

## DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

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**SUBJECT:** AR Choices in Homecare Renewal

**DESCRIPTION:**

Statement of Necessity

Pursuant to A.C.A. § 20-77-107, the Department of Human Services is authorized to establish and maintain an indigent medical care program. A.C.A. § 25-10-129 directs the Department to promulgate rules to assure compliance with federal statutes, rules, and regulations and to promulgate rules as necessary to receive any federal funds. Department rule promulgation authority is also provided under A.C.A. § 20-76-201(12) which directs the Department to make rules that are necessary to provide public assistance.

CMS approves HCBS waivers for a period of 5 years. The AR Choices in Homecare waiver expired 12/31/2020 and is currently operating under a temporary extension. This extension will allow DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021.

Rule Summary

The roles and responsibilities of the operating agencies (Division of Medical Services, Division of Aging, Adult, & Behavioral Health Services, Division of Provider Services and Quality Assurance, and Division of County Offices) will be clarified with this waiver renewal. The AR Choices Manual will now reflect the functional eligibility determinations and evaluations listed in the AR Choices waiver. The Personal Care Manual has been updated to remove duplication of ARChoices rules and references ARChoices Manual.

The appeals process language is updated throughout as necessary to reflect the automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for services are being updated for the next five years and additional waiver slots are added. The rate changes to \$5.12, which is a 12% increase. The Service Budget Limits are being updated, and the Provisional Service Plan option is being removed.

The financial impact is \$12,992,412 for State Fiscal Year (SFY) 2022 and \$13,615,716 for SFY 2023. The state share of increasing the Attendant Care and In-Home Respite Care rates is \$3,699,914 for SFY 2022 and \$3,864,140 for SFY 2023.

**PUBLIC COMMENT:** A public hearing was held on this rule on July 13, 2021. The public comment period expired August 2, 2021. 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, on behalf of CareLink

**1:** ARChoices Section 212.000(D) - Refers readers to the approved assessment manual. When reviewing this current on-line manual, there is no mention of ARChoices or how the tiers for LTSS are established and applied. Also, the eligibility rules have been red-lined and the rules only now reference the State Administrative Rule for level of care. This revision lacks transparency within the waiver for how the eligibility process is established, changed, and controlled.

**RESPONSE:** Thank you for your comment. The approved assessment tool manual is referenced to provide transparency in relation to the tool. Notwithstanding the final tier determination, the Level of Care eligibility is made by the Division of County Operation. The assessment of functional need is used as part of the process to determine medical eligibility and in the development of the PCSP. We have included reference to the State Administrative Rule to avoid possible incongruence should there be future rule change.

**2:** ARChoices Section 240.000 Prior Authorization - There is very little detail in this section. It needs to be changed to reflect the same language as the Personal Care Manual.

**RESPONSE:** Thank you for your comment. DHS will update this section to clarify that the authorization mechanism for the ARChoices program is the Person-Centered Service Plan. Additionally, sections 212.320 and 212.323 include language that the PCSP serves as the authorization for ARChoices waiver services.

**3:** ARChoices Section 262.300 Billing Instructions - The requirement for providers to supply the documentation proving that services were rendered at a time before or after the hospital discharge occurred has always been administratively burdensome. Medicaid has the information as a payor and has access to admission and discharge data. Unskilled home health providers do not have direct access to the information being requested. It requires significant administrative effort to obtain the required documentation.

With the implementation of state-wide requirement for Electronic Visit Verification systems, Medicaid has access to all information required to compare data and verify that services occurred before admission or after discharge without additional provider input. This section needs to be revised to eliminate the provider requirement and to reflect that Medicaid will verify that services have been provided before admission or after discharge. All information to verify this is within state data systems available to Medicaid.

**RESPONSE:** Thank you for your comment. It is the providers responsibility to develop and maintain sufficient written documentation to support each service for which billing is made.

**4:** Methods for Remediation / Fixing Individual Problems – References an Intra-agency agreement between AADHS and DMS. What are the parameters of this agreement and where can this agreement be reviewed?



**RESPONSE:** Thank you for your comment. Providers may request a copy of this agreement through the Freedom of Information process.

**5:** Appendix J Cost Neutrality – It is interesting to note that the state projects a 2.5% annual inflationary factor for SNF's in factor D derivation. The state makes no such annual inflationary consideration for ARChoices providers. There are always several years between rate changes for ARChoices services. This 2.5% annual inflationary consideration is not applied to ARChoices waiver provider operational inflationary costs/expense, however the 2.5% increase for SNF's is directly applies to inflationary expenses related to operations. This is yet another inequity between SNF's and HCBS.

**RESPONSE:** Thank you for your comment.

**6:** Rate for service - While the rate increase in the waiver is desperately needed, the rate setting methodology for In-home services is derived from "what is the minimum Medicaid can pay for this service" resulting in low wages and minimal benefits for workers. The rate setting process does not provide the opportunity to build a career ladder for in-home Aides nor does it focus on paying a wage that attracts high quality candidates. The rate is such that providers can only offer minimum wage or close to minimum wage pay. This is not conducive to providing high quality services and results in high turnover rate for this occupation, which is detrimental to participant care.

The state needs to engage in a more open conversation about this occupation and what skill sets would be preferable to deliver high quality customer care. This in turn would help ascertain what wage rate needs to be in place to support this high-quality care and in turn what rate would support the wage. Instead, the base assumption starting point for determining the rate is minimum wage, which here in Arkansas is \$ 11.00 per hour.

**RESPONSE:** Thank you for your comment. Under Executive Order 19-02 rates are reviewed on a regular cycle utilizing a standard rate review methodology.

**7:** Removal of Provisional Plans of Service - What is the plan to make ARChoices readily available to eligible participants? SNF's have the ability to begin services and then retro bill to first day of service after deemed eligible. No such provision is in place for ARChoices. With average processing of ARChoices initial applications exceeding 45 days or more it leaves many families with no choice but to select a facility placement over HCBS.

**RESPONSE:** In order to be determined eligible for the ARChoices waiver, individuals must meet both financial and medical eligibility requirements. Allowing for services to begin prior to determination of both financial and medical eligibility places both providers and individual at financial risk. Individuals with active full Medicaid benefit plans may receive services under state plan personal care until waiver services are approved.

**8: Additional Requirements/Access to Services** - In addition to topics already mentioned which fall into this category, the inability of DHS to issue a Prior Authorization at the same time as issuing the approved PCSP is detrimental to service providers and places participant services at risk. The prior authorization (PA) should be issued and coincide with the issuance of the PCSP. A prior authorization is required for a provider to be reimbursed for services. DHS issues the PCSP and expects providers to start services immediately upon receipt, but the Prior Authorization is not issued until a later date.

**RESPONSE:** Thank you for your public comment. DHS is reviewing internal processes to improve efficiency in systems. The authorization for services continues to be the Person-Centered Service Plan which is sent to the provider by the DHS PCSP/CC nurses.

**9: Service Budget Caps** - Tier 1: \$ 34,000; Tier 2: \$ 23,000; Tier 3: \$ 6,000

All service caps are set to low to ensure that participants in that particular level of care has a reasonable opportunity to remain in their homes as long as possible. In Tier 1 allowing only \$34,000 annually to someone that is totally dependent and requires extensive assistance is not sufficient to ensure Home and Community Based care will assist the individual from being institutionalized. Likewise Tier 2 participants need additional supports than the budget cap allows. However, the \$ 6,000 cap for Tier 1 services is the most egregious. These individuals meet the functional needs requirements to be eligible for ARChoices. This service cap barely provides any services at all. The cap should be at least doubled to ensure a level of care that keeps participants in their home and delays progression into Tiers requiring more care or institutionalization. The service budget cap should at least be doubled to \$ 12,000.

**RESPONSE:** The Service Budget Limit (SBL) amounts were adjusted to incorporate rate increases to ensure clients continued to receive services authorized, notwithstanding subsequent rate increases. SBL's limit the maximum dollar amount of services that may be authorized based on medical determination by the Division of County Operation. Section 212.200 outlines the process for adjustments to the SBL based on change in condition.

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

**1:** Section 200.120-262.410 -The Personal Care policy changed "beneficiary" to "client". The ARChoices policy changed "Beneficiaries" and "individuals" to "participants". Why was different terminology utilized?

**RESPONSE:** Notwithstanding any difference in the terminology the individuals referenced are the same.

**2:** Section 213.540 E: There are three applicable rules listed—Section 215.350, 215.351 and 262.100. Is there a Section 262.100?



**RESPONSE:** Thank you for your comment. The reference to Section 262.100 has been removed.

**3:** Section 200.120-262.410 of the Personal Care policy changed “beneficiary” to “client”. The ARChoices policy changed “Beneficiaries” and “individuals” to “participants”. Why was different terminology utilized between Personal Care and ARChoices policies?

**RESPONSE:** Notwithstanding any difference in the terminology the individuals referenced are the same.

**4:** Section 212.000 Item B: The last sentence of this paragraph may have an error with the change from ‘individual’ to ‘participant’.

**RESPONSE:** Language has been reviewed to ensure consistency in the manual.

**5:** Section 212.000 Item I: The policy states the “program provides for the entrance of all eligible persons on a first-come, first-served basis, once participants meet all functional and financial eligibility requirements.” Should “functional” be changed to “medical”?

**RESPONSE:** Thank you for your comment. The language has been updated.

**6:** Section 212.000 Item I states eligible persons will be served on a first-come, first-served basis. With the elderly, behavioral health (BH) and development disabled (DD) populations being combined in one waiver, should the slots be segregated to the different populations to assure availability for the elderly population? The average length of program eligibility for elderly waiver clients is much shorter than the BH and DD populations.

**RESPONSE:** The ARChoices waiver is a distinct waiver and has not been combined with BH or and DD waivers. The slots available under the ARChoice waiver are available only to those beneficiaries who have been determined eligible for the ARChoices waiver.

**7:** Section 212.200 “Waiver Renewal Process:” Item C states “unless one of the following conditions applies:” then lists item 1, item 2, item 3 “or the participant disenrolls from the ARChoices Waiver program.” Should this last item actually be numerated as item 4?

**RESPONSE:** This item is listed as item 4.

**8:** Section 212.300 lists the acronym for person-centered service plan (PCSP) several times, but some of the listings were transposed as PCPS in Items A and C.

**RESPONSE:** Thank you for your comment. The manual has been updated.

**9:** Section 262.300 Billing Instructions: With the detailed requirements for caregivers to utilize electronic visit verification for documenting and billing services, the policy requiring a provider to gather documentation to prove what time the participant was admitted to a facility needs to be changed. The state should have the information to determine what time the participant was admitted to a facility instead of placing another burden on the lowest paid provider to gather this information.

**RESPONSE:** Thank you for your comment. It is the provider's responsibility to develop and maintain sufficient written documentation to support each service for which billing is made.

**10:** Appendix 1-2: Rates, Billing and Claims— Rate Determination Methods: Even though various methodologies were used for rate determination, the rate is inadequate to support the services in our state when the minimum wage increase and other costs far exceeded the percentage increase in the rate. The added stress of low unemployment rates and shortage of workers with the ever-increasing older population has seriously threatened the viability of Home and Community-Based Services in our state.

**RESPONSE:** Thank you for your comment. Under Executive Order 19-02 rates are reviewed on a regular cycle.

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

**Q.** What is the status on CMS approval? **RESPONSE:** We do not have CMS approval, but I will provide the letter once we receive it.

The proposed effective date is pending legislative review and approval.

**FINANCIAL IMPACT:** The agency indicated that this rule has a financial impact.

Per the agency, this rule implements a federal rule or regulation. The cost to implement the federal rule or regulation is \$12,992,412 for the current fiscal year (\$3,699,914 in general revenue and \$9,292,498 in federal funds) and \$13,615,716 for the next fiscal year (\$3,864,140 in general revenue and \$9,751,576 in federal funds). The total estimated cost to state, county, and municipal government is \$3,699,914 for the current fiscal year and \$3,864,140 for the next fiscal year. The agency indicated that these amounts represent the state share of increasing the Attendant Care and In-Home Respite Care rates.

Per the agency, this rule will result in a new or increased cost or obligation of at least \$100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

*(1) a statement of the rule's basis and purpose;*



The AR Choice Waiver is being renewed as required by § 1915(c) of the Social Security Act. The current waiver expired 12/31/2020 and operates under a temporary extension until the renewal is approved.

*(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;*

The AR Choice Waiver is being renewed as required by § 1915(c) of the Social Security Act. The current waiver expired 12/31/2020 and operates under a temporary extension until the renewal is approved.

*(3) a description of the factual evidence that:  
(a) justifies the agency's need for the proposed rule; and*

We are adding 75 additional slots every year of the waiver to accommodate an increase in the aging population which allows individuals to remain in their homes. There is also a rate increase that is being implemented to create rate parity between personal care, attendant care, and respite.

*(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;*

*This rule will allow individuals to remain in their homes and to reduce more costly alternative placements.*

*(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;*

There are no less costly alternatives.

*(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;*

None

*(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and*

Existing rates and waiver capacity require an increase to ensure rate parity and an increasing aging population.

*(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:*

*(a) the rule is achieving the statutory objectives;*

The Agency must renew this waiver no later than every five years.

*(b) the benefits of the rule continue to justify its costs; and*

The State is required to demonstrate continued cost neutrality annually and to amend the waiver if cost neutrality is not met.

*(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.*

The State is required to demonstrate continued cost neutrality annually and to amend the waiver if cost neutrality is not met.

**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).



**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 Elizabeth Pitman  
CONTACT PERSON Mac Golden  
ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437  
PHONE NO. 501-563-7634 FAX NO. 501-404-4619 E-MAIL Mac.E.Golden@dhs.arkansas.gov  
NAME OF PRESENTER AT COMMITTEE MEETING Elizabeth Pitman  
PRESENTER E-MAIL Elizabeth.Pitman@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 (2) 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, 5<sup>th</sup> Floor  
Little Rock, AR 72201**

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1. What is the short title of this rule? AR Choices in Homecare Renewal

2. What is the subject of the proposed rule? Five-year renewal of the AR Choices in Homecare HCBS Waiver Program

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 be 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://humanservices.arkansas.gov/resources/promulgation-of-new-rules>

<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: July 13, 2021

Time: 11:00 a.m.

Place: Zoom Webinar,  
<https://us02web.zoom.us/j/84834973160>

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

August 2, 2021

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

July 1, 2021

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. Unknown

**FINANCIAL IMPACT STATEMENT**

**PLEASE ANSWER ALL QUESTIONS COMPLETELY**

**DEPARTMENT** Department of Human Services  
**DIVISION** Division of Medical Services  
**PERSON COMPLETING THIS STATEMENT** Jason Callan  
**TELEPHONE** (501) 320-6540 **FAX** \_\_\_\_\_ **EMAIL:** Jason.Callan@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** AR Choices in Homecare Renewal

- 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?

<b><u>Current Fiscal Year</u></b>		<b><u>Next Fiscal Year</u></b>	
General Revenue	<u>\$3,699,914</u>	General Revenue	<u>\$3,864,140</u>
Federal Funds	<u>\$9,292,498</u>	Federal Funds	<u>\$9,751,576</u>
Cash Funds	_____	Cash Funds	_____
Special Revenue	_____	Special Revenue	_____

Other (Identify) \_\_\_\_\_  
 Total \$12,992,412

Other (Identify) \_\_\_\_\_  
 Total \$13,615,716

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

**Current Fiscal Year**

General Revenue \$ \_\_\_\_\_  
 Federal Funds \$ \_\_\_\_\_  
 Cash Funds \_\_\_\_\_  
 Special Revenue \_\_\_\_\_  
 Other (Identify) \_\_\_\_\_  
 Total \$ \_\_\_\_\_

**Next Fiscal Year**

General Revenue \$ \_\_\_\_\_  
 Federal Funds \$ \_\_\_\_\_  
 Cash Funds \_\_\_\_\_  
 Special Revenue \_\_\_\_\_  
 Other (Identify) \_\_\_\_\_  
 Total \$ \_\_\_\_\_

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**

\$ 0

**Next Fiscal Year**

\$ 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**

\$ 3,699,914

**Next Fiscal Year**

\$ 3,864,140

The above amounts represent the state share of increasing the Attendant Care and In-Home Respite Care rates.

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;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
  - (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
  - (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
  - (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
    - (a) the rule is achieving the statutory objectives;
    - (b) the benefits of the rule continue to justify its costs; and
    - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

## NOTICE OF RULE MAKING

The Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) 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 October 1, 2021:

DMS renews the ARChoices in Homecare waiver as required by § 1915(c) of the Social Security Act ("the Act"). The current waiver expired 12/31/20 and operates under a temporary extension until the renewal is approved. To effectuate the renewal, DMS issues changes to the waiver, the ARChoices provider manual, and Personal Care provider manual as follows:

- Clarification of the roles and responsibilities of the operating agencies within DHS.
- Harmonization of the ARChoices Provider Manual to reflect the functional eligibility determinations and evaluations listed in the ARChoices waiver.
- Revision of the Personal Care Manual to remove duplication of ARChoices rules; refers to ARChoices Provider Manual.
- Updated language as necessary to reflect the automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out.
- Increase to the service rates to \$5.12 (a 12% increase).
- Removal of the Provisional Service Plan option.
- Addition of Waiver slots to ARChoices annually

The financial impact is \$12,992,412 for State Fiscal Year (SFY) 2022 and \$13,615,716 for SFY 2023. The state share of increasing the Attendant Care and In-Home Respite Care rates is \$3,699,914 for SFY 2022 and \$3,864,140 for SFY 2023.

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://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/>. Public comments must be submitted in writing at the above address or at the following email address: [ORP@dhs.arkansas.gov](mailto:ORP@dhs.arkansas.gov). All public comments must be received by DHS no later than August 2, 2021. 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.

A public hearing by remote access only through a Zoom webinar will be held on July 13, 2021, at 11:00 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at <https://us02web.zoom.us/j/84834973160>. The webinar ID is 848 3497 3160. If you would like the electronic link, "one tap" mobile information, listening only dial-in phone numbers or international phone numbers, please contact ORP at [ORP@dhs.arkansas.gov](mailto:ORP@dhs.arkansas.gov).

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

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. 4501960528



Elizabeth Pitman, Director  
Division of Medical Services



## **Statement of Necessity and Rule Summary**

### **AR Choices in Homecare Waiver Renewal**

#### **Statement of Necessity**

Pursuant to A.C.A. § 20-77-107 the Department of Human Services is authorized to establish and maintain an indigent medical care program. A.C.A. § 25-10-129 directs the Department to promulgate rules to assure compliance with federal statutes, rules, and regulations and to promulgate rules as necessary to receive any federal funds. Department rule promulgation authority is also provided under A.C.A. § 20-76-201(12) which directs the Department to make rules that are necessary to provide public assistance.

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