- Eliminating the requirement that providers submit the beneficiary's individualized service plan to DHS. However, providers are required to maintain copies of all current and prior service plans for audit purposes; and
- Requiring approval of a revised service plan only if the provider requests to provide more total monthly hours than are allocated in the current prior authorization. However, providers would still be required to maintain documentation of the medical need for any revisions made to the service plan. (Sections 214.200, 214.300, 215.200, 215.330, 215.351, and 244.000 of the Personal Care Manual)
- DHS is revising Section 215.360 regarding documentation and reporting of a significant change in a beneficiary's condition. The individualized service plan must identify individualized, beneficiary-specific standards, based on the identified risk factors, for when a caregiver or supervisor must document and report any significant change in the beneficiary's condition. If a caregiver or supervisor observes a significant change of condition, they must document and

report the change of condition as required by the change-reporting standards contained in the beneficiary's individualized service plan. Documentation must include the time and date the change was identified by the caregiver and a full description of the change. Within twenty-four (24) hours of a significant change of condition being reported, a registered nurse must evaluate and document an assessment of the beneficiary.

Revisions of ARChoices Targeted Case Management Medicaid Provider Manual and the Arkansas Medicaid Provider Manual include the following:

- Section 204.000(I)(3) of the Targeted Case Management Manual and page 6 of Supplement 1 to Attachment 3.1-A of the Arkansas Medicaid State Plan are revised to loosen the educational qualifications for ARChoices Targeted Case Managers by requiring them to have a bachelor's degree from an accredited institution in a health and human services field, or two years' experience in the delivery of human services to the elderly.

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- Added Section 262.312 regarding of quotients with decimals to mirror the Personal Care Provider Manual.

Revisions of the Arkansas Medicaid State Plan include the following:

- Supplement 1 to Attachment 3.1-A, Page 5 is revised to show that case management providers must now be certified by the Division of Provider Services and Quality Assurance.
- Supplement 1 to Attachment 3.1-A, Page 6 is revised to reflect the participation requirements for providers of TCM that are listed in the Targeted Case Management Medicaid Provider Manual.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on April 20, 2020. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Luke Mattingly, CEO/President, CareLink

COMMENT #1: The revisions do not incorporate telehealth options for RN and Qualified Supervisor interaction with participants. Current circumstances with COVID-19 highlight the need for Medicaid to incorporate technology into allowable options.
Revise the Manual to include telehealth options to augment or replace face-to-face visits.

RESPONSE: Given the vulnerabilities of these beneficiaries, the division determined it is in the best interest of beneficiaries to continue face-to-face supervisory visits.

Telehealth only provides limited information in relation to the beneficiary's overall health, well-being and environmental safety. Face-to-face interactions are required to fully assess all medical, functional and environmental factors that impact the beneficiary's safety and overall risk.

COMMENT #2: Revisions of the Personal Care Medicaid Provider Manual Section 215.200

"The provider must prepare a complete and accurate Individualized Service Plan with proposed hours and minutes and frequency of needed tasks consistent with the Task and Hour Standards."

Providers do not receive a copy of the Task and Hour Standards from eQHealth. How can we prepare an Individualized Service Plan consistent with the Task and Hour Standards?

RESPONSE: The Division will review and revise the language of Section 215.200. The maximum/minimum ranges in the Task and Hour Standards are used only to calculate the aggregate number of hours of care; they are not intended as limitations on actual performance of each individual instance of a task.

COMMENT #3: "DHS is reducing the amount of information required to be submitted by providers to request authorization to provide personal care services. DHS proposes to require only the following information:"

Is DHS revising the DMS-618 to include only the proposed information? If so, there isn't a shortened form to review and provide comments on. Or are providers responsible for creating their own request authorizations?

RESPONSE: The Division intends, based on implementation of manual revisions, to update the current DMS-618 to only include information required under the manual. 2

COMMENT #4: "DHS is revising Section 215.360 regarding documentation and reporting of a significant change in a beneficiary's condition."

To whom must the caregiver and supervisor report any significant change in the beneficiary's condition? What are the next steps after a change of condition is reported? Does a change of condition trigger a new assessment?

RESPONSE: The reporting of any significant change in condition would be based on individual agency policy and procedures.

COMMENT #5: "Within 24 hours of a significant change of condition, a registered nurse must evaluate and document an assessment of the beneficiary."

Which registered nurse must evaluate and document an assessment of the beneficiary? Provider, DHS, Optum? What kind of an assessment? What assessment tool?

RESPONSE: A provider agency registered nurse must evaluate and document an assessment.

The assessment would be conducted based on individual agency policy and procedure. The division will revise Section 215.360 to clarify the provider responsibility under this section.

COMMENT #6: The TCM SPA and TCM Section II are inconsistent on the frequency of monitoring. We would like the monitoring with service providers frequency to remain every other month as currently written in the SPA.

RESPONSE: The Division will review and revise the language of Section 218.300 C to be consistent with language in the SPA.

COMMENT #7: Section 218.300 C (Though not part of the proposed rule currently published, it makes sense to correct so the SPA and policy align.)

“Monitoring is allowed through regular contacts with service providers at least every month (should change this verbiage to every other month) to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least monthly, that the beneficiary continues to participate in the service plan and is satisfied with services.”

RESPONSE: The Division will review and revise the language of Section 218.300 C to be consistent with language in the SPA. 3

Commenter’s Name: Kim Steed, RN, BSN, Regional Director Community Care Operations, Community Care - Kindred at Home

COMMENT #1: 215.320 (B.) Identifying Frequency of In-Person Supervisory Visits – DHS should define “annually.” Example: if a supervisory visit is made on May 22nd, 2020; the annual supervisory visit can be made anytime – May 1-May 31st, 2021.

RESPONSE: The Division will revise Section 215.320, B to clarify “at least annually” as, “at least every 365 days”.

COMMENT #2: 215.360 Changes of Condition (NOTE: Added to Manual as well as to Aide training) Most providers already have the aides report beneficiary changes, so we agree with A. and B. **RESPONSE:** Thank you for your comment.

COMMENT #3: 215.360. C. states, “Within twenty-four (24) hours of a significant change of condition being reported, a registered nurse must evaluate and document an assessment of the beneficiary, including without limitation the reported change of condition.” Assessment is considered to be skilled and face to face. This is a non-skilled program. RN Assessments are non-reimbursable. This does not mirror Arkansas

Department of Health required rules. We are attaching our Attendant Instructions on reporting changes.

RESPONSE: Given the vulnerabilities of these beneficiaries, the division determined it is in the best interest of beneficiaries to continue face-to-face supervisory visits. Telehealth only provides limited information in relation to the beneficiary's overall health, well-being and environmental safety. Face-to-face interactions are required to fully assess all medical, functional and environmental factors that impact the beneficiary's safety and overall risk.

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Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following questions and received the following responses:

QUESTION #1: Why has DHS chosen to reduce the amount of information a provider must submit to obtain a PA (see section 215.200(B))? **RESPONSE:** The current rule requires that an individual’s physical dependency need for personal care services be based upon the results of the Arkansas Independent Assessment (ARIA). Some of the information required to be submitted by the current § 215.200(B) has become duplicative and unnecessary, as it is now collected as part of ARIA. DHS proposes to reduce the amount of information required by removing the pieces that duplicate what is obtained through ARIA, so as to reduce the administrative burden on providers.

QUESTION #2: Is an Individualized Service Plan, as referenced in section 215.200(E), required by statute? **RESPONSE:** The current rule requires the preparation of an Individualized Service Plan (see, e.g., §§ 215.200 and 215.300). Ark. Code Ann. §§ 20-10-806(b)(3)(A) and 20-10-2304(c)(3)(A) require a “plan of care” for each patient, and this requirement is fulfilled by the Individualized Service Plan required under both the current rule and the proposed rule.

QUESTION #3: What is the statutory authority for section 215.360, regarding changes of condition? **RESPONSE:** Arkansas Code Annotated §§ 20-76-201, 20-77-107, and 20-77-1709 authorize the Department to promulgate rules to implement and govern the Arkansas Medicaid Program.

QUESTION #4. What is the source for section 220.100(A)(3)'s requirement that an individual who personally provides personal care services to a beneficiary may not supervise another personal care aide providing personal care services to that same beneficiary? **RESPONSE:** Arkansas Code Annotated §§ 20-76-201, 20-77-107, and 20-77-1709 authorize the Department to promulgate rules to implement and govern the Arkansas Medicaid Program. Allowing two personal care aides to supervise each other while serving the same client would be a conflict of interest detrimental to the best interests of the client.

The proposed effective date is July 1, 2020.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the authority to administer assigned forms of public assistance and to make rules as necessary to carry out

its duties. Ark. Code Ann. § 20-76-201(1), (12). The Department is specifically tasked with establishing and maintaining an indigent medical care program. Ark. Code Ann. § 20-77-107(a)(1). This includes promulgating rules to ensure compliance with federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

**QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS
WITH THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Janet Mann
CONTACT PERSON Alexandra Rouse
ADDRESS PO Box 1437, Slot S295, Little Rock, AR 72203-1437
PHONE NO. (501) 508.8875 **FAX NO.** (501) 404.4619 **E-MAIL** Alexandra.Rouse@dhs.arkansas.g
NAME OF PRESENTER AT COMMITTEE MEETING Mark White
PRESENTER E-MAIL Mark.White@dhs.arkansas.gov

INSTRUCTIONS

- A. Please make copies of this form for future use.**
- B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
- C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
- D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two copies of the proposed rule and required documents. Mail or deliver to:**

**Jessica C. Sutton
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201**

SPA #2020-0011; ARChoices Medicaid Provider Manual, Personal Care
Medicaid Provider Manual, and Targeted Case Management Medicaid Provide
Manual.

- 1. What is the short title of this rule? Manual.

- 2. What is the subject of the proposed rule? See attached.

- 3. Is this rule required to comply with a federal statute, rule, or regulation? Yes No
If yes, please provide the federal rule, regulation, and/or statute citation. _____

- 4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes No
If yes, what is the effective date of the emergency rule? _____

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes No

5. Is this a new rule? Yes No
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes No
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes No
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should clearly labeled "mark-up."**

See attached.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

7. What is the purpose of this proposed rule? Why is it necessary? See attached.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b). <https://medicaid.mmis.arkansas.gov/general/comment/comment.aspx>

9. Will a public hearing be held on this proposed rule? Yes No
If yes, please complete the following:

Date: _____

Time: _____

Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

April 20, 2020

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

July 1, 2020

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See attached.

13. Please provide proof of filing the rule with the Secretary of State as required pursuant to Ark. Code Ann. § 25-15-204(e). See attached.

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. Personal Care Providers are expected to be in favor of these changes.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT David McMahon

TELEPHONE 501-396-6421 **FAX** _____ **EMAIL:** David.McMahon@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE SPA #2020-0011; ARChoices Medicaid Provider Manual, Personal Care Medicaid Provider Manual, and Targeted Case Management Medicaid Provider Manual.

- 1. Does this proposed, amended, or repealed rule have a financial impact? Yes No

- 2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes No

- 3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes No

If an agency is proposing a more costly rule, please state the following:

- (a) How the additional benefits of the more costly rule justify its additional cost;

- (b) The reason for adoption of the more costly rule;

- (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

- (d) Whether the reason is within the scope of the agency’s statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

- (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	<u>0</u>
Special Revenue	<u>0</u>
Other (Identify)	<u>0</u>

Next Fiscal Year

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	<u>0</u>
Special Revenue	<u>0</u>
Other (Identify)	<u>0</u>

Total 0

Total 0

(b) What is the additional cost of the state rule?

Current Fiscal Year

Next Fiscal Year

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	<u>0</u>
Special Revenue	<u>0</u>
Other (Identify)	<u>0</u>
Total	<u>0</u>

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Special Revenue	<u>0</u>
Other (Identify)	<u>0</u>
Total	<u>0</u>

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year

Next Fiscal Year

\$ 0

\$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

Next Fiscal Year

\$ _____

\$ _____

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes No

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective July 1, 2020:

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The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule on the Medicaid website at <https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx>. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **April 20, 2020**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6164.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. **4501888131**



Janet Mann, Director
Division of Medical Services

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Rule Summary

Revisions of the Personal Care Medicaid Provider Manual include the following:

- Section 220.100 of the Personal Care Manual requires an agency RN Supervisor to make an in-home visit for every beneficiary served by the agency at least once every 62 days. This requirement is based on an identical requirement contained in the Arkansas Department of Health (ADH) Rules and Regulations for Private Care Agencies in Arkansas. Act 811 of 2019 repealed the ADH requirement and replaced it with a requirement that each beneficiary be visited at least annually by a supervisor who may either be an RN or an individual with at least two years of full-time study in an institution of higher education. DHS is proposing to eliminate the parallel requirement contained in Section 220.100 and replace it with language that mirrors the new requirements. The Act requires supervisory visits to be made at a frequency that is “based on the specific needs of the patient.”
- Section 215.200 has been updated to require that, before furnishing any personal care services to an individual, the provider must prepare a complete and accurate Individualized Service Plan with proposed hours and minutes and frequency of needed tasks consistent with the Task and Hour Standards. The service plan must be prepared, certified, and signed by a supervisor or registered nurse. Documentation of the service plan and all revisions must be kept by the personal care provider.
- Section 215.320 has been inserted to require in-person supervisory visits at least annually but at a frequency determined by a registered nurse, the personal care provider, and the beneficiary or the beneficiary’s legal representative. The section states that the risk factors identified by the service plan must include any relevant medical diagnoses; the beneficiary’s mental status; the presence of family or other residents in the beneficiary’s home, and the frequency of their presence; and the beneficiary’s physical dependency needs, including the activities of daily living (ADL) with which the beneficiary needs assistance. 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. Parts of sections 215.330, 216.000, and 220.100 were revised to provide clarity for certain requirements. The revisions include updates to monthly hours provided, qualifications and restrictions for supervisory individuals, and specifications of annual visits. The revisions include a duty to observe, document, and report. The manual requires documentation of consultation in the beneficiary’s records, and includes a new subsection regarding early recognition and reporting of changes in a client’s condition.
- Changes are made throughout the rule to remove the requirement that a supervisor must be an RN. (Sections 216.000, 220.100, 221.000, 222.110, 222.120)

- DHS is reducing the amount of information required to be submitted by providers to request authorization to provide personal care services. DHS proposes to require only the following information:
 - Beneficiary and provider information;
 - Identification of alternative sources of personal assistance available to the beneficiary (family or friends, AAA, VA, Medicare, or other insurance, etc.);
 - Certification that the beneficiary's service plan will not duplicate any other in-home services of which the provider is aware;
 - The total number of hours per month which the provider seeks to offer for the beneficiary;
 - The frequency of in-person supervisory visits to be made by an agency supervisor, including information on the risk factors specific to the beneficiary and a justification for the frequency; and
 - The signed approval of the beneficiary or beneficiary's representative. (Section 215.200)

- DHS is also proposing changes to the Personal Care Manual regarding beneficiaries' individualized service plans:
 - Revising the Manual to clarify that a service plan is effective for one year from the date of the client's last Independent Assessment;
 - Eliminating the requirement that providers submit the beneficiary's individualized service plan to DHS. However, providers are required to maintain copies of all current and prior service plans for audit purposes; and
 - Requiring approval of a revised service plan only if the provider requests to provide more total monthly hours than are allocated in the current prior authorization. However, providers would still be required to maintain documentation of the medical need for any revisions made to the service plan. (Sections 214.200, 214.300, 215.200, 215.330, 215.351, and 244.000 of the Personal Care Manual)
 - DHS is revising Section 215.360 regarding documentation and reporting of a significant change in a beneficiary's condition. The individualized service plan must identify individualized, beneficiary-specific standards, based on the identified risk factors, for when a caregiver or supervisor must document and report any significant change in the beneficiary's condition. If a caregiver or supervisor observes a significant change of condition, they must document and report the change of condition as required by the change-reporting standards contained in the beneficiary's individualized service plan. Documentation must include the time and date the change was identified by the caregiver and a full description of the change. Within twenty-four (24) hours of a significant change of condition being reported, a registered nurse must evaluate and document an assessment of the beneficiary.

Revisions of ARChoices Targeted Case Management Medicaid Provider Manual and the Arkansas Medicaid Provider Manual include the following:

- Section 204.000(I)(3) of the Targeted Case Management Manual and page 6 of Supplement 1 to Attachment 3.1-A of the Arkansas Medicaid State Plan are revised to loosen the educational qualifications for ARChoices Targeted Case Managers by requiring them to have a bachelor's degree from an accredited institution in a health and human services field, or two years' experience in the delivery of human services to the elderly.