

# DHS Responses to Public Comments Regarding the ARChoices 3.0 Long Term Services Support (LTSS) Transformation Package Received after Deadline

David Jespersen, Billie Thaxton, Mae Agnew, Michael Zeno, Robert Parsons, Sheryl Lampe, Cindy Richardson, Victoria Berhiet, Sharon Neiser, Judy Lane, Cindy Leohmann, Dottie Davis, Pamela Snyder, Janet Gorman, Lois Erichsen, Zack Jeh, Lynne Nelson, Jacqueline Dison, Laura Hopper, Joseph Maynard, Melvin Hudson, and Sharon Britton (writing separately)

**Comment:** I am writing to oppose the Arkansas Department of Human Services rules and regulations issued on October 7, 2018. I oppose the regulations in their current form for the following reasons:

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) These cuts hurt families.

**Response:** Comment considered. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. DHS first previewed these changes in the spring and summer through a publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input. Because the comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement.

## Willie Davison

**Comment:** I am writing to oppose the Arkansas Department of Human Services rules and regulations issued on October 7, 2018.

IT IS NOT GODLY TO TREAT THE SICK AND ELDERLY IN AN UNCARING MANNER BY WITHHOLDING A FEW MEASLY TAX DOLLARS.

THESE ANTI POOR POLITICIANS AND THIER SUPPORTERS DON'T KNOW THAT THE GREATEST COMMANDMENT IS TO LOVE GOD AND THE SECOND GREATEST IS TO LOVE YOUR FELLOW MAN.

THIS PROPOSAL IS NOT LOVE AND IT CERTAINLY DOES NOT MAKE AMERICA GREAT AGAIN. IT MAKES AMERICA MEAN, CHEAP AND HATEFUL AS USUAL.

**Response:** Comment considered and accepted in part. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program.

**Tyka Scott, Timmy Smith, and Barbara Weese (writing separately)**

**Comment:** Please note the following comments related to the proposed rule change on AR Choices and Medicaid Personal Care Services (Ark. Code Ann. §§ 20-10-1704, 20-77-107, 20-77-128, 20-77-1304, 25-10-101 et seq., 25-10-129, and 25-15-201 et seq.)

I oppose three major components of the proposed rate: a lack of provision for minimum wage increase; prohibition of family caregivers in agency model and unfair advantage provided to Independent Choices Program; and overly-prescriptive documentation standards (Medicaid Task and Hour Standard).

First, Milliman sampled only eight providers to develop their rate. The current Arkansas minimum wage was used as the base, and voters recently approved a significant rate increase. Providers have been told by the Department that there are no plans to revisit this rate even in light of the minimum wage increase. This increase in the administrative burden far exceeds a very modest rate increase, and many providers will be unable to shoulder this additional expense.

**Response:** Comment considered. Because the minimum wage increase potentially affects many types of providers across Medicaid, DHS intends to take a system-wide approach to reviewing the increase and the need for any changes to address it.

**Comment:**

Second, the proposed rule's prohibition on paid family caregivers (to the 4th degree) in an agency model only puts frail and vulnerable Arkansans at risk and impacts jobs in rural communities. For many rural Arkansans, paid family caregivers provide a lifetime to care and mitigate the need for costlier, more acute services that may or may not be available close to home. Agencies screen all employees, including family caregivers, as part of their operation. Criminal registry checks and drugs screens are completed, and all employees receive a minimum of 40 hours of training. Also, a RN provides ongoing monitoring of caregivers and beneficiaries.

The proposed rule change does not prohibit paid family caregivers in the Independent Choices Program. I feel that this is in direct opposition to the Department's statement about fraud and abuse in the use of paid family caregivers. Caregivers who are hired directly by recipients in the Independent Choices

program are **not** required to receive the same level training. There is **not** the same oversight by a registered nurse. Until recently, caregivers in the Independent Choices program were **not** required to undergo criminal registry checks or drug screens. There is considerably **less oversight** in the Independent Choices Program which potentially puts people at risk.

**Response:** Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

**Comment:**

Third, the new Arkansas Medicaid Task and Hour Standard appears to be prescriptive and possibly restrictive in nature of the minutes assigned to each task. Beneficiaries served in Attendant Care and Personal Care programs vary in the care needs from day to day. A Plan of Care may indicate bathing 3 times per week, but a beneficiary may be unable to bathe during one of those days. In the proposed amendment, ADLs covered under Attendant Care Services and Personal Care Services include eating but EXCLUDE meal preparation. Providers are expected to feed recipients but are not allowed to prepare the food. Even recipients of home-delivered meals may require assistance in heating, unwrapping, and preparing the food for consumption. Providers should be able to prepare food, in addition to feeding recipients, as billable services.

The proposed rule will impact Arkansans all across the state. Providers may be unable to serve Medicaid recipients. Employees of agencies may lose their jobs. Many of the items contained in the rule change do not save the state money but, instead, will cost us in the long term. Care in one's own home is often the most cost-efficient and effective way to provide services. I would ask the Department delay the majority of the proposed rule. Outside of the implementation of the new assessment process on January 1, 2019, there is no reason to rush more than 600 pages. The Department did not show due diligence in providing providers, beneficiaries, stakeholders, and the public adequate time to read through and understand the proposed changes. There will be serious impact to people across the state, and we should have time to make sure that we are doing the right thing.

**Response:** Comment considered and accepted in part. The Task and Hour Standards are intended only to provide an aggregate limit on weekly or monthly hours, and not to dictate the time allocated for the actual performance of each individual task. The rule language is being clarified to make this explicit. Meal preparation is not excluded, it remains covered for both personal care and attendant care.

**Darlene J Kurtz**

**Comment:** I am writing to voice my opposition to the the Arkansas Department of Human Services rules and regulations proposal issued on October 7, 2018.

I'm against the regulations as now written because the reality is MOST people want to remain in their homes or apartments to enjoy the environment they created over their lifetimes.

Furthermore, in the long run, proposed funding cuts will result in MORE government costs by virtually forcing people to reside in institutions.

And it gets worse: the larger the institution the more likely there will be a reduction in quality care and safety while costly to the general tax paying public.

A question: why is it that nursing home agencies learned of these proposed changes ahead of me, a member of the general public? I am just shy of my 70th birthday, and yes, I am paying attention to this. Proposed changes will have an impact on me and my family members, one that is distasteful and unnecessarily hurtful.

**Response:** Comment considered and accepted in part. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. DHS first previewed these changes in the spring and summer through a publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input.

**Robert W. Wright, Mitchell, Blackstock, Ivers & Sneddon, PLLC**

**Comment:** I am submitting these comments on behalf of the Developmental Disabilities Provider Association. Many DD waiver plans also have Personal Care in them. The restriction on family members serving as caregivers and the prohibition on caregivers living in the same premises as the participant will create a huge problem for providing Personal Care services. In many sparsely populated areas, it may not be possible to find caregivers who are willing to take the job and who are not a relative of the consumer. In many cases, an individual who lives in the home with the participant (often a family member) is the only choice. For many waiver clients, family members are waiver caregivers. If the family members cannot provide Personal Care as well, it will be practically impossible to find staff who will go from home to home providing two hours of Personal Care per client. DHS has stated that this limitation is a program integrity issue. Family-member caregivers and caregivers living with participants are subject to the same regulations, restrictions, and controls as other caregivers. If there is a program integrity problem, then we urge DHS and OMIG to identify those who are non-compliant and deal with them rather than changing the policy in a way that will affect the ability to staff care for hundreds of waiver participants. We strongly urge reconsideration of this proposed rule.

We look forward to your consideration of these comments.

**Response:** Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

**Robert W. Wright, Mitchell, Blackstock, Ivers & Sneddon, PLLC**

**Comment:** Attached are comments on behalf of Arkansas Residential Assisted Living Association. We look forward to your careful consideration of these comments urge reconsideration of this proposed rule.

200.1.C. & D. DPSQA will certify providers and may impose a moratorium. We are opposed to giving DPSQA this authority without knowing the criteria and conditions that will govern such actions. There are already caps in place and counties with no Assisted Living Facilities in them. This action will limit the access of residents of those counties.

**Response:** Comment considered. The criteria for setting a moratorium are set forth in the federal regulations cited in the proposed rule.

**Comment:**

200.105.B. & 211.200 The proposed rules change the current 90-day notice of change in status requirement to "immediate" notification of a change in condition. If there is only one payment tier, why are providers required to notify the state of every change? This will just create extra administrative and record-keeping burdens for providers. It is also inconsistent with the provision that the State change the care plan in fourteen days if there is a "significant" change in condition. The manual should define what constitutes a "significant" change in order to avoid providers being penalized just because of a misunderstanding.

**Response:** Comment considered. A change of condition may necessitate a reassessment to determine whether or not the individual still meets the functional criteria for waiver eligibility, so as to ensure that the individual receives the appropriate services best suited to protect their health and safety. By eliminating the requirement that providers submit regular reports even where has not been a change of condition, the proposed rules actually reduce the administrative burden on providers.

**Comment:**

211.100.A., 211.200.3, & 250.100 Removal of the tier level reimbursement system will result in facilities "cherry-picking" residents and moving recipients out sooner than necessary due to lack of payment for services. In addition, the method the State used to determine the cost of care and the reimbursement amount is flawed. The Assisted Living industry is primarily private pay, and providers are reticent to provide information about their expenses and profits. Perhaps a more acceptable method of establishing costs and setting rates might be a percentage of charges the private market is paying. In addition, ALFs have not had to complete cost reports and do not have the expertise that other types of providers have.

A study that was done in the past showed that the cost of the physical facility influenced the cost of care more than the amount paid to aides. Assisted Living regulations have larger square footage requirements than is required for HUD efficiency apartments. In addition, there is a significant facility load that should be calculated in the cost.

There has not been an increase in Assisted Living reimbursement in three years, and now it is being proposed that the rate be cut 22% below the old rate. If this happens, it will have a devastating effect on the industry and will limit access of more disadvantaged persons needing the service. Many rural facilities may go out of business. The passage of the minimum wage amendment yesterday will place

additional pressure on salaries and make the impact of the rate reduction even more devastating because the wage increase will require increases all the way up the scale in order to maintain wage separation between groups of employees.

**Response:** Comment considered. It is not clear what this comment is referring to; neither section 211.100.A nor 250.100 relate to the tier system, and there is no section 211.200.3 in the proposed rules. There is nothing in the proposed rules that require providers to submit cost reports or other information about expenses and profits. The comment cites increased physical facility costs and facility load, but federal rules prohibit Medicaid from directly paying for room and board costs. These costs cannot be taken into account in determining an appropriate payment rate.

**Comment:**

200.100 RCF and ALF providers already have to have Background Checks. They do not have to have Child Maltreatment, and RCF providers do not have to have Adult and Long Term Care Resident Maltreatment Central Registry. There has been no provision for added reimbursement for these checks which do not appear to add any significant recipient safety feature. If the Department believes that more qualified employees should be hired, Medicaid reimbursement must be increased to pay for them.

**Response:** Comment considered. The proposed changes provide clarification to reflect existing statutory requirements.

**Comment:**

200.140, 213.120, 214.300 We see no reason to deny ALF 2 as a place of service for Medicaid Personal Care (MPC). The State has restricted the LCAL waiver to the point that it is not a viable option for many recipients in a timely manner. If an operator chooses to admit an SSI recipient under MPC until they could get a slot in the waiver, there is no programmatic justification for not allowing that.

**Response:** Comment considered. The current language allowing an ALF 2 facility to provide personal care services was added by mistake in the last revision of the rules, and personal care services are billed by an ALF 2 only rarely.

**Comment:**

201.131 There has been no information provided about the "certification" process the Department is seeking. Without knowing what this certification process and requirements are, we have to oppose this language being added to the MPC regulations.

**Response:** Comment considered. Any certification requirements will be limited to what is in the rules as approved; any additional certification requirements may be added only through a later promulgation process.

**Comment:**

215.200. A. The phrase "complete and accurate" is too subjective and would allow the Department to delay and send back any assessment for reasons that are not justified or related to the program. Subjective language in the manual has been used against providers selectively in the past. All requirements should be specific and include examples for guidance to providers.

B. The Department has taken the physician out of the Personal Care approval process but expects providers to make available the physician diagnoses complete with ICD 10 codes. What is the justification for this requirement? The Department has completely taken over the process, is paying

other entities to determine need, and is not proposing to pay providers any more to cover the costs of providing services and meeting the administrative requirements.

**Response:** Comment considered. DHS will work with providers to streamline form and documentation requirements. DHS has not proposed any change related to the reporting of ICD-10 codes for personal care beneficiaries.

**Robert W. Wright, Mitchell, Blackstock, Ivers & Sneddon, PLLC**

**Comment: GENERAL CONCERNS**

NOTE: Many of the changes to Attendant Care are mirrored in changes to Personal Care. To the extent these proposed changes apply to the Personal Care proposed rules, please consider them as comments on those rules as well.

The Process. DHS published some 600 pages of rules for promulgation on October 7-8. That gives interested parties only 30 days to comment because DHS is intent on making the new provisions effective January 1. These rules were developed without any meaningful prior input by providers or consumers or other interested parties, and they run counter to the direction that every study, survey, and expert encourages-allowing individuals to stay in their home where they prefer to live (and where the costs are less). In times past, DHS has worked with these groups prior to publication. The result was less objection, if any to the regulations, and generally a better product that reflected the expertise of all parties involved. The changes in these rules will have a very significant impact on clients, providers, and families. They should not be rushed through the process to meet an arbitrary deadline without the opportunity for meaningful stakeholder review and comment. DHS should take the time to get meaningful input from stakeholders and be willing to make changes when better alternatives are available.

**Response:** Comment considered. DHS conducted five public meetings and a webinar that were all publicized to providers in May 2018, in which DHS outlined the concepts being considered for this package. DHS listened to the questions and input raised by providers in these hearings and took them into account in preparing the rules that were ultimately published for public comment four months later. DHS has received additional comments during the public comment period and has made numerous substantive changes to the proposed rules in response to public comments.

**Comment:**

- DHS contracted with Milliman, who developed new rates for three ARChoices services. The most significant of those services is Attendant Care, where Milliman recommended an increase of twelve cents per hour. The rate calculation is riddled with assumptions, any one of which, if changed slightly, could have a significant effect on the rates. Milliman said that it received input from DHS and six provider surveys. A survey of six providers (a survey that lacked adequate specificity in how many of the entries were to be calculated) in a program as large as ARChoices is practically meaningless. Milliman's assumptions regarding salaries and benefits do not reflect the reality of many providers, who are competing with other employers to find employees. Milliman also assumed that all ARChoices Attendant Care direct care worker's time would be 100% billable, based on feedback from DAAS. This assumption reflects a total lack of understanding of the ARChoices program. Direct service employees spend time driving to clients' homes (which is not reimbursable by Medicaid but must be paid by the provider agency employer) and time on administrative tasks as well. This assumption regarding direct care

workers' billable time is just wrong. The rate also does not take into account the potential for upcoming increases in the minimum resulting from the passage of the ballot initiative yesterday. DHS officials have said there is no intention to adjust the rates if that initiative does pass. The current rate is already too low, as it is based on costs that are over three years old. To now calculate a rate based on a model based on incorrect assumptions not taking into account any past and upcoming cost increases is unacceptable. Milliman's own report acknowledges that actual provider costs may vary significantly from the calculated rate and advised DHS to consider all stakeholder issues, in addition to these modeled rates, when determining the rate to implement. We support Milliman's recommendation in this regard. However, as to the rates themselves, due to the use of inadequate and incomplete assumptions, the rates are inadequate and incomplete as well. The Department's failure to adjust Personal Care rates in accordance with Attendant Care is also problematic. These rates have been kept the same as each other for almost twenty years. This makes sense because some of the services are similar, the same staff may provide both services, and some clients change from one service to the other.

**Response:** Comment considered. Milliman, the actuary contracted by DHS, reviewed the costs of providing attendant care services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS has repeatedly said that the agency will review the effects of the minimum wage increase across of all of Medicaid and then take appropriation action program wide, rather than look only at individual rates in isolation.

**Comment:**

ARIA and Task and Hour Standards. ARChoices clients have already seen a reduction in hours of care under the ARPath assessment that was implemented in January 2016. Now the Department is moving to independent assessments by Optum and a Task and Hours grid to determine the number of hours of Attendant Care a client may receive. Given Optum's track record with personal assessments for Personal Care, relying on them for ARChoices assessments seems like a bad decision. There has been no discussion regarding the actual impact of the assessment and Task and Hour Standards. A provider or client cannot determine on their own what the result will be. Optum has shown very little flexibility in its assessments in other programs in terms of taking special circumstances into account. We realize that the Task and Hour Standards have been used in Texas. However, we have seen no information regarding the impact that the standards will have on elderly and disabled adults in Arkansas who depend on waiver services in order to stay in their homes. The documentation requirements will result in fewer in-home services and more individuals being forced to move into a nursing home.

**Response:** Comment considered. DHS has not proposed using the independent assessment results to solely determine attendant care hours. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary.

**Comment:**

Individual Services Budget Once the independent assessment and Task and Hours standards determine the number of hours of Attendant Care a waiver consumer needs, the services can still be restricted by application of the new Individual Services Budgets. The Department has determined set amounts depending on which of three groups a consumer fits into, and the consumer's waiver services cannot exceed that amount even if it means the consumer doesn't get as many Attendant Care hours as the assessment and Task and Hours Standards call for. The highest ISB level was calculated based on an action of the average nursing home costs in the state. The nursing home provider tax and the federal match on that revenue were not included, presumably because they do not represent a cost to the state. This exclusion artificially restricts the ISB amount-if the state is going to compare to the costs of nursing home care, all the costs are relevant, regardless of their source. If an individual is assessed and determined to be eligible for intermediate level of care and therefore potentially waiver-eligible, scores within the highest range of needs intensity in the Task and Hours Standards, and is found to be at the highest (Intensive) level for Individual Service Budget purposes could receive only \$30,000 per year in waiver services. That would fund just over 30 hours per week of Attendant Care and leave no funds available for home-delivered meals, PERS, or other waiver services. The proposed waiver states that if the authorized services within the ISB, other Medicaid services, and informal supports are inadequate to meet the consumer's needs, the DHS nurse is to counsel the consumer on other settings available (nursing homes, for example) or choose a different mix of services. The primary purpose of the ARChoices waiver is to allow people who can stay in their home to do so. Forcing individuals to choose between necessary assistance with activities of daily living or a full complement of meals each week should not be allowed. Requiring an individual to choose to go to a nursing home in order to receive all of the services they need is absolutely antithetical to the purpose of the waiver. We do appreciate the exception process; however, it can only be implemented for one year at most. The transition provisions are also a positive feature, but it is also limited in duration and amount. If DHS wants to move to an ISB model, they should do so in a way that maximizes consumer choice and ensures that staying in an individual's home is an option if feasible.

**Response:** Comment considered. The ISB amounts are based on the comparable state/federal cost for a nursing home stay; revenues related to the quality assurance fee are excluded to ensure a fair and accurate comparison since home- and community-based services do not have a comparable revenue source. Individuals will be able to access up to 64 hours of personal care services in addition to the waiver services under the ISB amount, ensuring that beneficiaries will have access to adequate care. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require.

**Comment:**

Waiver Slots. The new proposed waiver amendment increases the point-in-time caps for 2019 and 2020. While we appreciate this increase, there needs to be some consideration given now to the fact that the combination of the old ElderChoices and AAPD waivers is going to result in the elderly being squeezed out of the waiver. Elderly adults have a much shorter average stay on the waiver than physically disabled adults. The increased turnover in the elderly frees up slots more often, some of which are taken by physically disabled adults. Over time, this will result in more slots being filled by disabled adults and fewer by the elderly. This is an issue that should be recognized and addressed sooner rather than later.

**Response:** Comment considered. DHS proposed an increase in the caps based on enrollment trends and will continue to monitor these trends to make adjustments.

**Comment:**

Annual Provider Certification. Currently, most ARChoices providers are required to recertify every three years. The new regulation increases the frequency to annually. What is the purpose for this additional requirement which will just create an additional administrative burden for providers?

**Response:** Comment considered. All other Medicaid providers are required to re-certify annually; the ARChoices rules are being amended to bring ARChoices provider types in line with the other provider types in Medicaid.

**Comment:**

**SPECIFIC MANUAL PROVISIONS**

212.200 0.4.b. The ISB process is to assume that there will be no interruptions in waiver services due to a hospital, nursing home, or other short-term facility admission. In some cases, consumers require more care at home for a period of time after a hospital admission. Will the budget be adjusted to reflect that occurrence?

**Response:** Comment considered. The proposed rules permit exceptions in such instances, at section 212.200 (B)(4)(c).

**Comment:**

212.600 A.1 and A.3. The restriction on family members serving as caregivers and the prohibition on caregivers living in the same premises as the participant will create a huge problem for providing Attendant Care services. In many sparsely populated areas, it may not be possible to find caregivers who are willing to take the job and who are not a relative of the consumer. In many cases, an individual who lives in the home with the participant (often a family member) is the only choice. DHS has stated that this limitation is a program integrity issue. Family-member caregivers and caregivers living with participants are subject to the same regulations, restrictions, and controls as other caregivers. If there is a program integrity problem, then OHS and OMIG should identify those who are non-compliant and deal with them rather than changing the policy in a way that will affect the ability to staff care for hundreds of waiver participants.

**Response:** Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

**Comment:**

213.210 The list of IADLs restricts meal planning and preparation to meals consumed only by the participant. This is an unreasonable and unworkable restriction. Medicaid is not buying the food, so there is no additional cost if a waiver consumer shares a home with someone who is not a waiver consumer. In many cases, it is just as easy to cook for one as for two, and requiring this separation of meals will not be practical in some situations.

The restriction that Attendant Care excludes cleaning any space that is shared by the waiver participant with one or more adults are able to perform housekeeping in those areas. Does this mean that if a

husband is on the waiver and his wife is not, the Attendant Care worker may not do any cleaning in their single bedroom or bathroom or kitchen? Again, this restriction is impractical in many situations.

The elimination of traveling as an Attendant Care service will be a hardship for some waiver participants. Many waiver participants benefit cognitively and emotionally from the companionship and socialization of their Attendant Care provider. Prohibiting this as a billable Attendant Care service will have a negative impact on participants, particularly those who live alone and receive few if any visitors other than their Personal Care attendant.

213.240 Again, the restriction against relatives providing environmental accessibility adaptations or adaptive equipment is impractical. In many cases, the only person available to do these small jobs is a family member. If there are concerns regarding abuse, then DHS and OMIG should investigate and address those concerns rather than impose an unworkable new policy.

**Response:** Comment considered and accepted in part. Medicaid funds may not lawfully be used to pay for services for non-Medicaid beneficiaries. The proposed rules exclude coverage for cleaning of shared spaces only if the residence is shared with an adult who is physically able to clean the shared spaces. With regard to the family restriction of 213.240, please refer to the response to the comment above.

**Comment:**

213.311 and 213.323 Are volunteers in programs that provide home-delivered meals required to get a criminal background check and registry check?

The additional checks in addition to the criminal background check currently done on employees who deliver ARChoices meals to clients in their homes will increase costs to providers and delay the hiring process. The checks for the child maltreatment registry, the CAN/employment clearance registry, and the LTC facility resident maltreatment registry seem to be excessive in that home-delivered meal providers do not deliver to children or long-term care residents and do not use CNAs to deliver meals.

Providers who deliver meals are required to use a menu approved by a registered dietitian, have a current health department inspection, and have a current food permit. All of these regulations are reviewed and audited yearly. Requiring annual certification by DPSQA will just add another expense and administrative hurdle for providers who are already well-regulated.

213.323 K. Meal providers receive care plans that have the total number of hours for Personal Care and Attendant Care but not the frequency of services. The meal provider (which may be a different entity) would have to call the Personal Care and Attendant Care provider to find out how many days the client is receiving those services. This will be an administrative burden on both providers to require this communication, and it will represent an additional cost with no increase in an already inadequate reimbursement rate to cover the cost.

213.700 The same issues apply to relatives providing respite care as already discussed above.

**Response:** Comment considered and accepted in part. The criminal background and central registry check requirements mirror the requirements of state law. Ark. Code Ann. § 20-38-101(3)(A) exempts volunteers from the definition of “employee” for the statutory requirement. Existing rules already require certification for home-delivered meal providers, the only change in the proposed rules is changing the name of the DHS office with responsibility for certification. Meal providers will be apprised

of the frequency of personal care/attendant care through the service plan. With regard to the family restriction of 213.700, please refer to the response to the comment above.

**James Smith, Virgil Howard, Arnold Wilcox, Judith Roberson, Betty R. Owens, Barbara Hedges, Ruby Lunsford, Ervin Holland, Alice Keener, Betty Williamson, Lynda D. Mead, Linda Rowe, Bonnie Heavener, Sallie Riggins, Claudene Eisely, Andrea Bosch, Phyllis Simon, Fred E. Eisely, Sheila M. Schumacher, Evaughn Ralls, Martha Edwards, Jo Eldridge, Crystel Vaughn, Sharon E Mannon, Lorelei Meador, Janet Roberts, Charles Roberts, Thomas D. Meador, Johnnie Faye Kinkade, Roberta L. Williams, and Winfred E. Gerber (writing separately)**

**Comment:** I recognize that as the Leader of one of Arkansas' largest and most diverse departments, you have a very difficult job. As that leader it is time for you to step up and do something to correct the huge mistakes being proposed by the Division of Aging and Adult Services.

The unduplicated waiting list established to put order into the backlog of applicants for the Living Choices Waiver is effectively preventing many deserving frail elderly from participating in the program that is designed to meet the stated mission of the Department of Human Services.

The proposed rule changes published by this Division will, ultimately, completely destroy the Living Choices program over time and seriously damage many of the other programs designed to accomplish the goals of the Department's Mission statement. I sincerely hope this is simply a misguided attempt to improve services to the aging population of Arkansas and not a deliberate attempt to shut it down to save a few dollars to be spent elsewhere. In either case you will soon have to make major changes to your Department's Mission statement.

The Oaks in Mena is a prime example of severe damage already being done to a facility that, since its beginning, has continuously performed on an above average level. Until the waiting list became overburdened, The Oaks maintained a very high occupancy level with a waiting list for entrance into the facility. Over the last six months The Oaks has lost eight Living Choices Waiver residents. This has resulted in monthly income loss of approximately \$14,000.00 and the necessity to draw upon required reserves to make payroll obligations. You can readily see this is unsustainable. The end result is loss to the community of 25 jobs, and a beginning displacement of 30 frail elderly residents with questionable adequate placement in locations that meet requirements of your Mission statement.

Cuts to the reimbursement rates is simply devastating to any facility whose financing requirements dictate the admission of low-income residents only. Those facilities have no control over pay rates as do private pay facilities. The proposed reimbursement rate for Living Choices participants is below the cost of providing services to those residents. The fact is that cost-of-living increases to keep up with inflation stopped in 2014 even though cost of operation has continued to rise. Food costs, insurance rates, and maintenance costs are just an example of rises that must be dealt with to keep going.

PLEASE EXERT YOUR LEADERSHIP INFLUENCE TO CORRECT THESE DEVASTATING MISTAKES.

**Response:** Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to

develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The recommended rate does not include amounts for food costs, insurance rates, or maintenance costs, because federal rules prohibit Medicaid from paying for room and board costs for assisted living beneficiaries. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

### **Lisa Masters**

**Comment:** The Arkansas Dept. of Human Services is currently preparing a new five-year plan for Medicaid eligibility requirements and Medicaid funds disbursement.

Proposals that have been published and distributed for public comment will have a potentially disastrous effect on all Medicaid services, most especially on the assisted living services currently offered to the Medicaid eligible frail, elderly Arkansas residents.

When The Oaks at Mena was built, financial entities required the facility to serve only those who meet the annual income limits published by HUD. At that time, State officials with the Dept. of Human Services assured the Ouachita Senior & Retirees, Inc. that the Medicaid waiver program, also known as the Living Choices Assisted Living Waiver Program, would be available to residents of The Oaks at Mena for the duration of the 30-year financial obligations to the financing agencies.

Since that promise was made, OHS has continued to approve new facilities for Medicaid Living Choices funded services and continues to approve elderly patients for the Living Choices Waiver. This has resulted in a gross underestimate of the numbers of Medicaid eligible applying for the services.

The DHS answer was to establish a cap on the number of unduplicated waivers that would be active in any given year and a waiting list on which anyone who was approved for the Living Choices Waiver would be placed to wait for a slot to open. This list is to be updated only once each year. This simply means that if a slot is opened due to a recipient leaving the program that slot remains empty until the system is updated at the beginning of the next year.

This arrangement has inflicted serious damage to the successful operation of The Oaks at Mena. During this year, eight residents have been lost and our next waiver eligible applicant is number 116 on the waiting list. This means that our eligible waiver applicants have very little chance of actually being awarded an active waiver by the beginning of the new year. The loss of monthly income to The Oaks at Mena currently is approximately \$14,000.00 per month. This condition is unsustainable for continued operation.

**Response:** Comment considered and accepted in part. DHS could not have promised that the Living Choices program would be available for 30 years, because Living Choices is a Medicaid waiver that is limited to 5 years, and any renewal of the waiver requires federal approval. Under current rules, DHS must approve new providers that meet the waiver requirements, and DHS must continue to admit new beneficiaries who meet eligibility requirements, subject to the caps on participation. These participation

caps are not new; the Living Choices waiver has been capped since its inception. DHS has modified the proposed rules to increase the cap numbers so that waiver slots may be reused through the year and will not have to be held open until the following year.

**Doyle Beck, Lorene Beck, Sue Babel, and Sheila M. Schumacher (writing separately)**

**Comment:** First, I would like to commend you for many of the changes you have initiated to make Arkansas a better place in which to live. There is one area, however, that disagreement with your efforts to effect change must be noted. That area is the proposed changes to the rules for administration of the Medicaid waiver programs. As pointed out in a recent meeting in your office, these changes will have a disastrous effect on services to many Arkansas citizens, especially the frail elderly.

Research studies relating to the reimbursement rate for various waivers is obviously false and misleading. Using the Living Choices Waiver as an example this rate was set nearly ten years ago with annual rates being changed in pace with social security. The rate adjustments stopped in 2014 and no reimbursement rates have been adjusted since that time, although inflation has continued to affect the cost of doing business. The rate cut of nearly 22% proposed by DHS will have a devastating effect on all assisted living facilities whose residents are served by the Living Choices Waiver. A prime example is The Oaks at Mena whose rating with DHS has been well above average since it began operations. The tax credit funding model under which The Oaks operates dictates that only low-income residents may be served. The cost of operation has risen considerably since The Oaks opened. The insurance which is required by the funding agencies doubled this year alone from \$6,000.00 to \$12,000.00 along with raises in food costs and maintenance costs to list just a few of the raises.

The waiting list initiated to bring order to the overload on the cap placed on waiver recipients has become a serious log jam to The Oaks continued success. In the last six months this facility has lost eight residents without any chance of maintaining our resident census. This translates to a monthly loss of income of nearly \$14,000.00. Totally unsustainable. The Oaks is currently requesting the use of reserve funds to make payroll each pay period. This puts the facility out of compliance with ADFA regulations until reserves can be brought back up to the required level.

Economic Joss to Mena economy of TWENTY-FIVE jobs and displacement of 30 RESIDENTS is serious not only to the welfare of the residents but also to the economy of the small rural community of Mena.

Without your immediate action to correct this very serious problem the damage to the community will be long lasting since we don't receive much of the economic benefits of State government enjoyed by more populated areas of Arkansas.

**Response:** Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The recommended rate does not include amounts for food costs, insurance rates, or maintenance costs, because federal

rules prohibit Medicaid from paying for room and board costs for assisted living beneficiaries. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. Under current rules, DHS must approve new providers that meet the waiver requirements, and DHS must continue to admit new beneficiaries who meet eligibility requirements, subject to the caps on participation. These participation caps are not new; the Living Choices waiver has been capped since its inception. DHS has modified the proposed rules to increase the cap numbers so that waiver slots may be reused through the year and will not have to be held open until the following year.