EXHIBIT H

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Independent Assessment for Personal Care and Criminal Background Check Requirements for Providers

DESCRIPTION: This rule requires an Independent Assessment and Prior Authorization for individuals receiving Personal Care Services through State Plan Services. Additionally, the state is updating provider manuals to clarify that the owners, principals, employees, and contract staff of certain providers must submit to criminal background checks.

PUBLIC COMMENT: A public hearing was held on August 8, 2017. The public comment period expired on August 11, 2017. The Department provided the following public comment summary:

During the public comment period for the ARChoices and Personal Care Provider Manual revisions, Arkansas DHS received comments from an attorney representing an Area Agency on Aging (AAA), the Arkansas Association of Area Agencies on Aging, Disability Rights Arkansas, two large providers of waiver and personal care services, an attorney representing the Arkansas Residential Assisted Living Association (ARALA), and a company that owns several Residential Care Facilities (RCFs) who provide personal care with a separate letter from the RCFs' attorney.

Comment: The majority of commenters were concerned with the requirement of all owners, principals, employees, and contract staff must submit to a national criminal background check, identity verification, and fingerprinting. It was called excessive and unnecessary. Many said that this would be a financial burden for agencies and contracted employees with no Medicaid reimbursement. There was also a concern that it could delay services due to the length of time it takes to receive results of national background checks in some areas of the state.
Response: DAAS will amend the language to require the provider to comply with current state law and regulations, ensuring consistency with other Medicaid programs. That is, a State criminal records check every 5 years and a Federal records check if the individual hasn't lived or worked in the State for 5 consecutive years.

Comment: One commenter suggested changing the wording in Personal Care at 213.230 (item C) from "Employ and supervise direct care staff who:" to "Ensure supervision of employed or contracted direct care staff who:"
Response: As this was not part of the scope of this revision, we will take this under advisement and consider the change at the next revision.

Comment: A couple commented that the added language in Personal Care at 201.120 (items D-K) do not fit under the heading.
Response: This was a mistake. This language is a duplicate of other sections. We will make the correction.

Comment: The forms still reference physician signature, which is presumably an error since the physician has been removed from the authorization process.
Response: Yes, those will be removed from the forms with the implementation of the policy.

Comment: Section 200.130 – The section deletes a statutory requirement that Personal Care Agencies be licensed by the Department of Labor. That requirement is also part of the Health Department licensure requirements. Is it the Department's intent to make it easier for agencies to become Personal Care Agencies and, by extension, Personal Care Providers? Can existing Class B Home Health providers change their licensure to Personal Care Agencies? Will Personal Care Agencies have geographic restrictions like Home Health Agencies? It was our understanding that DHS and OMIG were planning to impose more program integrity requirements on Personal Care Providers. This change seems to do just the opposite.
Response: Yes, providers will no longer have to be licensed by the Department of Labor. DHS will work with the Department of Health so regulations are consistent and comply with State law.

Comment: Section 214.200 – This section retains the current six-month timeframe for the validity of a case plan. However, at stakeholder meetings, Optum, the state's Independent Assessment (IA) contractor, has stated its intent to complete IAs on an annual basis, with the ability to request a revision if the client's condition changes. ARChoices plans already provide for one-year authorization of personal care if it is included in the plan. Given the additional steps added to the process, the state should provide for all Personal Care Plans to be effective for one year.
Response: The provider manual will be amended to allow Personal Care Plans to be in effect for 1 year.

Comments: Section 215.330 – A reference to physician authorization in Subsection 3.a. is presumably an error and should be removed. And, Section 214.200 – The Note in this section refers to a "physician's authorization." Given that the physician has been removed from the process, this is presumably an error.
Response: Those are noted and will be corrected.

Comment: Sections 215.320 and 340 – Given that the initial request for Prior Authorization can be submitted via fax according to Section 242.000, there is no reason why original documents of notices of service initiation delay or termination of services in these sections should have to be submitted via mail. We would suggest that these follow-up requirements be deleted or changed to allow submission via fax.
Response: This was not part of the original revisions. DHS will consider this at the next revision.

Comment: Section 242.000 – This section says that the care plan, completed by the provider RN, must be submitted to DHS. We have been told at stakeholder meetings that the submission will be to DHS, which will then transmit the information electronically to Optum on a periodic basis for Optum to actually perform the assessments. After the IA is completed, the results will be submitted to DHS, and a DAAS RN will meet with the client to develop a plan and choose a provider. This means that the provider who spent the time, money, and effort to have its RN complete the DMS-618 may have done that work for another provider to end up serving the beneficiary. The Independent Assessment Guide does not provide any details on how the process will occur for Personal Care, but if an individual makes an initial choice of a provider to do the initial RN assessment and submit the form for Prior Authorization, that choice should be honored after the IA if the individual is approved for services.

Response: DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date.

Comment: Related to the previous comment: Section 242.000 – This section says that the provider—in this case, the RCF or ALF—submits the first six pages of the DMS-618 to DHS, who then provides it to the IA contractor, who then performs the in-person assessment. At stakeholder meetings, we have been told that after the IA results are provided to DHS, a DHS employee will contact the individual to discuss a care plan and their choice of a Personal Care provider. Does this mean that the beneficiary will have the choice of changing providers at the suggestion of a DHS employee? That puts the residential Personal Care provider in the untenable position of accepting a resident for admission, completing the occupancy agreement, having an RN fill out the care plan, commencing services, beginning the process of helping the resident acclimate to a new environment, arranging for mental health or other services that the beneficiary might require, and then facing the possibility of the resident choosing a different provider based on their discussion with the DHS staff regarding provider choice. This is an unacceptable risk for a provider who makes the initial investment in admitting a resident. If a resident has chosen an ALF or RCF, there should not be a risk that the new resident will be influenced to choose another provider after the IA is completed.

Response: DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date to ensure no delay in access to services.

Comment: Section 242.000C – Given the availability of easy-to-use email encryption, DHS should consider allowing submission of the required documents for Prior Authorization via encrypted email.

Response: We will take this into consideration.

Comment: Section 243.000 – Will a Prior Authorization Number be provided for each individual that the provider will have to use for billing purposes, or will the authorization be automatically entered into the claims processing system so that claims consistent with the approved claim are paid and those that are not consistent with the approved plan are not paid?

Response: DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date.

Comment: A representative for Residential Care Facilities (RCFs) commented that RCFs should be exempt from the Prior Authorization (PA) process through the Independent Assessment (IA) because of their unique situation. Paraphrasing: the individual is already in the RCFs care and the PA would add an "administrative layer" that would delay authorization of services that RCFs are required to provide. She also states that the proposed regulations appear to conflict with the RCF regulations through the Office of Long Term Care, but doesn't specifically say how.
Related Comment: Representative from ARALA requests, due to the above issues and that RCFs and ALFs are required to provide services from the time of admission, DHS retains the current mechanism, or, if the IA is to be used, allow RCFs and ALFs to bill from the date of admission until the IA results are received, regardless of whether the individual is eventually approved.
Response: All Personal Care services will be subject to the Independent Assessment and Prior Authorization based on assessed need. DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date.

Comment: Two commenters requested that DHS hold a public hearing.
Response: A public hearing was held on August 8, 2017, at 4:30 at AEDD. It was published in the notice of rulemaking that was advertised in the Arkansas Democrat Gazette and the Medicaid website.

Comment: State Plan Amendment – The SPA removes the 64-hour benefit limit and replaces it with language that states that Prior Authorization would be pursuant to the IA. Does that mean there is no benefit limit for Personal Care anymore? Can residential providers get more than 64 hours per month equivalent if a resident's needs justify it?
Response: That is correct. The benefit limit will be based on their assessed need through the IA. This will eliminate the need for extension of benefits requests.

Comment: Related to the IA: Will the full MnCHOICES assessment be used for the Personal Care population? What is the algorithm that will be used to translate responses on the IA into a determination of which of the ten rate tiers an RCF or ALF resident falls into? What is the appeal process for the IA if the tier level is lower than necessary to support the services required by the RCF or ALF resident? Who can appeal the IA results? All of these issues should be addressed for Medicaid Personal Care. As stated previously, the regulations should allow the current assessment, care plan, and tiered reimbursement to remain for residents of RCFs and ALFs as the provision of Personal Care in the residential setting is very different than going into an individual's home.
Response: For Personal Care, the Independent Assessment will take into account the Activities of Daily Living as an eligibility criteria similar to the criteria listed in Medicaid State Plan.

Comment: Medicaid Personal Care rates are inadequate and rate increases occur years apart. We have attempted to resolve these funding issues with DHS and legislatively, all to no avail. Because the IA has the potential to reduce reimbursement even further if clients are denied or are assigned to lower tiers, this process should be delayed until adequate rates are established. Our providers will vigorously oppose any apparent attempt

to finance the new IA process by reducing services and tier levels to beneficiaries. DHS' interests would be better served in focusing on providing adequate reimbursement rates rather than implementing an untried IA process that is likely to reduce care to high-need residents of RCFs and ALFs.
Response: Increasing the rate is not part of the scope of this revision; however, the Personal Care rate increased to $18 per hour on January 1, 2016.

Comment: Though many of the proposed changes direct the public to the IA Guide for more information, the IA Manual, as the only "guide" published by DHS directly discussing the IA, does not provide the information needed. Consequently, the public is left with little information regarding the process and no way to fully comment on the proposed rule changes.
Response: DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date.

Comment: The State Plan proposed changes continue to use outdated terminology. ICF/MRs should be ICF/IIDs.
Response: This is noted and will be corrected.

Comment: Section 213.300 – Is this an exclusion of "dual-eligible" recipients completely, or for only the services covered and paid by Medicare?
Response: The exclusion is for services covered by other non-Medicaid payors.

Comment: Section 213.300 – In regard to Attribution – will there be an allowance for the accounting for the cost of unpaid services that an individual receives, but is in a spend-down category? Although the state does not pay for services while they are in spend-down, those services are still a cost to the provider; thus will you consider looking at those unpaid services as a part of attributing to a given PASSE based on primary BH/DD provider? How will the unpaid services in a spend-down category be considered?
Response: No, there is no allowance for the accounting for the cost of unpaid services that an individual receives for attribution.

Comment: Clarification for how beneficiaries will be identified to undergo an independent assessment and/or be referred for an independent assessment, including self-referral. Will this be the same or similar to that of the Office of Behavioral Health Provider Manual Section 213.100?
Response: For DD, a client must be on the DD waiver or seek admission to an ICF. For BH, clients who are currently receiving RSPMI services and recommended by DHS; clients who are currently receiving RSPMI services and recommended by RSPMI provider; clients seeking inpatient psychiatric admission; and clients who are utilizing high amounts of Tier 1 services. DHS will continue to review service data to identify individuals that may need higher levels of care.

Comment: A description of the criteria, algorithm, and thresholds for each tier level.
Response: See Attachment "B."

Comment: Assessment for Beneficiaries with Behavioral Health and Developmental/Intellectual Disabilities Service Needs1 provided on July 13, 2017, PASSE APPLICANT has the following comments:
– It is unclear regarding the methods (survey tool, observation, interview, etc.) that are used to complete this assessment and requests clarification from the State how the assessment is conducted. PASSE APPLICANT requests clarification if the assessment will take place in person, telephonically, and a detailed description of methods used.
– PASSE APPLICANT requests a copy of the tool to further assess its assessment of the identified domains.
– The assessment tool does not appear to take into consideration the beneficiaries' diagnoses, including their comorbidities or the acuity of their conditions. PASSE APPLICANT advocates that this information be included as it is critical to the appropriate Tier assignment and corresponding level of coordination of member care.
– The assessment tool does not appear to assess for natural supports. PASSE APPLICANT requests that the tool includes an assessment of natural supports.
– The assessment tool does not appear to take into consideration utilization of health care services, including urgent care, emergency department, or psychiatric placements. PASSE APPLICANT recommends that utilization of high-cost levels of care be included in the assessment tool as this is directly correlated with one of the principle objectives of Act 775 of the 2017 Arkansas General Session to "slow or reverse spending growth for enrollable Medicaid beneficiary populations," in addition to statute-required performance measures to monitor "reduction in unnecessary hospital emergency department utilization," "reduction in avoidable hospitalizations for ambulatory-sensitive conditions," and "reduction in hospital readmissions."
– The assessment tool does not appear to take a forensic/legal history, including if the beneficiary is currently assigned to court ordered treatment, is a sex-offender, or has any other legal implications that may be deterministic in their care.
Response: See Attachment "B."

Comment: PASSE APPLICANT requests clarification of the 'broader array of services' that will qualify a beneficiary for Tier II.
Response: Please see the Outpatient Behavioral Health Services manual, which specifies the services contained within Tier II (Rehabilitative Level).

Comment: PASSE APPLICANT requests clarification of the 'additional criteria' that will be used to qualify a beneficiary for Tier III.
Response: See Attachment "B."

Comment: PASSE APPLICANT requests clarification of the 'institutional level of care criteria' referenced herein and recommends the State include a citation for this criteria in this policy manual.
Response: Institutional Level of Care Criteria is the eligibility criteria for the DDS waiver. Please see DDS Policies 1035, 1086 – DDS Community Employment Supports Waiver, Document, Manual, and Standards.

Comment: PASSE APPLICANT requests clarification regarding the Independent Assessment and the information the PASSE will be provided by the State in order to develop the total care plan. PASSE APPLICANT recommends this information include, at a minimum:
– Demographic information, including clinical information and contact information for the beneficiary, their legal guardian, and an emergency contact
– Independent assessment tool raw data
– Prior two-years claim history for the beneficiary
Please see comments submitted in section 213.300 of this document.
Response: DHS has the ability to report on claims filed by providers, procedure codes bill for and paid, dollar amounts paid, units paid, etc. that can be shared with the PASSE. An agreed upon time frames of data transfer will be discussed with each successful PASSE applicant.

Comment: At the top of the page, as part of the program overview, assurances are made that the State will "ensure" that at least two PASSEs will always remain enrolled in order to provide beneficiaries with a choice. DRA would like to see the steps which would be taken by the State in order to ensure that at least two PASSEs are available to beneficiaries. We are concerned that without at least two functioning PASSEs, the Provider-Led Care model will not operate as intended and cause harm to beneficiaries who will be unable to receive care.
Response: We agree that clients should have a choice. If two PASSE entities do not remain, the State will not move forward with the organized care model.

Comment: When discussing the tiers of service for Behavioral Health Clients, the application says that eligibility for Tier III levels of service will be identified by "additional criteria." These additional criteria are not explained any further in the document. While this may refer to information gathered during the independent assessment process, it is unclear in this instance.
Response: See Attachment "B."

Comment: On the topics of timely access to services and capacity standards for the PASSEs, the application states that each PASSE must have an adequate referral network and an adequate number of care coordinators for all attributed beneficiaries. No mention is made of ongoing oversight to ensure that these standards are being maintained, or of penalties for failing to meet these standards.
Response: The PASSE Provider Manual Section 250.000 "Metrics, Accountability, Reports, and Quality Assurance and Performance Improvement (QAPI)" addresses these standards. Section 152.000 in the PASSE Provider Manual addresses sanctions.

Comment: The section on disenrollment from a PASSE states that the good cause reasons for a beneficiary to disenroll from a PASSE during the 12 month lock-in period are "all of the reasons listed in 42 C.F.R. 438.56(d)(2)." Among the reasons listed in the statute is "poor quality of care," which is not defined in the statute or clarified in the waiver application. We are concerned about situations when there is a conflict between the beneficiary and DDS about quality of care and who decides whether the beneficiary can disenroll from a PASSE. Given that the lock-in period can keep a beneficiary with a PASSE for up to 12 months, the grounds for disenrollment during the lock-in period should be both as clear as possible, especially when there are quality of care issues. To the greatest extent possible, the system should also defer to the choice and judgment of the beneficiary.
Response: We agree the system should defer to the beneficiary's choice.

Comment: On this page a reference is made to an Attribution Methodology Concept Paper attached to the application. There are references made throughout the application to other attached documents which flesh out the various topics of discussion. None of these attachments were provided with the materials released for public comment. All attachments should be provided with material available for public comment, in order to provide stakeholders with the full context for the materials they are meant to discuss.
Response: This topic was previously discussed in the white paper released June 27, 2017. Please see Attachment "A."

The agency states that CMS approval is required for these rules; as of August 23, 2017, that approval is pending. The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: The estimated savings of implementing this rule is $17,268,000 for each of the current fiscal year and the next fiscal year ($5,030,168 in general revenue and $12,237,832 in federal funds). There is a $200,000 estimated cost for each of the current fiscal year and the next fiscal year to entities affected by the rule.

The state is moving forward with a CMS requirement for providers to submit to an independent, national criminal background check, identity verification, and fingerprinting.

Since there is 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, the agency submitted the following information:

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

The purpose of the rule is to improve Arkansas Medicaid program integrity and meet federal requirements for national fingerprint-based criminal background checks and identify verification of Medicaid providers and other persons with an ownership interest or management or supervisory responsibility for a provider organization.

EXHIBIT H

The proposed rule will require national criminal background checks, identity verification, and fingerprinting of all owners, principals, employees, and contract staff of personal care providers, individuals providing self-directed personal assistance, home health agency providers, hospice providers, and private duty nursing providers in order to prevent provider fraud and abuse and protect vulnerable Medicaid beneficiaries from caregivers and others affiliated with provider organizations who have criminal records, are not qualified, or are otherwise excluded from participation in federally funded health programs.

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

See Response below to question (3).

(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:

The proposed rule is necessary and appropriate to:

- Strengthen the integrity of the Arkansas Medicaid program and reduce the risk to taxpayers and beneficiaries of waste, fraud, abuse, overpayments, improper care, and participation by unqualified or excluded providers, owners, or supervisors.

- Meet applicable federal requirements including 42 U.S.C. 1396a (a)(77) and (kk), 42 U.S.C. 1396b(i)(2)(A), 42 CFR Part 455 Subpart E, the Medicaid Provider Enrollment Compendium (MPEC), and other program integrity guidance issued by the Centers for Medicare and Medicaid (CMS) and the federal Office of Inspector General (OIG).

(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 reasonably effective, efficient, or less costly alternatives to the proposed rule given: (a) the explicit purposes and functions of fingerprint-based national background checks and identity verifications, (b) the processes and safeguards necessary to fully and securely perform the tasks involved, (c) the scope and goals of new federal requirements, (d) proven best practices in Medicaid program integrity, and (e) the potential risks to the State and beneficiaries in the absence of the proposed rule policies.

The data systems, technology, processes, and procedures for valid, reliable, and independent fingerprint-based national background checks and identity verifications are well established and widely used by government agencies and the private section throughout the US. There is ample competition among qualified vendors who are able to meet federal and state requirements in a cost effective manner.

(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:

The Department of Human Services will respond to public comments as appropriate following the public comment period. At this time, it is not believed that any alternatives exist that would meet federal requirements and meet Medicaid program integrity needs.

(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:

This proposed rule expands the scope of current background check-related requirements to (a) improve Medicaid program integrity in home care services; (b) strengthen existing rules which either do not include these requirements or require them only in certain circumstances; (c) strengthen safeguards to reduce risks of limited, inadequate, or unavailable background checks, fingerprinting, or non-verified identities; and (d) meet federal requirements under 42 U.S.C. 1396a (a)(77) and (kk), 42 U.S.C. 1396b(i)(2)(A), 42 CFR Part 455 Subpart E, the Medicaid Provider Enrollment Compendium (MPEC), and other program integrity guidance issued by the Centers for Medicare and Medicaid (CMS) and the federal Office of Inspector General (OIG).

(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:

On an ongoing basis, the Department of Human Services monitors Arkansas Medicaid program requirements for providers and makes or proposes modifications to rules, processes, and procedures as appropriate in response to best practices, innovations, experience, program integrity risks, feedback from stakeholders, and changes in state law or federal statutes, regulations, waivers, and guidance.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, the Department of Human Services ("Department") shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See* Ark. Code Ann. § 20-76-201(1). The Department shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(12).

EXHIBIT H

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 Dawn Stehle

CONTACT PERSON Brad Nye

ADDRESS P.O. Box 1437, Slot S295

PHONE NO. 501-320-6306 **FAX NO.** 501-404-4619 **E-MAIL** Brad.nye@dhs.Arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Craig Cloud

PRESENTER E-MAIL Craig.cloud@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:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Independent Assessment for Personal Care and Criminal Background Check Requirements for Providers

2. What is the subject of the proposed rule? Personal Care Independent Assessment and Prior Authorization and Criminal Background Check Requirements for Home Health; Private Duty Nursing; Hospice; Personal Care; IndependentChoices; and ARChoices Providers

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."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? This new rule will require an Independent Assessment and require Prior Authorization for individuals receiving Personal Care Services through State Plan Services. These changes will save the state $17,268,000. Additionally, the State is updating provider manuals to clarify that the owners, principals, employees and contract staff of certain providers must submit to criminal background checks.

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://www.medicaid.state.ar.us/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.)
August 11, 2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
January 1, 2018

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 and the Arkansas State Library

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. _____

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Janet Mann

TELEPHONE _____ **FAX** _____ **EMAIL:** _____

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 Independent Assessment for Personal Care and Criminal Background Check Requirements for Providers

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		**Next Fiscal Year**	
General Revenue	($17,268,000)	General Revenue	($17,268,000)
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

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

Current Fiscal Year		Next Fiscal Year	
General Revenue	($5,030,168.00)	General Revenue	
Federal Funds	($12,237,832)	Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		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

$ $200,000

Next Fiscal Year

$ $200,000

The State is moving forward with a CMS requirement for providers to submit to an independent, national criminal background check, identity verification, and fingerprinting.

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;

The purpose of the rule is to improve Arkansas Medicaid program integrity and meet federal requirements for national fingerprint-based criminal background checks and identify verification of Medicaid providers and other persons with an ownership interest or management or supervisory responsibility for a provider organization.

The proposed rule will require national criminal background checks, identity verification, and fingerprinting of all owners, principals, employees, and contract staff of personal care providers, individuals providing self-directed personal assistance, home health agency providers, hospice providers, and private duty nursing providers in order to prevent provider fraud and abuse and protect vulnerable

Medicaid beneficiaries from caregivers and others affiliated with provider organizations who have criminal records, are not qualified, or are otherwise excluded from participation in federally funded health programs.

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

See Response below to question (3)

(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;

The proposed rule is necessary and appropriate to:

- **Strengthen the integrity of the Arkansas Medicaid program and reduce the risk to taxpayers and beneficiaries of waste, fraud, abuse, overpayments, improper care, and participation by unqualified or excluded providers, owners, or supervisors.**

- **Meet applicable federal requirements including 42 U.S.C. 1396a (a)(77) and (kk), 42 U.S.C. 1396b (i)(2)(A), 42 CFR Part 455 Subpart E, the Medicaid Provider Enrollment Compendium (MPEC), and other program integrity guidance issued by the Centers for Medicare and Medicaid (CMS) and the federal Office of Inspector General (OIG).**

(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 reasonably effective, efficient, or less costly alternatives to the proposed rule given: (a) the explicit purposes and functions of fingerprint-based national background checks and identity verifications, (b) the processes and safeguards necessary to fully and securely perform the tasks involved, (c) the scope and goals of new federal requirements, (d) proven best practices in Medicaid program integrity, and (e) the potential risks to the State and beneficiaries in the absence of the proposed rule policies.

The data systems, technology, processes, and procedures for valid, reliable, and independent fingerprint-based national background checks and identity verifications are well established and widely used by government agencies and the private section throughout the US. There is ample competition among qualified vendors who are able to meet federal and state requirements in a cost effective manner.

(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;

The Department of Human Services will respond to public comments as appropriate following the public comment period. At this time, it is not believed that any alternatives exist that would meet federal requirements and meet Medicaid program integrity needs.

(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

This proposed rule expands the scope of current background check-related requirements to (a) improve Medicaid program integrity in home care services; (b) strengthen existing rules which either do not include

these requirements or require them only in certain circumstances; (c) strengthen safeguards to reduce risks of limited, inadequate, or unavailable background checks, fingerprinting, or non-verified identities; and (d) meet federal requirements under 42 U.S.C. 1396a (a)(77) and (kk), 42 U.S.C. 1396b (i)(2)(A), 42 CFR Part 455 Subpart E, the Medicaid Provider Enrollment Compendium (MPEC), and other program integrity guidance issued by the Centers for Medicare and Medicaid (CMS) and the federal Office of Inspector General (OIG).

(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.

On an ongoing basis, the Department of Human Services monitors Arkansas Medicaid program requirements for providers and makes or proposes modifications to rules, processes, and procedures as appropriate in response to best practices, innovations, experience, program integrity risks, feedback from stakeholders, and changes in State law or federal statutes, regulations, waivers, and guidance.