Public Comments Regarding Rule 289 - Second Notice - Personal Care and Arkansas Independent Assessment Provider Manuals

Emily Mizell, Esq.

Aegis Legal Advisors, PLLC

Comment: Thank you for the opportunity to submit public comments regarding the proposed Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals. We appreciate the Department's efforts to clarify program requirements and support consistent administration of Medicaid for personal care services. The comments below request clarification on proposed changes that may affect provider compliance obligations, beneficiary access to services, and reimbursement expectations.

1. Criminal Background Check Requirements

The proposed rule at Section 200.100.A.2 states that all "employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq." This request seeks clarification regarding whether the proposed rule is intended to require a national criminal history records check for every employee and contract staff member, regardless of the individual's length of continuous Arkansas residency.

As currently understood, the cited Arkansas Code provisions require criminal history records checks for personal care employees, but the federal or national background check requirement has historically been understood to apply to employees or contract staff who have not lived continuously in Arkansas for the preceding five (5) years. See Ark. Code Ann. § 20-38-103.

Is the quoted language in Section 200.100.A.2. intended to require national or federal background checks for all employees and contract staff, regardless of whether they have lived continuously in the state for the past five (5) years? Or, do employees only need national/federal background checks if the personal care provider cannot verify the applicant has lived continuously in this state for the past five (5) years pursuant to Ark. Code Ann. § 20-38-103?

2. Definition of Beneficiary's Family for Medicaid Personal Care Purposes

Section 235.100.C. states that Arkansas Medicaid will not reimburse for personal care services performed by a member of the "beneficiary's family" and identifies specific individuals who are treated as members of the "beneficiary's family" for such purposes. We request confirmation that only the individuals expressly listed in the proposed rule are included within the definition of "member of the beneficiary's family" for Medicaid personal care purposes.

Additional clarification would be helpful regarding adult beneficiaries. Specifically, if the beneficiary is an adult, does the proposed family-member limitation include the beneficiary's parent? We also request confirmation whether personal care services may be performed by relatives or other individuals who are not expressly listed, including an adult child, cousin, grandchild, significant other

who is not married to the beneficiary, niece or nephew, or in-law, who is not otherwise expressly prohibited by Section 235.100.C.

Because providers must screen workers before assigning services and must ensure that claims are submitted only for covered services furnished by permissible caregivers, your guidance will help avoid inconsistent interpretations, avoidable denials due to caregiver assignments, and later recoupment risk.

3. Personal Care Services in Level II Assisted Living Facilities

Previously, under Sections 213.000.D., 213.120.A.3., and 213.500.B, personal care services provided at a Level II Assisted Living Facility were excluded from coverage under the program. The proposed changes to Section 235.100.B remove previous reference to a Level II Assisted Living Facility as a location where personal care services cannot be provided. We request clarification whether this deletion is intended to allow Medicaid personal care services to be provided to a beneficiary residing in a Level II Assisted Living Facility.

If personal care services may now be provided in a Level II Assisted Living Facility, we request that the Department confirm what reimbursement rules that apply. This clarification is important because assisted living residents, personal care providers, and facilities need to understand whether personal care services may be authorized and billed in Level II settings, and whether any reimbursement reduction, duplication-of-services limitation, or facility-service offset applies.

Conclusion

For the reasons stated above, we respectfully request that the Department provide clarification before final adoption and revise the manuals as needed to ensure that providers can apply the requirements consistently. Clear guidance on background check obligations, family-member limitations, and service availability in Level II Assisted Living Facilities will promote compliance, reduce administrative uncertainty, and support appropriate beneficiary access to covered personal care services. Thank you for your time and consideration of these comments.

Response: The State appreciates your comments on this proposed rule-making package.

1. Criminal Background Check Requirements

Section 200.100 references two Arkansas Code citations and the expectation is that the provider will act in accordance with these statutes regarding when a fingerprint is required.

2. Definition of Beneficiary's Family for Medicaid Personal Care Purposes

The list in Section 235.100 is exclusive and specifically calls out "a MINOR's parent, stepparent, foster parent or anyone acting as a MINOR's parent.

3. Personal Care Services in Level II Assisted Living Facilities

Please refer to Section 235.100 where there is a list of locations where personal care CANNOT be provided. Assisted Living Level II is not contained in the excluded list and can provide personal care.

Yukiko Taylor, Executive Director

Developmental Disabilities Provider Association (DDPA)

Comment: Please find attached the formal public comments from the Developmental Disabilities Provider Association (DDPA) regarding the proposed changes to the Arkansas Independent Assessment Provider Manuals.

We appreciate the opportunity to review these updates and provide feedback on behalf of our member organizations and the individuals we serve.

If you have any questions, require additional documentation, or need further clarification regarding our submission, please do not hesitate to contact me.

Respectfully submitted,

DDPA appreciates DHS's work to implement the proposed updates to the Personal Care and Arkansas Independent Assessment (ARIA) Provider Manuals. However, DDPA recommends that DHS provide additional clarification before finalizing the ARIA manual, particularly as it relates to Developmental Disabilities(DD)/CES Waiver participants and providers.

The proposed ARIA language references an abbreviated reassessment option for Developmental Disabilities assessments, but the manual does not define the abbreviated process in sufficient operational detail. The draft should specify who qualifies for the abbreviated assessment, whether the process may be completed by desk review, what documentation will be reviewed, whether provider/guardian input is required, what triggers a full reassessment, and how results will be communicated to beneficiaries, guardians, PASSEs, and providers.

DDPA also requests clarification regarding the applicable reassessment timeline for DD/CES Waiver participants. The proposed document includes annual reassessment or annual evaluation language for certain sections, including Behavioral Health and aging waiver programs, but the DD/CES section does not clearly state whether CES Waiver reassessments will occur annually or follow another cycle. DHS should clearly identify the reassessment frequency and whether the abbreviated assessment option changes any existing process.

Because assessment results may assign or affect tiering, inform PCSP development, and relate to PASSE payment, DHS should also clarify whether abbreviated reassessments may change tier assignment, PASSE payment, service authorization, PCSP scope, or provider reimbursement. DHS should specify when any changes take effect, what notice is required, and whether current services remain in place during reassessment, review, correction, dispute, or appeal.

DDPA further recommends that DHS define the post-assessment workflow, including who updates the PCSP, required timelines, provider and guardian notice, beneficiary or guardian signature requirements, and whether current services continue until a revised PCSP is finalized and authorized.

Finally, DDPA recommends that DHS publish a clean corrected version of the proposed ARIA manual before finalization. The current draft contains unresolved formatting, redline, and merged-text artifacts, including incorrect-looking dates, merged headings, and remaining Personal Care language in the ARIA section. These issues should be corrected to ensure the final provider manual is clear,

accurate, and consistently interpreted by DHS, PASSEs, providers, beneficiaries, guardians, and assessors.

Detailed List and Comments

Relating to Abbreviated independent Assessment:

1. The abbreviated independent assessment process is referenced but not defined.

Document location:

• PDF page 20, ARIA Section II, Section 201.00

Relevant paragraph begins: “Reassessments may be conducted in person or through the use of telehealth.”

Comment:

Please add a dedicated subsection for the abbreviated Developmental Disabilities (DD)/CES assessment process. That subsection should define eligibility criteria, required documentation, permissible assessment methods, provider/guardian participation, full reassessment triggers, notice requirements, and continuity-of-care protections.

2. The effective date and approval path for Developmental Disabilities/CES abbreviated reassessments is unclear.

Document location:

• PDF page 20, ARIA Section II, Section 201.00

Relevant paragraph begins: “Reassessments may be conducted in person or through the use of telehealth.”

Response: The State appreciates your comments on this proposed rule-making package.

Eligibility criteria, documentation, assessment methods, participation, nor notice requirements are affected by the addition of shortening the assessment process. An abbreviated version of each assessment tool will be available and can be utilized **upon request** beginning January 1, 2027, which is the proposed effective date of this rule-making package. The branching logic and tiering remain the same.

Comment:

Please explicitly state the effective date for abbreviated DD/CES reassessments and identify whether implementation depends on CMS approval, a 1915(c) waiver amendment, state plan amendment, or other federal/state authorization.

Response: The 1915(c) does not require amendment to initiate an abbreviated assessment; however, the 1915i State Plan Amendment for behavioral health does require an amendment that has a proposed effective date of January 1, 2027.

3. Provider documentation expectations for abbreviated DD/CES reassessments are not identified.

Document location

• PDF page 20, ARIA Section 201.000

Paragraph referencing the abbreviated/focused assessment option.

• PDF page 22, ARIA Section 210.100 — Referral Process

Behavioral Health section states that supporting documentation related to treatment services necessary to address functional deficits may be provided.

Response: Thank you for your comment. Please see response above.

Comment:

Please add a documentation checklist for abbreviated DD/CES reassessments and clarify what provider, guardian, family, PASSE, and clinical documentation may be submitted or considered.

4. The document does not define when an abbreviated assessment must convert to a full reassessment.

Document location

• PDF page 20, ARIA Section 201.000

Paragraph referencing the abbreviated/focused assessment option.

• PDF page 22, ARIA Section 210.100

• Behavioral Health language states that reassessments occur annually unless a change in circumstances requires a new assessment.

• PDF pages 34, 38, and 42

• ARChoices, Living Choices, and PACE sections reference evaluations and reassessments when there is a significant change in circumstances.

Response: Thank you for your comment. Please see response above.

Comment:

Please list specific triggers requiring a full DD/CES reassessment, including significant change in circumstances, functional decline or improvement, new safety risks, loss of natural supports, hospitalization, placement change, or provider/guardian request with supporting documentation.

5. The impact of abbreviated reassessments on tiering, PASSE payment, service authorization, and provider reimbursement is unclear.

Document location

• PDF page 20, ARIA Section 201.000 states that the focused assessment will use the same tier logic as the standard assessment.

• PDF page 21, ARIA Section 201.000 states that assessment results assign the individual into a tier.

• PDF page 21, ARIA Section 201.000 states that for services delivered through a PASSE, the tier is used in determining the actuarially sound global payment made to the PASSE.

• PDF pages 27-32, Section 220.300 includes DD/DDS tiering logic.

Response: Thank you for your comment. Please see response above. This will not change payment, authorization or reimbursement.

Comment:

Please clarify whether abbreviated reassessments may change tier assignment, PASSE payment, service authorization, or PCSP scope. DHS should also specify the effective date of changes, notice process, dispute/appeal process, and continuity-of-care protections.

6. Desk review, telehealth, and in-person reassessment parameters are unclear for DD/CES Waiver participants.

Document location

• PDF page 20, ARIA Section 201.000

General statement that reassessments may be conducted in person or through telehealth.

• PDF page 22, ARIA Section 210.100

Behavioral Health-specific statement that initial assessments are in person, with the option of telemedicine for Behavioral Health reassessments.

Response: Thank you for your comment. Please see response above.

Comment:

Please clarify the permitted modalities for DD/CES abbreviated reassessments and identify safeguards to ensure accurate functional assessment when the review is not conducted fully in person.

7. The DD/CES populations covered by the abbreviated option are not clearly defined.

Document location

• PDF page 20, ARIA Section 201.000 references individuals with DD/ID and individuals with severe behavioral health needs.

• PDF page 20, ARIA Section 201.000 states that reassessments for Behavioral Health and Developmental Disabilities assessments will have an abbreviated option.

• PDF page 21, ARIA Section 201.000 includes PASSE-related language.

• PDF pages 27-32, Section 220.300 includes DDS tiering logic.

Response: Thank you for your comment. Please see response above.

Comment:

Please define the exact IDD populations covered by the abbreviated assessment option and state whether it applies only to active CES Waiver participants served through PASSEs.

Other:

8. The reassessment frequency for DD/CES Waiver participants is unclear.

Document locations:

• PDF page 22, ARIA Section II, Section 210.100 – Referral Process

Behavioral Health language states: "Reassessments will occur annually unless a change in circumstances requires a new assessment."

• PDF page 27, ARIA Section II, Section 220.300 — Tiering

DD/DDS tiering logic begins but does not clearly state the DD/CES reassessment cycle in the reviewed text.

• PDF pages 34, 38, and 42

ARChoices, Living Choices, and PACE sections include annual evaluation language or references to evaluations at least every twelve months.

Response: Thank you for your comment. Please see response above. There are no changes to reassessment cycles.

Comment:

Please clearly state the reassessment frequency for DD/CES Waiver participants and specify whether the proposed abbreviated assessment option changes any existing reassessment cycle.

9. The document does not address continuity of services while reassessment, review, correction, or appeal is pending.

Document location

• PDF page 21, ARIA Section 201.000

Paragraph explaining that assessment results assign an individual into a tier and are used to develop the individual's PCSP.

• PDF page 21, ARIA Section 201.000

Paragraph stating that, for PASSE-delivered services, the tier is used in the determination of the actuarially sound global payment made to the PASSE.

• PDF page 21, ARIA Section 201.000

Paragraph stating that the PCSP represents the final decision for setting the amount, duration, and scope of HCBS for the individual.

Response: Thank you for your comment. Please see response above.

Comment:

Please add clear continuity-of-care language stating that current services and supports remain in place during reassessment processing, review, correction, dispute, or appeal unless an immediate health or safety issue requires a different action.

10. The results packet and provider access to assessment results are not specific enough.

Document location

• PDF pages 20-21, ARIA Section 201.000

Paragraph beginning: “The results of the assessment are provided…”

Response: Thank you for your comment. Please see response above. This will not change our current appeal process.

Comment:

Please specify who receives assessment results, when results are issued, whether providers receive the complete results packet, how guardians or authorized representatives are notified, and what process exists for clarification, correction, reconsideration, or appeal.

11. PCSP update responsibilities and timelines are not clearly stated.

Document location

• PDF page 21, ARIA Section 201.000

Paragraph stating that assessment results are used to develop the PCSP with the Medicaid beneficiary.

• PDF page 21, ARIA Section 201.000

Paragraph stating that the DHS ARIA vendor does not participate in PCSP development or service provision.

• PDF page 21, ARIA Section 201.000

Paragraph stating that the PCSP represents the final decision for the amount, duration, and scope of HCBS.

Response: Thank you for your comment. Please see response above. There is no change to this process.

Comment:

Please define the post-assessment workflow, including who updates the PCSP, required timelines, provider/guardian notice, signature requirements, authorization steps, and whether current services continue until a revised PCSP is finalized.

12. Formatting, redline, and merged-text errors create interpretation risk.

Response: Thank you for your comment. Please see response above. This is a marked up version required under state code.

Comment:

Please publish a clean corrected version of the proposed ARIA manual before finalization, with all redline artifacts removed, effective dates corrected, headings corrected, grammar corrected, and tiering tables verified.

13. Personal Care language appears to remain in the ARIA manual despite the stated intent to remove Personal Care from ARIA.

Document location

• PDF page 2

Notice of Rule Making states that because a standardized assessment tool such as ARIA is not required for SPPC, the rule removes the personal care section from the ARIA manual.

• PDF page 33

ARIA Section II includes the merged heading "PERSONAL CARE SERVICESARCHOICES."

• PDF pages 33-34

Section 230.100 contains language referring to Personal Care service providers initiating IA referrals and PC providers resubmitting requests.

• PDF page 38

Text states: "The PC assessment is not used to assign clients to a PASSE."

Response: Thank you for your comment. Please see response above.

Comment:

Please remove or correct remaining Personal Care language in the ARIA manual and clearly separate SPPC, ARChoices, Living Choices, PACE, Behavioral Health, and Developmental Disabilities content.

14. Developmental Disabilities tiering tables should be republished in clean, readable format.

Document location

• PDF page 27, Section 220.300 — Tiering begins.

• PDF pages 28-29, Safety tiering criteria.

• PDF pages 29-31, Behavior tiering criteria.

• PDF pages 31-32, Self-Care tiering criteria.

Response: Thank you for your comment. Please see response above.

Comment:

Please republish the DD tiering logic in clean tables and identify which domains or questions are included in an abbreviated reassessment versus a full reassessment.

15. Provider-facing implementation guidance is needed before the proposed effective date.

Response: Thank you for your comment. Please see response above. Training will be provided prior to January 1, 2027, when this abbreviated version will be available for beneficiaries upon request.

Comment:

It would be extremely helpful if DHS could issue provider-facing implementation guidance before the rule becomes operational. This guidance should include FAQs, workflow diagrams, documentation checklists, sample notices, provider training, and clear instructions for handling pending reassessments, PCSP updates, and service-continuity issues.

Response: Thank you for your comment. Please see response above. Training will be provided prior to January 1, 2027, when this abbreviated version will be available for beneficiaries upon request.

Cathy Robertson, Owner

1 Source Senior Care

Comment: Attached are my comments in response to the public comment period for the new personal care manual.

1. Financial Impact of Bi-Annual Registry Checks

- Reference: Section 200.100 B
- Comment: Requiring Adult Maltreatment and Child Maltreatment registry checks every two years imposes a significant, recurring financial burden on providers operating within an already strained fiscal environment.
- Recommendation: We respectfully request that the State maintain the current five-year background check cycle. Furthermore, we urge the State to consider implementing a unified, cost-effective, cumulative background check portal similar to the model utilized in Oklahoma, which processes five distinct background checks through a single interface for a reasonable flat fee ($19.00).

2. Standardizing Personal Care Aide Certification Requirements

- Reference: Section 210.200 A 3
- Comment: The proposed manual states that an aide must possess an active certification as a "Certified Personal Care Aide" but lacks an explicit definition or framework for achieving this designation. If this language intends to default to the Department of Health (DOH) standards, DOH requires proof of a completed 40-hour training course. Because home care agencies operate in a competitive market, proprietary training certifications are rarely exchanged between employers.

Consequently, an aide seeking dual employment or changing agencies would be forced to repeat an unpaid 40-hour training course despite already performing identical services elsewhere.

- Recommendation: To prevent unnecessary employment barriers for hiring caregivers where there is already as severe shortage, and reduce operational duplication, we request the reinstatement of Section 222.100 E from the current manual. This provision allows agencies to waive the 40-hour training repetition based on verifiable prior field experience.

3. Protection of Beneficiary Personal Identifiable Information (PII)

- Reference: Section 220.200 A 2 b
- Comment: The mandate requiring a beneficiary's Medicaid number and date of birth to be available on the aide's daily service log presents a significant data privacy and cybersecurity risk. Requiring field staff to host sensitive PII on mobile devices increases the vulnerability of a highly susceptible population to identity theft and fraud. Field aides have no operational or care-related need to view or document a client's Medicaid number or birth date at the time of service.
- Recommendation: Remove the requirement to include Medicaid numbers and dates of birth on field logs. This compliance and billing data can be generated via secure administrative electronic reports rather than point-of-care documentation.

4. Exclusion of Shopping from Activities of Daily Living (ADLs)

- Reference: Section 235.300 B 11
- Comment: Categorizing shopping as an ADL introduces profound logistical, financial, and liability challenges. Aides would be required to utilize personal vehicles for work-related transit without standardized mileage or fuel reimbursement, creating an inequitable burden on frontline staff. From an agency perspective, this reclassification essentially converts personal vehicles into company vehicles during shifts, drastically escalating commercial auto insurance requirements. Furthermore, requiring aides to handle clients' cash, debit cards, or credit cards compromises financial safeguards for vulnerable beneficiaries.
- Recommendation: Remove shopping from the ADL framework.

5. Exclusion of Non-Medical Transportation Accommodations

- Reference: Section 235.300 B 12
- Comment: Permitting aides to transport beneficiaries to medical appointments and employment activities shifts the operational scope of personal care agencies into that of a specialized transportation provider. This introduces severe liability risks regarding traffic accidents, property damage, personal injury, and third-party claims. Furthermore, it shifts substantial commercial auto insurance liabilities to the provider and places fragile clients in vehicles driven by individuals untrained in defensive medical transit.
- Recommendation: Omit the transportation ADL from the revised manual, maintaining consistency with the exclusions currently outlined in the ARCHoices manual.

6. Operational Clarification for Original Evaluation Referrals

- Reference: Section 230.300 A
- Comment: The requirement to maintain an original Evaluation Referral on file for audit compliance introduces a completely new administrative protocol. Clear guidance is needed regarding how the Department of Human Services (DHS) intends to distribute these original documents to providers in a timely manner.
- Recommendation: If providers are expected to retrieve these documents retrospectively for all active clients, we request that DHS issue a formal mandate to primary care physicians clarifying their obligation to complete these forms. Additionally, we request an extended implementation grace period before this specific item becomes subject to audit penalties.

7. Resolution of Conflicting Supervisor Training Regulations

- Reference: Section 235.300 E 1 c
- Comment: The provision allowing a qualified supervisor to train a personal care aide directly conflicts with Section 9 A 2 of the Arkansas Department of Health Rules for Private Care Agencies.
- Recommendation: We request that DHS and the Department of Health establish regulatory consensus. We propose a framework where a qualified supervisor may conduct the initial skills training, followed by a formal competency evaluation performed by a Registered Nurse.

8. Protection of Proprietary Client Service Records

- Reference: Section 235.700 C 3 a
- Comment: Mandating a current provider to transfer a beneficiary's complete service record to a new, competing agency requires the forced sharing of proprietary internal documentation and clinical workflows.
- Recommendation: Maintain the established protocol: each incoming agency should utilize its own Registered Nurse to conduct an independent, objective clinical assessment rather than forcing the exchange of internal provider records.

9. Defined Standards for Provider-to-Provider Notifications

- Reference: Section 235.700 C
- Comment: The revised text mandates "notification to the other provider agency" during transitions but lacks a defined mechanism for proving successful transmission or receipt. Without clear guidelines, providers face compliance vulnerabilities if a receiving agency fails to acknowledge communications.
- Recommendation: Establish a formalized notification process. DHS should maintain a verified registry of provider contact emails. The regulations should explicitly state that a standard electronic delivery receipt or email confirmation sent to the registered address constitutes sufficient, legally binding "proof of notification."

10. Mitigation of Service Gaps During Agency Transfers

- Reference: Section 235.700 C 3
- Comment: Implementing a mandatory transition waiting period exceeding 30 days will exacerbate existing gaps in care. For example, if a client has lacked active services for two months and requests an agency transfer on May 2nd, the proposed timeline could delay the resumption of care until July 1st. This delay poses a severe continuity-of-care risk to the beneficiary.
- Recommendation: Retain the current transfer timeline or introduce an expedited "emergency transfer protocol" to ensure vulnerable individuals are not left without essential care due to administrative delays.

11. Elimination of Rigid "Daily Maximum" Caps and Task Schedules

- Reference: Section 260.160
- Comment: Implementing rigid, daily hour caps and day-specific task constraints fails to account for the unpredictable nature of home health care and heavily penalizes both the client and the agency. A strict daily maximum creates severe operational friction:
    - If an aide misses a specific weekday shift due to an emergency, those authorized hours are permanently lost and cannot be rescheduled later in the week, directly depriving the client of required care.
    - If an urgent, unexpected care need arises minutes before a shift ends (e.g., a client soils themselves), the aide cannot legally stay to assist without violating the daily maximum or creating uncompensated overtime liability for the provider.
    - Clients lose the autonomy to adjust their care schedules based on how they feel day-to-day, eliminating the flexibility required to safely manage varying physical conditions.
- Recommendation: Remove all references to strict daily maximum caps and day-specific task mandates. While we recognize that these measures aim to prevent the premature exhaustion of monthly authorized hours, rigid daily rules prevent practical, responsive caregiving. Compliance should continue to be evaluated against the broader monthly authorized hour allotment.

12. Flexibilities in Functional Needs Assessments for Schedule Adjustments

- Reference: Section 235.300 F
- Comment: The requirement for a completely new functional needs assessment for any permanent alteration to service delivery is administratively prohibitive when paired with daily maximums. Routine lifestyle adjustments—such as a client shifting hours from a Wednesday to a Thursday to accommodate medical appointments—would trigger a full nursing re-assessment and state approval process.
- Recommendation: Modify the language to ensure that functional needs assessments evaluate overall clinical eligibility and baseline care requirements, allowing providers the administrative flexibility to adjust daily schedules to fit the beneficiary's changing routine without triggering a formal reassessment.

Response: The State appreciates your comments about this rule-making package.

1. Financial Impact of Bi-Annual Registry Checks

Under 42 CFR § 455.434, state Medicaid agencies establish risk-based screening levels and require criminal background checks, including fingerprinting when applicable, for providers categorized as high risk. CMS also expects states to maintain ongoing program integrity oversight and may require screening activities that are more stringent than the federal minimum when necessary to protect beneficiaries and Medicaid funds. As a result, the frequency of background checks for certain provider types is driven by federal program integrity requirements and state oversight responsibilities rather than provider-specific concerns.

2. Standardizing Personal Care Aide Certification Requirements

The manual language does reflect the requirements of the Arkansas Department of Health as they are the sole agency certifying PC aides. DHS cannot, by manual, waive or override a DOH certification requirement.

3. Protection of Beneficiary Personal Identifiable Information (PII)

This section of the manual is not intended to create any new documentation requirements. Each client's personal information is loaded into the EVV systems used by providers. The manual reflects that the systems contain all the required information for Medicaid billing.

4. Exclusion of Shopping from Activities of Daily Living (ADLs)

This isn't a reclassification; this was and continues to be on the list.

5. Exclusion of Non-Medical Transportation Accommodations

This is not mandating that the PC aide must provide transportation, but the PC aide must assist the beneficiary with obtaining transportation or accompanying the beneficiary for ADL assistance. The personal care agency can have its own business practices regarding offering transportation to beneficiaries, in the same way that a beneficiary has freedom of choice. This section was intended to allow the agency to bill for time spent accompanying the beneficiary.

6. Operational Clarification for Original Evaluation Referrals

Thank you for your comment.

7. Resolution of Conflicting Supervisor Training Regulations

This section allows LPNs to serve as qualified supervisors (Section E. 1. a.-d.). RNs, who can also serve as qualified supervisors, are required to cover the elements listed in Section E. 2. a.-b. These are in line with existing regulations from the Department of Health.

8. Protection of Proprietary Client Service Records

Thank you for your feedback. The assessment is a medical/health record, which belongs to the patient/beneficiary and therefore should stay with the patient/beneficiary. The provider is the custodian, not the owner.

9. Defined Standards for Provider-to-Provider Notifications

The new transfer form indicates the notification method used by the agency (email, posted mail, other). This can be kept on file to document the agency's communication efforts to another agency.

10. Mitigation of Service Gaps During Agency Transfers

The new transfer process has been established to ensure a smooth transfer of continuous services between providers and to act in the best interest of the beneficiary. If a transferring beneficiary wants to continue receiving service from the current provider, they may do so. Waivers could be considered in exceptional cases where the safety of the beneficiary is in question.

11. Elimination of Rigid "Daily Maximum" Caps and Task Schedules

The daily limit is a billing integrity control, not a restriction on when care may be furnished. There is no carryover time between days. Care may still be delivered on any day of the week consistent with the beneficiary's treatment plan. Providers are barred from billing above the authorized daily maximum.

12. Flexibilities in Functional Needs Assessments for Schedule Adjustments

The schedule can be adjusted any time at the request of the beneficiary, not the aide or the agency. All changes to the service plan must be documented. The language in the manual states that a new functional needs assessment is triggered only by a PERMANENT change to service delivery. This would not include a schedule adjustment.

Randi Metcalf, Chief Operations Officer

CareLink

Comment: Elimination of Daily Maximum Caps and Day-Specific Task Schedules

Reference: Section 260.160

Comment: Establishing a fixed daily maximum creates unnecessary operational challenges that can negatively affect both clients and providers. For example, when a caregiver is unable to work a scheduled day due to an emergency, the client is often unable to make up those authorized service hours later in the week, resulting in a permanent loss of needed care.

Additionally, if an unexpected care need occurs just before the end of a scheduled shift, the caregiver may be unable to remain long enough to address the situation without exceeding the daily hour limit or creating uncompensated overtime liability for the provider. These restrictions reduce the flexibility necessary to respond to real-life caregiving situations and can leave clients without essential assistance.

Recommendation: Eliminate references to daily maximum hour limits and day-specific task requirements that limit providers' ability to deliver responsive, person-centered care. Compliance should instead be measured against the client's total monthly authorized hours, allowing providers to adjust schedules as needed while remaining within the overall authorized service allocation.

Response: The State appreciates your comment about this rule-making package. Please see previous response regarding billing integrity above.

Cody Garrison, Vice President

Arkansas Home Helpers

Comment: I respectfully submit this public comment encouraging the Arkansas Department of Human Services to explore the creation of a centralized repository for criminal background checks and required registry screenings for healthcare and long-term services and supports providers participating in Arkansas Medicaid. Healthcare providers throughout Arkansas are facing significant workforce shortages while simultaneously experiencing increasing costs associated with recruiting and onboarding qualified employees. One area where meaningful efficiencies could be achieved without compromising beneficiary safety is the background screening process. Currently, provider agencies are often required to obtain new criminal background checks and registry screenings—including Adult Maltreatment Registry and Child Maltreatment Registry checks—for applicants who may have recently completed identical screenings for another Arkansas healthcare employer. As a result, providers incur duplicate expenses, applicants experience unnecessary hiring delays, and valuable caregiver positions remain vacant while services go unfilled. A centralized, secure repository could address these challenges while preserving all existing safety standards. Under this model, DHS would maintain a secure system containing the results of required criminal background checks and registry clearances that have already been completed in accordance with Arkansas law. Before initiating a new background screening, an authorized provider could determine whether an applicant already has qualifying screenings on file that remain within the legally required timeframe. If the existing screenings satisfy all regulatory requirements, the provider could rely upon those results to meet hiring requirements. If the screenings have expired, are incomplete, or otherwise fail to meet applicable standards, the provider would simply obtain new background checks and registry screenings under current procedures. Florida provides a successful example of this concept. The Florida Agency for Health Care Administration (AHCA) administers the Care Provider Background Screening Clearinghouse, a secure statewide system that allows participating healthcare providers and state agencies to share qualifying Level 2 background screening results rather than requiring duplicate screenings each time an employee changes employers. The Clearinghouse also provides ongoing eligibility monitoring and notifications if an individual's eligibility status changes, helping providers remain compliant while reducing administrative burden. Since its implementation, Florida reports that the Clearinghouse has processed millions of screenings and has saved providers and taxpayers hundreds of millions of dollars by preventing unnecessary duplicate background checks. Arkansas could implement a similar system that incorporates criminal background checks, Adult Maltreatment Registry checks, Child Maltreatment Registry checks, and any other screenings required for employment by DHS. Such a repository would allow authorized providers to verify whether an applicant already has current, compliant screening results on file before ordering new screenings. This approach would provide several important benefits: Reduce unnecessary duplication of criminal background and registry screenings. Lower hiring costs for Medicaid providers and other healthcare employers. Shorten onboarding timelines, allowing qualified caregivers to begin serving beneficiaries more quickly. Improve workforce mobility by eliminating repetitive administrative requirements when employees move between qualified healthcare employers. Increase access to care by helping providers fill critical direct care positions more efficiently. Maintain existing beneficiary protections by requiring providers to obtain new screenings whenever current results no longer satisfy

state or federal requirements. Reduce administrative workload for both providers and state agencies by centralizing verification and documentation. Importantly, this proposal does not reduce screening requirements or weaken protections for vulnerable Arkansans. Instead, it allows providers to utilize existing, valid screening results that have already been completed and verified under Arkansas law, avoiding unnecessary duplication while preserving all current eligibility standards. As Arkansas continues to address healthcare workforce shortages, innovative administrative solutions such as a centralized background screening repository can help reduce costs, improve efficiency, and expand access to care without compromising quality or patient safety. I respectfully encourage the Arkansas Department of Human Services to convene providers, state agencies, and other stakeholders to evaluate the feasibility of developing an Arkansas Care Provider Background Screening Repository modeled after successful programs implemented in other states, including Florida. Such a system would modernize Arkansas's hiring process, improve workforce mobility, reduce unnecessary expenditures, and help ensure that Medicaid beneficiaries receive timely access to the care they need. Thank you for your consideration of this recommendation and for your continued efforts to strengthen Arkansas's healthcare workforce and improve access to quality care throughout the state.

Response: The State appreciates your comments about this rule-making package. We are unable to address such a large scale overhaul of the background check system at this time but we will keep it under consideration going forward.

Cody Garrison, Vice President

Arkansas Home Helpers

Comment: Public Comment Regarding Proposed Changes to the Arkansas Personal Care Provider Manual

To Whom It May Concern,

I respectfully submit this public comment in opposition to the proposed revision to the Arkansas Personal Care Provider Manual that would require a current Personal Care provider agency to provide its internally developed nursing assessment and careplan to a newly selected provider agency upon transfer of services.

While I fully support policies that promote continuity of care and protect beneficiaries during provider transitions, this proposed requirement is not the appropriate mechanism to achieve those goals.

The nursing assessment and individualized care plan developed by a provider agency are professional work products created by that agency's licensed nurse based on his or her own independent clinical judgment, observations, assessment findings, and professional recommendations. These documents are not simply administrative records; they represent the licensed nurse's clinical evaluation and professional responsibility for the care provided.

Requiring one provider agency to transfer its proprietary nursing assessment and care plan to another provider creates several significant concerns.

First, it undermines the professional responsibility of the receiving provider's licensed nurse. Every provider agency is responsible for independently assessing a beneficiary before initiating services. A new provider should perform its own nursing assessment and develop its own individualized care plan based upon its own clinical findings. This ensures the nurse assumes professional accountability for the careplan being implemented and confirms that the plan accurately reflects the beneficiary's current condition and needs.

Second, the proposed requirement raises liability concerns.

If a receiving provider relies upon another agency's assessment and care plan rather than conducting its own comprehensive evaluation, it becomes unclear which provider bears responsibility should the assessment be incomplete, outdated, or no longer reflective of the beneficiary's condition. Independent assessments protect both beneficiaries and providers by ensuring accountability remains clear.

Third, these assessments represent significant investments by provider agencies.

Provider agencies employ licensed nurses, invest in training, quality assurance, documentation systems, and clinical oversight to develop comprehensive nursing assessments and individualized care plans. Requiring agencies to provide these proprietary clinical work products to competitors without compensation creates an inequitable business requirement that extends beyond what is necessary to facilitate a safe transition of care.

Fourth, continuity of care can be achieved without transferring proprietary clinical documents.

The beneficiary's authorized service plan, physician orders when applicable, medication information, emergency contacts, schedules, and other records necessary for uninterrupted service can all be transferred without requiring one provider to surrender its independently developed nursing assessment and care plan. The receiving provider can then complete its own nursing assessment promptly upon admission while maintaining continuity of services.

Arkansas Medicaid has long recognized the importance of provider accountability and independent clinical judgment. This proposed requirement shifts responsibility away from the receiving provider's obligation to perform its own assessment and instead encourages reliance upon another organization's clinical work product.

A better approach would be to require the receiving provider to complete its own nursing assessment and individualized care plan within a specified timeframe following admission, while requiring the transferring provider to cooperate in the transfer of essential service information necessary to prevent any interruption in care.

This approach preserves continuity of care, protects beneficiaries, maintains professional nursing standards, clearly establishes provider accountability, and respects the intellectual and professional work product developed by each licensed provider agency.

For these reasons, I respectfully urge the Arkansas Department of Human Services to remove this proposed requirement from the Personal Care Provider Manual and instead adopt language that supports timely independent nursing assessments by the receiving

provider while ensuring appropriate transfer of essential beneficiary information necessary for uninterrupted services.

Thank you for your consideration of these comments and for your continued commitment to providing high-quality personal care services to Arkansas Medicaid beneficiaries.

Response: The State appreciates your comments about this rule-making package. Please see previous response outlining that a provider is a custodian of a beneficiary's record, not the owner. The assessment is a medical/health record, which belongs to the patient/beneficiary and therefore should stay with the patient/beneficiary. Additionally, the new form is required moving forward so there is no proprietary interest.

MegAnne Townsend, Corporate Operations Manager

Townsend Healthcare

Comment: This memo presents public comments from a Provider of Care regarding the proposed changes to the State Plan Personal Care Program.

Before the specific comments are made, we would like to make some general comments to set the framework for the many revisions to the current plan. These general comments are summarized below:

- The overall goal of the revisions by the State should be to streamline and reduce, if possible, the regulations to allow the Providers to comply with the intent of the Personal Care Program (i.e. take care of the Clients ADL's to allow them to remain at home and not in institutions) but not become more burdensome and increase the cost of compliance to the Providers with unnecessary regulations which are, in effect, unfunded mandates.
- The proposed revisions consistently are written using phrases such as "treatment prescription", "treatment plan", "progress notes" and other medical terms and requirements that lend themselves to higher levels of care than Personal Care Companies are licensed to provide. Personal Care Companies can only provide unskilled services (ADLs) with primarily unskilled workers (i.e. CNA's, PCA's, etc.) These workers are not trained to assess or write progress notes, etc. No medical services can be provided under our license.
- The Federal Guidelines for Personal Care are more permissive than the Proposed State Plan regarding Personal Care Supervision and Transportation.

Section II-STATE PLAN PERSONAL CARE CONTENTS

200.000 GENERAL INFORMATION

200.100 Participation Requirements for State Plan Personal Care Providers 9-1-26

B. Each employee must successfully pass the following:

1. A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann.§ 20-38-103;

2. An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;

3. An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years.

4. An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and

Comment Summery Response:

- Background and Registry Checks cost $22.00 State / $13.00 FBI for federal checks. (Federal Background will have a price increase 10/26 amount unknown.)
- Adult and Child Maltreatments Database search cost $20.00 with $2.00 processing fee to check DHS Registry.
- Medicaid Provider Enrollment is provided by Gainwell Technologies who also completes background checks to determine whether a Provider Identification Number (PIN) number is issued to a Practitioner.
- This process should be streamlined since Gainwell Technologies already does background checks. There is no need for the Personal Care Providers to duplicate this process.
- The above also includes the Arkansas Sex Offender Central Registry which should be done for both Aides as well as Clients.

Request: Gainwell Technologies should be the one stop for all background checks to assure compliance with the regulations. The Maltreatment Database search Fees were established to cover research, printing and mailing of reports. No fee should be charged for checking DHS internal databases.

210.000 DOCUMENTATION REQUIREMENTS

210.200 State Plan Personal Care Provider Documentation Requirements 9-1-26

e. All treatment plans;

Comment Summery Response:

- Use of “All Treatment plans” and would assume Personal Care is a Skilled Medical Service by a Credentialed Provider which it is not. It is a Non-Medical Unskilled Service by an Uncredentialed Provider (Personal Care Aide)

Request: To Utilize Non-Medical language in place of Skilled Medical Language in the Rules for Personal Care.

210.000 DOCUMENTATION REQUIREMENTS

210.200 State Plan Personal Care Provider Documentation Requirements 9-1-26

2. Treatment plan service log documentation, which must be completed at the time-of service delivery and at a minimum include:

iii. If the personal care aide discontinues or interrupts the beneficiary's service-plan-required activities at one location to begin service-plan required activities at another location, the aide must record the beginning and ending times of service at each location.

e. Any service performance difficulties;

f. Notes on the beneficiary's condition or other data or criteria required by the treatment plan;

h. Name(s), credential(s), and signature(s) of the personal care aide who performed the service; and

3. Weekly or more frequent progress notes outlining the condition of the beneficiary;

Comment Summery Response:

- Authenticare will not adequately provide the capabilities to implement these changes.
- Authenticare does not include the beneficiary's DOB in the Aide Service log or Worker Activity Report
- Providing both Medicaid ID and DOB to the Personal Care Aide could impact HIPAA.
- Authenticare cannot cumulatively add a day's clock in and out times. Each clock in and out is identified as an individual claim. MMIS will reject the duplication of more than 1 claim per day. To process this claim would take additional work and expense to process by splitting and manually adjusting the split shift.
- Any service performance difficulties the aide would be documenting would be related to the tasks that they themselves performed: Cooking, Housekeeping, Shopping, etc.
- Notes on the beneficiary's condition or treatment plan for are beyond the scope of practice of the uncredentialed PCA whose tasks are for nonmedical tasks only.
- Name, credential (s) and signature of the personal care aide who performed the service is not a feature of the State's Authenticare EVV system as the aide is non credentialed.
- Weekly or more frequent progress notes outlining the condition of the beneficiary are beyond the scope of practice for a PCA. They are to assist with unskilled, non-medical tasks and are unqualified to determine treatment progress of a Beneficiary.

- The listed ADL on both the Authenticare App and the care plan is either completed or not completed by the checked box on the app. i.e.: Personal Grooming, Bathing, Meal Preparation, Toileting, Housekeeping, Ambulation, Medication, Shopping, Dressing/Undressing and Laundry. Any service delivery difficulty the aide would be documenting would be how well they completed the task of i.e. cooking and cleaning.

Request: Clarification on clocking in and out for a location change to shopping and doctor appointments.

Personal Care Aides should not make Treatment Plan progress notes on a Beneficiary as that is beyond scope of practice.

Authenticare is not compatible with the added requirements.

235.300 Personal Care Services

E. The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered:

1. The qualified supervisor must complete the following at least monthly:

2. A supervising registered nurse must conduct an on-site evaluation of a day's service delivery to a beneficiary as required in the treatment plan, but no less often than annually. On each on-site evaluation, the supervising registered nurse must:

a. Observe and document.

iii. The interaction and relationship between the beneficiary and the personal care aide; and

Comment Summery Response:

- Referencing the CMS document "Preventing Medicaid Improper Payments for Personal Care Services: "Approved supervising entities may include nurses (both Registered Nurses and Licensed Practical Nurses), PCS agency staff, case managers, other agency staff deemed qualified, and in some cases the beneficiary."

- A Registered Nurse to complete an on-site evaluation of a day's service delivery to a beneficiary of non-skilled activities such as meal preparation, housekeeping and laundry for 3-5 hours is an unfunded mandate. It is not defined as a Supervisory Visit.

- Registered Nurse must complete an updated Personal Care Function Assessment & Treatment Plan which is an unfunded mandatory requirement. Both Home Health and the Veterans Administration allow this to be a billable expense.

- The State of Arkansas should not create a more regulatory burden than the Federal Government. As can be seen from the above CMS document, the CMS language is clearly permissive language by saying "may" not "shall". It also refers to "other Personal Care

Provider staff who are deemed qualified." We believe that we should allow and define "other approved supervising entities" so that this person, versus a Registered Nurse, could perform these services. This would reduce costs to the Personal Care Provider while ensuring compliance with the regulation. The State of Arkansas already has a Registered Nurse Shortage; this would add to that problem without any measurable benefit as we do not need supervision of skilled care.

Request: Change a supervising registered nurse to a qualified supervisor and remove a day's service delivery to be on-site evaluation only, without a time constraint.

260.170 Unit Billing Restrictions

E. Daily Service Limits

Comment Summery Response:

- Per the Office of the Inspector General: "Personal care services (PCS) is a Medicaid benefit for the elderly, people with disabilities, and people with chronic or temporary conditions. It assists them with activities of daily living and helps them remain in their homes and communities. Examples of PCS include bathing, dressing, light housework, money management, meal preparation, and transportation. "
- This service is a benefit for the recipient. Regulating a strict daily bathing, dressing schedule is not real world.
- Personal Care Services are a care plan not a medical treatment plan that can be measured by progress notes. Tasks cannot be forced on a beneficiary.

Request: Keep the current standards of 64 hours per month with a 3 x week minimum frequency service visit.

Response: The State appreciates your comments about this rule-making package.

200.100 Background checks: Please see previous response above on this topic.

210.000 – 210.200 Documentation Requirements "Treatment plans": The term "Treatment plan" is used consistently with all state plan services. It is used here to create cohesion across services.

210.200 Documentation Requirements: Please see previous response above on this topic.

235.300 Personal Care Services: Thank you for your comment. There has been no change to the time expectations of the on-site evaluation.

260.170 Unit Billing Restrictions: Please see previous response above on this topic.

Rianna Rowland, Director of HR & Compliance

Superior Senior Care

Comment: We appreciate the opportunity to provide comments to the recent proposed regulation changes. Please see our comments below:

200.100 Participation Requirements for State Plan Personal Care Providers 9-1-26

B. Each employee must successfully pass the following:

2. An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;

3. An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;

SSC Response:

Mandating maltreatment checks every two years instead of every five years places a significant administrative and financial burden on both caregivers and providers. It is unclear why these registries cannot be made available at no cost to authorized providers, similar to the Arkansas Sex Offender Registry, the Caregiver Employment Clearance Registry, the DHS Excluded Provider List, and the OIG Excluded Provider List.

While provider reimbursement rates remain stagnant, the costs associated with required background screenings continue to rise. In an industry already facing a nationwide caregiver shortage, increasing the frequency and cost of these required checks creates an unnecessary barrier to caregiver recruitment and retention, ultimately reducing access to care for Arkansas' most vulnerable populations.

We respectfully request that the current five-year renewal requirement remain unless and until a cost-effective means of accessing the Registries are made available to providers.

Response: The State appreciates your comments about this rule-making package. Please see the previous response above on this topic.

Cathy Robertson

Public hearing held remotely 06/17/26 @ 9:00 AM CST

Comment: The new manual in Section 210.200 does not include the exclusion for the qualification for aides for prior work experience. I would like to see that put back in, because asking an aide to go through a 40-hour course when they move from one agency to another or if they are working for two agencies concurrently would be a burden. The second comment I have is Section 260.160, paragraph B specifically says that we must bill in a 15-minute increment, which means 0 to 15 minutes would be one unit and section 260.190 explains how to round. I would like a clarification on which is correct. Is it 0 to 15 is 1 unit, or is it 8 to 22, like it is today? That's all I have.

Response: The State appreciates your comments about this rule-making package. The manual language does reflect the requirements of the Arkansas Department of Health as they are the sole agency certifying personal care aides.

Billing is still done in 15-minute increments. If a unit of service (equal to 15 minutes) is billed, a minimum of eight minutes must be provided.