DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: ARChoices 1-20, LCAL 1-20, PERSCARE 3-20, ARChoices and Living Choices Waiver Amendments, and Medical Services Policy C-265, I-630, I-640, and L-120

DESCRIPTION:

Statement of Necessity

The proposed rule change seeks to change the way appeals and evaluations are handled for Long Term Care and Home and Community Based (HCBS) waiver programs.

For the current appeals process, when a beneficiary receives a notice of adverse action, the beneficiary must request that their case remain open during the appeals process. With this change, the beneficiary's case will automatically remain open during the appeals process, unless the petitioner affirmatively opts out of receiving ongoing services pending the appeal.

Steps are being added for members of HCBS waiver programs to request reassessments by the DHS RN when necessary or if a change in condition warrants a change to the Person-Centered Service Plan (PCSP).

Rule Summary

Medical Services Policy (MSP) is being updated to incorporate the new appeals process.

MSP C-265 – Pace Disenrollment: A sentence has been added stating, "If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out."

MSP I-630 – ARChoices Waiver: A sentence has been added stating, "If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out."

MSP H-640 – Assisted Living Facility (ALF): A sentence has been added stating, "If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out."

MSP L-120 – Continuation of Assistance or Services During Appeal Process:

- Added paragraph "In cases where an adverse action is taken against a beneficiary who qualifies for an institutional level of care (e.g. ARChoices, Living Choices, TEFRA,

Autism, PACE, CES/DD, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and LTC/nursing home), if a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits pending the hearing decision, they must opt out."

- Added statement that in all other cases benefits will not continue if the petitioner does not file for hearing within the then day notice period, or five days in the case of probable fraud.

- Made other technical corrections.

Medicaid Provider Manuals are being updated to include the following:

ARChoices in Home Care and Community-Based 2176 Waiver

- Section 212.000 – Eligibility for the ARChoices Program: Grammatical and technical corrections.

- Section 212.050 – Definitions: Added definitions for "Assessment," "Evaluation," "Functional Eligibility," and "Reassessment."

- Section 212.200 – Prospective Individual Services Budget: Changed "Division of Aging, Adult, and Behavioral Health Services" to "Department of Human Services Registered Nurse." Added that the DHS RN may order a reassessment of the participant based on a change of condition.

- Section 212.312 – Comprehensive Person-Centered Plan (PCSP): Added the statements, "Prior to the expiration of the 365 days, financial and functional eligibility will be reviewed for renewal of the PCSP. Functional eligibility will be determined by an evaluation done by the DHS RN."

- Section 212.500 – Reporting Changes in Beneficiary's Status: Added that a Targeted Case Manager is responsible for referring the beneficiary for evaluation of any beneficiary complaints or change of condition. Added the statement, "The DHS RN will determine if a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RN's evaluation of the beneficiary."

Living Choices Assisted Living

- Section 211.100 – Eligibility for the Living Choices Assisted Living Program: Added "evaluation" to process for beneficiary intake.

- Section 211.125 – Added definitions for "ARIA Assessment Tool," "Assessment," "DHS RN," "Evaluation," "Extensive Assistance," "Functional Eligibility," "Independent Assessment Coordinator," "Reassessment," and "Serious Mental Illness or Disorder."

- Section 211.150 – Level of Care Determination: Changed "functional disability" to "functional eligibility." Added the statements, "An evaluation is completed annually by the DHS RN to determine continued functional eligibility. Should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment."

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 9, 2020. The agency provided the following summary of the comments it received and its responses to those comments:

Commenter's Name: Robert W. Wright, Mitchell Blackstock Law Firm

COMMENT: The Medical Services policy is being changed to make the "default" in the event of an adverse action continuing services rather than requiring the beneficiary to request continuation. If the services continue and the hearing officer finds in favor of the beneficiary, am I correct that Medicaid pays for the continued services between the notice and the hearing decision? What if the hearing officer upholds the adverse action? Who is responsible for the continued services between the adverse action and the hearing decision? Thank you.

RESPONSE: Medicaid services will continue for the designated population during the appeal process. Beneficiaries who do not wish to continue benefits pending the appeal may elect to discontinue benefits. If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, per current federal regulations.

Commenter's Name: Kay Newton, RN, Home Care Administrator, Area 2, Area Agency on Aging of Southeast Arkansas

COMMENT:

I have worked in the Home Health industry for 30 years and during this time, I have watched the Aides work hard to maintain the elderly population in their home setting. Allowing the elderly to remain in their homes is one of the most important factors in promoting well-being and longevity of life. In order to allow clients to age gracefully in the home setting, we must provide them with the services they desperately need including ARChoices waiver programs.

The COVID-19 pandemic is only one example of why the elderly population benefit from receiving services in their homes. Their home is a much safer environment than a facility setting. They deserve the many Home and Community Based services that are available and allow them to remain in the safety and comfort of their homes.

The rapid increase in minimum wage, without a rate increase for this program, threaten in-home services. The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0022. In addition, the Service Budget caps will need to increase to accommodate the recommended increase in the Personal Care rate along with the prospective increase in the Attendant Care and Respite rates. Waiver recipients are among the frailest older Arkansans and they deserve in-home care. Thank you.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Luke Mattingly, on behalf of CareLink

COMMENT 1: Submitted by CareLink

212.200 Prospective Individual Services Budget, D. Methodology for Determining Individual Services Budgets,

The maximum individual service budget for a participant…

These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates Without increasing the caps, service recipients receiving maximum care will see a reduction in services

At a minimum 2.a. should be increased to $ 34,134

At a minimum 2.b. should be increased to $ 22,756

At a minimum 2.c. should be increased to $ 5,689

In general, the caps are set too low and should be raised even higher than the above limits to allow for more care.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

COMMENT 2: The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Waiver service recipients are amongst the frailest older Arkansans and deserve in-home care. If the rate is not adjusted to offset the rapid increase in minimum wage these services will be unsustainable after the minimum wage increases again on Jan 1, 2021 without an increase to the rate.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

COMMENT 3: 212.050 Definitions

Evaluation means the process completed, at a minimum of every three hundred sixty-five (365) days, by the DHS RN to determine continued functional eligibility or a change in medical condition that may impact continued functional eligibility.

Please clarify which DHS RN determines continued functional eligibility (OLTC or DAABHS) and the procedure for determining continued functional eligibility or a change in medical condition.

RESPONSE: During the annual review process, documentation of changes or lack thereof in functional ability or medical condition will be determined by the DAABHS RN. The review of functional and medical information for final determination of eligibility and level of care will be completed by an RN with the Division of County Operations.

COMMENT 4: How is the evaluation determination communicated to providers?

RESPONSE: The evaluation determination will continue to be communicated to providers in the same manner as today. The DAABHS RNs will communicate via AAS-9511.

COMMENT 5: FUNCTIONAL ELIGIBILITY means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one (1) of the following three (3) 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) 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 themselves or others; or
The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

Missing #3 for the third component of the eligibility criteria, beginning with "the individual has a diagnosed medical condition…."

RESPONSE: Thank you. We have made corrections to the document.

COMMENT 6: 212.312 Comprehensive Person-Centered Service Plan (PCSP)

The comprehensive PCSP expiration date will be three hundred sixty-five (365) days from the date of the DHS RN's signature on form AAS 9503, the ARChoices PCSP. Prior to the expiration of the 365 days, financial and functional eligibility will be reviewed for renewal of the PCSP. Functional eligibility will be determined by an evaluation done by the DHS RN. Once the renewal is either approved or denied by the DHS Division of County Operations the providers will be notified by the DHS RN. The notification of the approval will be in writing via a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS -9511 reflecting the date of denial.

Please explain the evaluation method and tools used for determining functional eligibility that will be done by the DHS RN and when it will be performed. Which DHS RN will complete the evaluation, OLTC or DAABHS?

Inserting the above statement for renewals confuses the intent for this paragraph. This paragraph explains to providers how the initial comprehensive PCSP is processed if services began under a provisional PCSP. For clarity, I recommend removing the inserted language from the original paragraph and creating a separate paragraph that speaks to the renewal process rather than the approval process. There is a difference between approvals/renewals and denials/closures.

RESPONSE: DHS is proposing that the rules related to the federally required eligibility re-evaluation conducted each year be modified to permit a DHS Division of Aging, Adult, and Behavioral Health Services (DAABHS) nurse to conduct the eligibility re-evaluation based on a personal interview with the client (in-person when it is safe to do so) and review of the client's current records.

- The process to schedule re-evaluations would begin 90 days from the date services would otherwise end.
- Following that interview, the nurse would report one of the following scenarios to the Division of County Operations (DCO) eligibility team:
    - Client's functional needs have not significantly changed and continues to meet requirements for services. DCO staff would then complete financial and medical review and extend beneficiary's eligibility another year. OR
    - An independent assessment should be given to determine whether functional needs have changed significantly. DCO staff would then work with Optum to schedule a new independent assessment for the client. OR
    - Client's functional needs have significantly changed to the point he or she no longer meets the eligibility criteria for placement in an intermediate care nursing facility because of improvement. DCO would then inform the client of his or her appeal rights. OR
    - Client's functional needs have significantly increased, requiring placement in a skilled nursing facility and is no longer eligible for LTSS HCBS services. DCO would then coordinate with DAABHS staff and the Division of Provider Services and Quality Assurance (DPSQA), to help the client and family with nursing home placement or provide information on other resources along with the client's appeal rights.
- Any recommendation from the DAABHS nurse that a client's services should be terminated or reduced would be reviewed by an internal panel of clinicians and confirmed as the appropriate recommendation prior to any action taken on the client's case.
- While a nurse evaluation will be used to determine continued eligibility based on the personal interview and review of client records, the levels of service the client receives will continue to be guided by the objective Task & Hour Standards based on the client's responses to his or her initial independent assessment.

Changes will be made as per this public comment. A new paragraph will include the inserted language.

COMMENT 7: 212.500 Reporting Changes in Beneficiary's Status

The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in service need, referring the beneficiary for evaluation of any beneficiary complaints or change of condition to the DHS RN, or DHS RN Supervisor immediately upon learning of the change. The DHS RN will determine if a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RNs evaluation of the beneficiary.

What does the DHS RNs evaluation consist of? What are the beneficiary's appeal rights if the DHS RN determines a reassessment is not necessary? How will the DHS RN notify the Targeted Case Manager of the decision to reassess or not reassess?

RESPONSE: DHS is proposing that the rules related to the federally required eligibility re-evaluation conducted each year be modified to permit a DHS Division of Aging, Adult, and Behavioral Health Services (DAABHS) nurse to conduct the eligibility re-evaluation based on a personal interview with the client (in-person when it is safe to do so) and review of the client's current records.

- The process to schedule re-evaluations would begin 90 days from the date services would otherwise end.
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  - Client's functional needs have not significantly changed and continues to meet requirements for services. DCO staff would then complete financial and medical review and extend beneficiary's eligibility another year. OR
  - An independent assessment should be given to determine whether functional needs have changed significantly. DCO staff would then work with Optum to schedule a new independent assessment for the client. OR
  - Client's functional needs have significantly changed to the point he or she no longer meets the eligibility criteria for placement in an intermediate care nursing facility because of improvement. DCO would then inform the client of his or her appeal rights. OR
  - Client's functional needs have significantly increased, requiring placement in a skilled nursing facility and is no longer eligible for LTSS HCBS services. DCO would then coordinate with DAABHS staff and the Division of Provider Services and Quality Assurance (DPSQA), to help the client and family with nursing home placement or provide information on other resources along with the client's appeal rights.
- Any recommendation from the DAABHS nurse that a client's services should be terminated or reduced would be reviewed by an internal panel of clinicians and confirmed as the appropriate recommendation prior to any action taken on the client's case.
- While a nurse evaluation will be used to determine continued eligibility based on the personal interview and review of client records, the levels of service the client receives will continue to be guided by the objective Task & Hour Standards based on the client's responses to his or her initial independent assessment.

- The beneficiary retains all appeals rights based on notification of an adverse action.
- DHS RN notifies TCM that request for reassessment has been approved or denied via electronic mail.

COMMENT 8: Waiver Contact – This should be Ashley Fisher not Ashley Foster

RESPONSE: Yes, we will make this correction.

COMMENT 9: B-6(i) Procedures to Ensure Timely Reevaluations

The following language is stricken, "Each Targeted Case Manager is also required to maintain a "Tickler" system to track the Medicaid eligibility reevaluation date and the service plan expiration date. If the reassessment process has not been completed timely,

the Targeted Case Manager notifies the DHS RN prior to the expiration date of the current service plan."

Will DHS be removing the requirement to maintain a tickler system from Section II of Targeted Case Management Medicaid provider manual?

RESPONSE: Not at this time.

COMMENT 10: Please provide a stakeholder engagement meeting to explain the application and revised terminology before submitting to Legislature for approval.

RESPONSE: DHS will make staff available to meet with stakeholders to discuss changes to the waiver.

Commenter's Name: Luke Mattingly, on behalf of the Arkansas Area Agency on Aging Association

COMMENT 1: 212.200 Prospective Individual Services Budget, D. Methodology for Determining Individual Services Budgets,

The maximum individual service budget for a participant…

These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates Without increasing the caps, service recipients receiving maximum care will see a reduction in services

At a minimum 2.a. should be increased to $ 34,134

At a minimum 2.b. should be increased to $ 22,756

At a minimum 2.c. should be increased to $ 5,689

In general, the caps are set too low and should be raised even higher than the above limits to allow for more care.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

COMMENT 2: The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Waiver service recipients are amongst the frailest older Arkansans and deserve in-home care. If the rate is not adjusted to offset the rapid increase in minimum wage these services will be unsustainable after the minimum wage increases again on Jan 1, 2021 without an increase to the rate.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Katie Bell, Director of Housing, Area Agency on Aging of Northwest Arkansas

COMMENT: 212.200 Prospective Individual Services Budget, D. Methodology for Determining Individual Services Budgets, 2. The maximum individual service budget for a participant…

These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates Without increasing the caps, service recipients receiving maximum care will see a reduction in services

At a minimum 2.a. should be increased to $ 34,134

At a minimum 2.b. should be increased to $ 22,756

At a minimum 2.c. should be increased to $ 5,689

The caps are set too low and should be raised even higher than the above limits to allow for more care. Quality of life should always be a priority.

The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Waiver service recipients are amongst the most frail older Arkansans and deserve in-home care. If the rate is not adjusted to offset the rapid increase in minimum wage these services will be unsustainable after the minimum wage increases again on Jan 1, 2021 without an increase to the rate.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent

assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Angie Dunlap, Director of Senior Center Services, Area Agency on Aging of Northwest Arkansas

COMMENT: To Whom it May Concern,

On the proposed rule: ARChoices 1-20, LCAL 1-20, PERSCARE 3-20, ARChoices and Living Choices Waiver Amendments, and Medical Services Policy C-265, I-630, I-640, and L- 120, I would like to provide the public comment for this rule.

This rate is increase is much needed to sustain the Medicaid Personal Care services and has been needed for quite some time.

Rapid escalation of minimum wage rates have created a dire situation that tis threatening services without this rate increase. Thank you,

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Barbara Flowers, Executive Director, Area Agency on Aging of West Central Arkansas, Inc.

COMMENT: These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates.

Without increasing the caps, service recipients receiving maximum care will experience a reduction in services. The caps are set too low and should be increased to allow for services these participants need in their homes to prevent early institutionalization.

The Attendant Care and Respite Care rates should be increased to match the proposed Medicaid Personal Care rate in SPA 20-0222. Waiver recipients typically need more services to meet their needs to live independently in their homes. If the rate is not adjusted to offset the rapid increase in minimum wage, these services will be unsustainable after the minimum wage increases again on January 1, 2021 without an increase to the rate. Thank you,

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Jacque McDaniel, Executive Director, East Arkansas Area Agency on Aging

COMMENT 1: Waiver services enable frail and disabled beneficiaries to receive services that are critical to maintain their viability and independence from a nursing facility. Beneficiaries and their families depend on these services, therefore, in light of minimum wage increases, as well as other cost increases, the individual service budgets need to be raised to adequately fund services.

In 212.200 Prospective Individual Services Budget, D. Methodology for Determining Individual Services Budgets, 2. The maximum individual service budget for a participant…

These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates.

Without increasing the caps, service recipients receiving maximum care will see a reduction in services

At a minimum 2.a. should be increased to $ 34,134

At a minimum 2.b. should be increased to $ 22,756

At a minimum 2.c. should be increased to $ 5,689

In general, the caps are set too low and should be raised even higher than the above limits to allow for more care.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

COMMENT 2: Waiver services require a reliable network of providers to accommodate these must needed services. With increases in Arkansas' minimum wage in six out of seven years, the sustainability of quality home and community-based services was in imminent danger of broad provider network collapse.

Because Home and Community-Based Services cost a fraction of the cost of institutional care, it is imperative the Attendant Care and Respite Care rates in the waiver increase to match the proposed Medicaid Personal Care Rate in SPA 20-0222. This rate increase needs to be effective January 1, 2021 consistent with the Personal Care rate change and to coincide with the next mandatory minimum wage increase.

An increase in the attendant care and respite care rate from $18.24 per hour to $20.48 per hour will provide the relief needed to secure much desired home and community-based services for the near future. This was an important step in the right direction of caring for our frail and disabled population!

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Bill Dearmore, Director of Client Services, Area Agency on Aging of Northwest Arkansas, Inc.

COMMENT: Please consider increasing the caps of the Individual Service Budget to accommodate the recommended increase in the Personal Care Rate. Without increasing the caps, service recipients receiving maximum care will see a reduction in services.

The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Thank you for you [*sic*] consideration.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Brad Bailey, Executive Director, Area Agency on Aging of Northwest Arkansas

COMMENT: The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Waiver service recipients are amongst the most frail older Arkansans and deserve in-home care. If the rate is not adjusted to offset the rapid increase in minimum wage these services will be unsustainable after the minimum wage increases again on Jan 1, 2021 without an increase to the rate.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

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

Q. What is the status on CMS approval for the waivers? **Response:** We are in the process of answering CMS's Informal Request for Additional information.

The proposed effective date is January 1, 2021.

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

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).