NOTICE OF RULE MAKING

Arkansas Department of Human Services

Pursuant to 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., the Director of the Division of Medical Services of the Department of Human Services is proposing to create a new medical assistance rule, known as the "Arkansas Medicaid Task and Hour Standards," and to amend the following medical assistance rules: "ARChoices in Homecare § 1915(c) Home and Community-Based Services Waiver" and the "ARChoices in Homecare Home and Community-Based Services (HCBS) Waiver Manual" (also known and referred to collectively as ARChoices); the "Living Choices Assisted Living § 1915(c) Home and Community-Based Services Waiver" and the "Living Choices Assisted Living Manual" (also known and referred to collectively as Living Choices); "Supplement 4 to Attachment 3.1-A of the Medicaid State Plan Under Title XIX of the Social Security Act" (a State Plan Amendment) and the "IndependentChoices Manual" (also known and collectively referred to as "IndependentChoices" or "Self-Directed Personal Assistance Services"); "Page 10aa of Attachment 3.1-A of the Medicaid State Plan Under Title XIX of the Social Security Act" (a State Plan Amendment) and the "Personal Care Manual" (also known and collectively referred to as "Personal Care"); and the "Program of All-Inclusive Care for the Elderly (PACE) Manual" (also known and referred to as PACE). "§ 1915(c)" refers to section 1915(c) of the federal Social Security Act governing Medicaid HCBS waiver programs.

Effective January 1, 2019, the Department of Human Services (DHS) Division of Medical Services is proposing the following updates and changes to the rules governing the following five Arkansas Medicaid programs and services:

1. **ARChoices in Homecare § 1915(c) Home and Community-Based Services (HCBS) Waiver Program (ARChoices), with updates and changes made through amendments to the current federal HCBS waiver, amendments to the ARChoices Waiver Manual, and the new Arkansas Medicaid Task and Hour Standards;**

2. **Living Choices Assisted Living § 1915(c) HCBS Waiver Program (Living Choices) with updates and changes made through amendments to the current federal HCBS waiver, amendments to the Living Choices Assisted Living Manual, and the new Arkansas Medicaid Task and Hour Standards;**

3. **Medicaid Self-Directed Personal Assistance Services Program (IndependentChoices), as provided under § 1915(j) of the Social Security Act, with updates and changes made through a Medicaid State Plan Amendment, amendments to the IndependentChoices Manual, and the new Arkansas Medicaid Task and Hour Standards;**

4. **Medicaid Personal Care Services delivered under the Medicaid State Plan, with updates and changes made through a Medicaid State Plan Amendment, amendments to the Personal Care Manual, and the new Arkansas Medicaid Task and Hour Standards; and**

5. **Program of All-Inclusive Care for the Elderly (PACE), with updates and changes made through amendments to the PACE Manual.**

Proposed updates and changes effective on January 1, 2019 and affecting the five programs and services include, without limitation:

Administrative Changes:

- Terminology and division of administrative responsibilities for the programs are revised to reflect the separation of the units of the former DHS Division of Aging and Adult Services into the DHS Division of Aging, Adult, and Behavioral Health Services (DAABHS), the DHS Division of Provider Services and Quality Assurance (DSPQA), and the DHS Division of County Operations (DCO). ARChoices and Living Choices are amended to add DPSQA as a second operating agency. ARChoices is amended to transfer responsibility for determining financial eligibility to DCO. IndependentChoices is amended to designate DPSQA as the primary operating agency. PACE is amended to designate DAABHS as the primary operating agency.
- Assignments of responsibilities between DHS staff and DHS vendors are revised, and the processes followed by DHS staff and DHS vendors are revised.
- Transition language concerning the 2016 transition to ARChoices from ElderChoices and AAPD is repealed.
- For IndependentChoices, certain terms are renamed or rephrased, and the term "communications manager" is eliminated. Assignments of responsibilities between DHS staff and DHS vendor(s) are revised.

Changes in Eligibility Requirements and Limitations for ARChoices Waiver, Living Choices Waiver, and PACE:

- The Cognitive Performance Scale is eliminated as one of the three alternative tests for functional eligibility for ARChoices, Living Choices, and PACE, to be replaced with a requirement that an individual have a primary or secondary diagnosis of Alzheimer's disease or related dementia and be cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others.
- The Change in Health, End-Stage Disease and Signs and Symptoms (CHESS) is eliminated as one of the three alternative tests for functional eligibility for ARChoices, Living Choices, and PACE, to be replaced with a requirement that an individual have a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.
- The current ARChoices point-in-time cap, which limits the number of participants who may be enrolled in ARChoices at any one time, is revised to increase the point-in-time caps by year as follows: Calendar Year 2019, 9,071 participants maximum; and Calendar Year 2020, 9,434 participants maximum.
- Based on the changes to eligibility requirements, some individuals who would not be eligible for ARChoices, Living Choices, and PACE under the current rules may be eligible under the rules as amended; and some individuals who would be eligible under current rules may not be eligible under the rules as amended.

Independent Assessment Changes:

- DHS has selected an outside contractor ("DHS Independent Assessment Contractor") to perform independent assessments that gather functional need information using the Arkansas Independent Assessment (ARIA) instrument for each applicant and participant for ARChoices, Living Choices, IndependentChoices, Personal Care, and PACE.
- The independent assessments performed by the DHS Independent Assessment Contractor will replace the independent assessments currently performed by DHS registered nurses (RNs) using the ArPath assessment instrument for ARChoices, Living Choices, IndependentChoices, and PACE, as well as replace references to the MDS-HC assessment for IndependentChoices.

- For each individual assessed, the ARIA independent assessment instrument will generate a proposed level of care evaluation for the purposes of determining functional eligibility for ARChoices, Living Choices, Personal Care, and PACE. The level of care evaluation generated by ARIA will be reported as a "Tier Level" of Tier 0, 1, 2, or 3 to help further differentiate individuals by need. The DHS Office of Long Term Care (OLTC) will make the final level of care determination for ARChoices, Living Choices, and PACE after reviewing the ARIA assessment results. Individuals receiving a Tier 0 will be ineligible for Personal Care services.
- The results of the ARIA independent assessment and information gathered during the assessment will be used to develop the beneficiary's person-centered service plan for ARChoices or Living Choices; to allocate hours of service for attendant care, respite care, and personal care under ARChoices and IndependentChoices, through the use of the Arkansas Medicaid Task and Hour Standards; to calculate the amount of the Cash Expenditure Plan for IndependentChoices, through the use of the Arkansas Medicaid Task and Hour Standards; and to allocate hours of service and develop an individualized plan of care for Personal Care, through the use of the Arkansas Medicaid Task and Hour Standards.
- Based on the changes to the independent assessment, some individuals who would not be eligible for ARChoices, Living Choices, Personal Care, and PACE under the current rules may be eligible under the rules as amended; and some individuals who would be eligible under current rules may not be eligible under the rules as amended.
- Based on the changes to the independent assessment, ARChoices, IndependentChoices, and Personal Care beneficiaries may see an increase, decrease, or no change in the number of hours of attendant care and/or personal care assigned to them, and IndependentChoices beneficiaries may see an increase, decrease, or no change to the amounts of their respective Cash Expenditure Plans.

Allocation of Hours of Service for Attendant Care, Respite Care, and Personal Care:

- The Resource Utilization Groups (RUGs) methodology currently used to allocate attendant care hours for ARChoices is repealed.
- DHS is creating a new rule, known as the Arkansas Medicaid Task and Hour Standards (THS), to be the written methodology used by DHS and its staff and contractors as the basis for calculating the number of attendant care hours, personal care hours, and/or respite care hours that are reasonable and medically necessary to perform needed activities of daily living (ADLs) and instrumental activities of daily living (IADLs) tasks that are covered and reimbursable. The THS provides a standardized process for calculating the amount of reasonable, medically necessary services hours, with the minute ranges and frequencies, and adjustments for availability of other, non-Medicaid supports.
- The THS includes four components: a Needs Intensity score for each ADL and IADL task; the number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score; the frequency with which a task is necessary and reasonably performed; and the amount of assistance with ADLs and IADLs provided by other sources.
- The number of service hours/minutes that are determined medically necessary and authorized for each necessary task by week/month are calculated consistent with the THS grid and based on responses by the participant and their representatives to certain relevant questions in the ARIA assessment instrument, and as appropriate, other information obtained from the participant and participants' representatives or from a participant's physician.
- The THS establishes minute ranges for each task consistent with the Needs Intensity score, allowing DHS staff or contractors to select a number of minutes within that range for each task. Deviations from the minute ranges are permitted with written justification and written supervisory approval.

- ARChoices and Personal Care are revised to use the THS to calculate the number of attendant care, respite care, and/or personal care hours that may be allocated to a beneficiary in the person-centered service plan or individualized plan of care. IndependentChoices is revised to use the THS to calculate the reasonable quantity of hours to perform medically necessary tasks covered under self-directed personal assistance, which in turn determines the amount of the beneficiary's Cash Expenditure Plan.
- Personal Care services will be based on an individualized plan of care that is developed based on the ARIA independent assessment results, information submitted by the personal care provider, and the THS. Personal Care services are to be individually designed to assist with a beneficiary's assessed physical dependency needs related to certain routine activities of daily living and instrumental activities of daily living.
- Personal Care services for all beneficiaries age 21 and older will be strictly limited to 64 hours per month. Although current rules permit extensions of benefits to allow more than 64 hours per month, these provisions are repealed.
- Based on the changes to the allocation of hours of service for attendant care, respite care, and personal care, ARChoices, IndependentChoices, and Personal Care beneficiaries may see an increase, decrease, or no change in the number of hours of attendant care, respite care, and/or personal care assigned to them, and IndependentChoices beneficiaries may see an increase, decrease, or no change to the amounts of their respective Cash Expenditure Plans.

Individual Services Budgets in ARChoices:

- ARChoices is revised to implement an Individual Services Budget (ISB) that is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. The projected total cost of all authorized waiver services in a person-centered service plan may not exceed the ISB amount for that participant. With one exception noted below, the ISB will limit the availability of all services received under the waiver, including without limitation attendant care, respite care, and personal care services, whether received through agency care or through self-direction under IndependentChoices. The ISB will not limit the availability of non-waiver Medicaid state plan services. The ISB will not apply to environmental accessibility adaptations/adaptive equipment.
- If a participant's ISB limits or requires changes to the services that could otherwise be authorized for the participant, a DHS registered nurse (RN) will work with the participant to choose a different mix, type, or amount of covered waiver services. If the DHS RN determines that the waiver services available within the limit of the ISB are insufficient to meet the participant's needs, the DHS RN will counsel the participant on Medicaid-covered services in other settings that may be available to meet their needs.
- Participants may request exceptions to the ISB in certain situations. Exception requests will be reviewed and acted upon by a panel of nurses chosen by DAABHS.
- The ISB limit will apply to a new participant with their first person-centered service plan and thereafter. The ISB limit will apply to an existing participant on the earlier of when their waiver eligibility is re-determined; their level of care is reaffirmed or revised; a new independent assessment or re-assessment is performed; their person-centered service plan expires or renews or is extended or revised; or they are admitted to or discharged from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or are transferred from a hospice facility. In any other case, the ISB will apply 60 days after the effective date of these rules changes.
- The ISB is based on a participant's ISB Level, as determined by DAABHS from a review of the participant's Independent Assessment. The three ISB Levels and the corresponding ISB amounts are:

- Intensive: The participant requires total dependence or extensive assistance from another person in all three areas of mobility, feeding, and toileting. The ISB for a participant with an assessed ISB Level of Intensive is $30,000 annually.
- Intermediate: The participant requires total dependence or extensive assistance from another person in two of the areas of mobility, feeding, or toileting. The ISB for a participant with an assessed ISB Level of Intermediate is $20,000 annually.
- Preventative: The participant meets the functional need eligibility requirements for ARChoices in Section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate. The ISB for a participant with an assessed ISB Level of Preventative is $5,000 annually.

- For a participant with total waiver expenditures of more than $30,000 in calendar year 2018, the participant will be granted a Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures in calendar year 2018. In the year following the Transitional Allowance, the participant's maximum Individual Services Budget will be 95% of the participant's total waiver expenditures in calendar year 2019. For each participant, DHS will calculate the participant's "total waiver expenditure" for purposes of the Transitional Allowance on an annualized basis, excluding expenditures for environmental accessibility adaptations/adaptive equipment.

Limits, Restrictions, and Exclusions on Services:

- ARChoices is revised to provide that if the self-directed delivery model is chosen by an individual other than the beneficiary, that individual may not be the paid employee.
- ARChoices is revised to require that a person-centered service plan may not include attendant care hours unless the plan provides for at least 64 hours per month of personal care services. Attendant care services are intended to supplement personal care services available under the Medicaid state plan.
- ARChoices is revised to redefine when certain waiver services may be provided to a participant by a relative, and to prohibit the provision of certain waiver services by an individual who lives with the participant or has a business partnership or financial or fiduciary relationship with the beneficiary, or by certain providers employing such an individual.
- ARChoices and IndependentChoices are amended to exclude certain services from coverage and reimbursement, including without limitation certain medical or licensed services; services provided for someone other than the participant; companionship, socialization, entertainment, and recreational services or activities; housecleaning for home areas shared with a person physically able to perform housekeeping of those areas; habilitation services; and services received or available on a comparable or substitute basis from other sources.
- ARChoices is amended to clarify that attendant care and personal care services require prior authorization, while other services provided under an authorized person-centered service plan do not require separate prior authorization.
- IndependentChoices is amended to redefine the purpose and permissible uses of the Cash Allowance, and to establish and itemize which goods and services are excluded from coverage and reimbursement under the program. It is also amended to eliminate references to extensions of benefits for personal care services.
- Tasks performed as part of Personal Care services, including without limitation assistance with medication, will be subject to Arkansas State Board of Nursing Position Statement 97-2.
- Personal Care services for all beneficiaries age 21 and older will be strictly limited to 64 hours per month. Although current rules permit extensions of benefits to allow more than 64 hours per month, these provisions are repealed.
- When Personal Care services are delivered through a home health agency or private care agency, the person providing the direct care who works for the agency may not reside (permanently,

seasonally, or occasionally) in the same premises as the beneficiary; may not have a business, financial, or fiduciary relationship of any kind with the beneficiary or the beneficiary's legal representative; and may not be related to the beneficiary by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

- Personal Care services may include employment-related personal care associated with transportation.
- Current language setting an eight-hour limit on shopping for personal care items and transportation to stores to shop for personal care items is repealed.
- The Personal Care Manual is revised to establish certain conditions of coverage and reimbursement. The conditions include without limitation that the personal care services must be reasonable and medically necessary, supported by the individual's latest nursing evaluation, and consistent with the individual's service plan; the services must be expressly authorized in an approved prior authorization; the services must not be available from another source; the services may not be in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services; the services must be provided by qualified, Medicaid-enrolled, DPSQA-certified providers; and must be provided in compliance with all applicable Arkansas Medicaid program regulations and provider manuals, and with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.
- The Personal Care Manual is revised to impose certain exclusions from coverage and reimbursement. These exclusions include without limitation certain medical or licensed services; services provided for someone other than the participant; companionship, socialization, entertainment, and recreational services or activities; habilitation services; and mental health counseling or services.
- The length of Personal Care prior authorizations is extended from six months to one year but may be modified if the beneficiary has a change of condition.
- Based on the use of the ISB and/or the changes to limits and restrictions on services, ARChoices, Living Choices, IndependentChoices, and Personal Care beneficiaries may see an increase, decrease, or no change in the services or funds available to them or included on their person-centered service plan, cash expenditure plan, or individualized plan of care.

Availability and Definitions of Services:

- The Adult Family Homes service in ARChoices is eliminated. Any beneficiary currently receiving this service will be unable to receive this service after January 1, 2019.
- A new service, Prevocational Services, is added to ARChoices for participants with physical disabilities.
- The definition of Attendant Care services in ARChoices is amended to eliminate three tasks: "Managing Finances," "Communication," and "Traveling." The definition is also amended to define "health-related tasks" and to modify and clarify the definitions of the following tasks: "personal hygiene," "mobility/ambulating," "meal planning," "laundry," "shopping," and "housekeeping." The definition is amended to specify circumstances under which Attendant Care services are not covered or reimbursable.
- The definitions and requirements for "Respite Care" are revised to clarify and limit when respite care is covered and reimbursed.
- The Personal Care service definitions and restrictions for "Consuming Meals" are revised to include the intake of fluids and to exclude meal preparation.
- The Personal Care service definitions and restrictions for "Personal Hygiene" are clarified to mean grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene.

- The Personal Care service definitions and restrictions for "Mobility and Ambulation" are clarified to mean functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive equipment.
- The Personal Care service definitions and restrictions for "Incidental Housekeeping" are clarified to refer only to areas that are directly used by the beneficiary.
- The Personal Care service definitions and restrictions for "Shopping" are clarified to include items necessary for the beneficiary's health.

Service and Provider Requirements and Limitations:

- Providers under ARChoices, IndependentChoices, and Personal Care will be required to undergo state and national, fingerprint-based criminal background checks and central registry checks and repeat those checks on a regular basis consistent with state law.
- Provider certification requirements for ARChoices are amended to require all providers to recertify annually.
- ARChoices is amended to clarify when an environmental accessibility adaptation/adaptive equipment provider is required to submit a plumbing or electrical license with a bid, and to require bids to specify what work, if any, requires such a license.
- Providers of frozen home-delivered meals under ARChoices must contact each client daily, Monday through Friday, in person or by phone, to ensure the individual's safety and well-being, unless the client receives attendant care or personal care services more than three times per week, or the client receives only weekend meals.
- DHS will require providers of Attendant Care Services, Respite Care, and Home-Delivered Meals under ARChoices to participate in Electronic Visit Verification (EVV), consistent with new federal requirements.
- For Living Choices, DPSQA will be authorized to temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers, consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the approval of the federal Centers for Medicare and Medicaid Services (CMS). All Living Choices providers will be required to be certified by DPSQA.
- Living Choices providers will be required to immediately report to DHS any changes in a beneficiary's condition, rather than the current requirement of quarterly monitoring. The quarterly monitoring requirements are eliminated.
- For IndependentChoices, backup caregivers will now be required to enroll as caregivers with DPSQA.
- For Personal Care, current language permitting Level II Assisted Living Facilities (Level II ALFs) and Division of Developmental Disabilities Services Community Providers to enroll as personal care providers and to provide personal care services is repealed.
- All Personal Care providers will be required to be certified by DPSQA.
- Form/documentation requirements for Personal Care individualized service plans, requests submitted by providers, and service logs are clarified and revised. Service plan revisions will be required to be submitted as amended prior authorization requests.
- Reimbursement provisions and methodologies for residential care facilities (RCF) and assisted living facilities (ALF) are revised to use the term "Payment Level" in place of the term "Level of Care," and to incorporate the THS into the determination of the Payment Level.
- PACE is clarified to make explicit that failure to submit a PACE provider application to DAABHS at the same time or prior to submitting the application to CMS shall constitute grounds for DAABHS denying or delaying approval of the application.

Payment Changes:

- For ARChoices, the unit of service for Personal Emergency Response System (PERS) is changed from 1 day to 1 month, with a limit of 12 units per year.
- For Living Choices, the existing four-tier payment structure for assisted living facilities is eliminated and replaced with a single, statewide daily rate for all beneficiaries.

Taken together, all of the proposed changes outlined above will impact beneficiaries. Individual beneficiaries may see an increase or reduction in the amount, level, duration, frequency, type, and mix of services available to them, or their services may remain the same. Initial or continued eligibility for or enrollment in the ARChoices or Living Choices waiver programs or PACE, or eligibility for coverage of Personal Care Services or IndependentChoices services may be positively or adversely affected in individual cases.

Taken together, all of the proposed changes outlined above will also impact the providers of services, including, without limitation, provider operations, finances, billing practices, staffing, and compliance.

The ARChoices Waiver Amendment, Living Choices Waiver Amendment, Personal Care State Plan Amendment, and IndependentChoices State Plan Amendment are further subject to review and approval by the federal Centers for Medicare and Medicaid Services (CMS).

DHS estimates that the proposed changes outlined above are expected to result in a net decrease in aggregate Medicaid expenditures of $9.27 million in State Fiscal Year 2019 and $13.92 million in State Fiscal Year 2020.

The rules will be effective January 1, 2019.

Public hearings will be held on these changes on the following dates, times, and locations:
- Monday, October 15, 2018, 5pm, Arkansas College of Osteopathic Medicine, 7000 Chad Colley Blvd, Fort Smith, AR;
- Thursday, October 18, 2018, 5pm, Drew Memorial Hospital Conf. A., 778 Scoggin Dr., Monticello, AR;
- Thursday, October 22, 2018, 5pm, UA Hope Hempstead Hall, 2500 South Main St., Hope, AR;
- Tuesday, October 29, 2018, 5pm, Arkansas Enterprises for the Developmentally Disabled, 105 E Roosevelt Rd., Little Rock, AR; and
- Wednesday, November 7, 2018, 5pm, St. Bernard's Medical Center Auditorium, 225 E. Jackson Ave., Jonesboro, AR.

The proposed rules are available for review and inspection as follows: (1) at the DHS Division of Medical Services, Office of Policy Coordination and Promulgation, 2nd Floor, Donaghey Plaza South Building, 700 Main Street, P.O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437; (2) on the Arkansas Medicaid website (https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx), which may be downloaded from the "Proposed Rules for Public Comment" section of the website's general menu; and (3) in a different format (such as large print) by contacting DHS at (501) 320-6429.

All comments must be submitted in writing to the DHS Office of Policy Coordination and Promulgation, at the above address, or by email to becky.murphy@dhs.arkansas.gov, and received by DHS no later than close of business on November 7, 2018.

The Department of Human Services' Office of Legislative and Intergovernmental Affairs is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to age, religion, disability, political affiliation, veteran status, sex, race, color, or national origin.

Director of DHS Division of Medical Services

SUMMARY

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- The independent assessments performed by the DHS Independent Assessment Contractor will replace the independent assessments currently performed by DHS registered nurses (RNs) using the ArPath assessment instrument for ARChoices, Living Choices, IndependentChoices, and PACE, as well as replace references to the MDS-HC assessment for IndependentChoices.
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- The results of the ARIA independent assessment and information gathered during the assessment will be used to develop the beneficiary's person-centered service plan for ARChoices or Living Choices; to allocate hours of service for attendant care, respite care, and personal care under ARChoices and IndependentChoices, through the use of the Arkansas Medicaid Task and Hour Standards; to calculate the amount of the Cash Expenditure Plan for IndependentChoices, through the use of the Arkansas Medicaid Task and Hour Standards; and to allocate hours of service and develop an individualized plan of care for Personal Care, through the use of the Arkansas Medicaid Task and Hour Standards.
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Allocation of Hours of Service for Attendant Care, Respite Care, and Personal Care:

- The Resource Utilization Groups (RUGs) methodology currently used to allocate attendant care hours for ARChoices is repealed.
- DHS is creating a new rule, known as the Arkansas Medicaid Task and Hour Standards (THS), to be the written methodology used by DHS and its staff and contractors as the basis for calculating the number of attendant care hours, personal care hours, and/or respite care hours that are reasonable and medically necessary to perform needed activities of daily living (ADLs) and instrumental activities of daily living (IADLs) tasks that are covered and reimbursable. The THS provides a standardized process for calculating the amount of reasonable, medically necessary services hours, with the minute ranges and frequencies, and adjustments for availability of other, non-Medicaid supports.
- The THS includes four components: a Needs Intensity score for each ADL and IADL task; the number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score; the frequency with which a task is necessary and reasonably performed; and the amount of assistance with ADLs and IADLs provided by other sources.
- The number of service hours/minutes that are determined medically necessary and authorized for each necessary task by week/month are calculated consistent with the THS grid and based on responses by the participant and their representatives to certain relevant questions in the ARIA assessment instrument, and as appropriate, other information obtained from the participant and participants' representatives or from a participant's physician.
- The THS establishes minute ranges for each task consistent with the Needs Intensity score, allowing DHS staff or contractors to select a number of minutes within that range for each task. Deviations from the minute ranges are permitted with written justification and written supervisory approval.
- ARChoices and Personal Care are revised to use the THS to calculate the number of attendant care, respite care, and/or personal care hours that may be allocated to a beneficiary in the

person-centered service plan or individualized plan of care. IndependentChoices is revised to use the THS to calculate the reasonable quantity of hours to perform medically necessary tasks covered under self-directed personal assistance, which in turn determines the amount of the beneficiary's Cash Expenditure Plan.

- Personal Care services will be based on an individualized plan of care that is developed based on the ARIA independent assessment results, information submitted by the personal care provider, and the THS. Personal Care services are to be individually designed to assist with a beneficiary's assessed physical dependency needs related to certain routine activities of daily living and instrumental activities of daily living.
- Personal Care services for all beneficiaries age 21 and older will be strictly limited to 64 hours per month. Although current rules permit extensions of benefits to allow more than 64 hours per month, these provisions are repealed.
- Based on the changes to the allocation of hours of service for attendant care, respite care, and personal care, ARChoices, IndependentChoices, and Personal Care beneficiaries may see an increase, decrease, or no change in the number of hours of attendant care, respite care, and/or personal care assigned to them, and IndependentChoices beneficiaries may see an increase, decrease, or no change to the amounts of their respective Cash Expenditure Plans.

Individual Services Budgets in ARChoices:

- ARChoices is revised to implement an Individual Services Budget (ISB) that is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. The projected total cost of all authorized waiver services in a person-centered service plan may not exceed the ISB amount for that participant. With one exception noted below, the ISB will limit the availability of all services received under the waiver, including without limitation attendant care, respite care, and personal care services, whether received through agency care or through self-direction under IndependentChoices. The ISB will not limit the availability of non-waiver Medicaid state plan services. The ISB will not apply to environmental accessibility adaptations/adaptive equipment.
- If a participant's ISB limits or requires changes to the services that could otherwise be authorized for the participant, a DHS registered nurse (RN) will work with the participant to choose a different mix, type, or amount of covered waiver services. If the DHS RN determines that the waiver services available within the limit of the ISB are insufficient to meet the participant's needs, the DHS RN will counsel the participant on Medicaid-covered services in other settings that may be available to meet their needs.
- Participants may request exceptions to the ISB in certain situations. Exception requests will be reviewed and acted upon by a panel of nurses chosen by DAABHS.
- The ISB limit will apply to a new participant with their first person-centered service plan and thereafter. The ISB limit will apply to an existing participant on the earlier of when their waiver eligibility is re-determined; their level of care is reaffirmed or revised; a new independent assessment or re-assessment is performed; their person-centered service plan expires or renews or is extended or revised; or they are admitted to or discharged from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or are transferred from a hospice facility. In any other case, the ISB will apply 60 days after the effective date of these rules changes.
- The ISB is based on a participant's ISB Level, as determined by DAABHS from a review of the participant's Independent Assessment. The three ISB Levels and the corresponding ISB amounts are:
    - Intensive: The participant requires total dependence or extensive assistance from another person in all three areas of mobility, feeding, and toileting. The ISB for a participant with an assessed ISB Level of Intensive is $30,000 annually.

- Intermediate: The participant requires total dependence or extensive assistance from another person in two of the areas of mobility, feeding, or toileting. The ISB for a participant with an assessed ISB Level of Intermediate is $20,000 annually.
- Preventative: The participant meets the functional need eligibility requirements for ARChoices in Section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate. The ISB for a participant with an assessed ISB Level of Preventative is $5,000 annually.

- For a participant with total waiver expenditures of more than $30,000 in calendar year 2018, the participant will be granted a Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures in calendar year 2018. In the year following the Transitional Allowance, the participant's maximum Individual Services Budget will be 95% of the participant's total waiver expenditures in calendar year 2019. For each participant, DHS will calculate the participant's "total waiver expenditure" for purposes of the Transitional Allowance on an annualized basis, excluding expenditures for environmental accessibility adaptations/adaptive equipment.

Limits, Restrictions, and Exclusions on Services:

- ARChoices is revised to provide that if the self-directed delivery model is chosen by an individual other than the beneficiary, that individual may not be the paid employee.
- ARChoices is revised to require that a person-centered service plan may not include attendant care hours unless the plan provides for at least 64 hours per month of personal care services. Attendant care services are intended to supplement personal care services available under the Medicaid state plan.
- ARChoices is revised to redefine when certain waiver services may be provided to a participant by a relative, and to prohibit the provision of certain waiver services by an individual who lives with the participant or has a business partnership or financial or fiduciary relationship with the beneficiary, or by certain providers employing such an individual.
- ARChoices and IndependentChoices are amended to exclude certain services from coverage and reimbursement, including without limitation certain medical or licensed services; services provided for someone other than the participant; companionship, socialization, entertainment, and recreational services or activities; housecleaning for home areas shared with a person physically able to perform housekeeping of those areas; habilitation services; and services received or available on a comparable or substitute basis from other sources.
- ARChoices is amended to clarify that attendant care and personal care services require prior authorization, while other services provided under an authorized person-centered service plan do not require separate prior authorization.
- IndependentChoices is amended to redefine the purpose and permissible uses of the Cash Allowance, and to establish and itemize which goods and services are excluded from coverage and reimbursement under the program. It is also amended to eliminate references to extensions of benefits for personal care services.
- Tasks performed as part of Personal Care services, including without limitation assistance with medication, will be subject to Arkansas State Board of Nursing Position Statement 97-2.
- Personal Care services for all beneficiaries age 21 and older will be strictly limited to 64 hours per month. Although current rules permit extensions of benefits to allow more than 64 hours per month, these provisions are repealed.
- When Personal Care services are delivered through a home health agency or private care agency, the person providing the direct care who works for the agency may not reside (permanently, seasonally, or occasionally) in the same premises as the beneficiary; may not have a business, financial, or fiduciary relationship of any kind with the beneficiary or the beneficiary's legal

representative; and may not be related to the beneficiary by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

- Personal Care services may include employment-related personal care associated with transportation.
- Current language setting an eight-hour limit on shopping for personal care items and transportation to stores to shop for personal care items is repealed.
- The Personal Care Manual is revised to establish certain conditions of coverage and reimbursement. The conditions include without limitation that the personal care services must be reasonable and medically necessary, supported by the individual's latest nursing evaluation, and consistent with the individual's service plan; the services must be expressly authorized in an approved prior authorization; the services must not be available from another source; the services may not be in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services; the services must be provided by qualified, Medicaid-enrolled, DPSQA-certified providers; and must be provided in compliance with all applicable Arkansas Medicaid program regulations and provider manuals, and with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.
- The Personal Care Manual is revised to impose certain exclusions from coverage and reimbursement. These exclusions include without limitation certain medical or licensed services; services provided for someone other than the participant; companionship, socialization, entertainment, and recreational services or activities; habilitation services; and mental health counseling or services.
- The length of Personal Care prior authorizations is extended from six months to one year but may be modified if the beneficiary has a change of condition.
- Based on the use of the ISB and/or the changes to limits and restrictions on services, ARChoices, Living Choices, IndependentChoices, and Personal Care beneficiaries may see an increase, decrease, or no change in the services or funds available to them or included on their person-centered service plan, cash expenditure plan, or individualized plan of care.

Availability and Definitions of Services:

- The Adult Family Homes service in ARChoices is eliminated. Any beneficiary currently receiving this service will be unable to receive this service after January 1, 2019.
- A new service, Prevocational Services, is added to ARChoices for participants with physical disabilities.
- The definition of Attendant Care services in ARChoices is amended to eliminate three tasks: "Managing Finances," "Communication," and "Traveling." The definition is also amended to define "health-related tasks" and to modify and clarify the definitions of the following tasks: "personal hygiene," "mobility/ambulating," "meal planning," "laundry," "shopping," and "housekeeping." The definition is amended to specify circumstances under which Attendant Care services are not covered or reimbursable.
- The definitions and requirements for "Respite Care" are revised to clarify and limit when respite care is covered and reimbursed.
- The Personal Care service definitions and restrictions for "Consuming Meals" are revised to include the intake of fluids and to exclude meal preparation.
- The Personal Care service definitions and restrictions for "Personal Hygiene" are clarified to mean grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene.
- The Personal Care service definitions and restrictions for "Mobility and Ambulation" are clarified to mean functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive equipment.

- The Personal Care service definitions and restrictions for "Incidental Housekeeping" are clarified to refer only to areas that are directly used by the beneficiary.
- The Personal Care service definitions and restrictions for "Shopping" are clarified to include items necessary for the beneficiary's health.

Service and Provider Requirements and Limitations:

- Providers under ARChoices, IndependentChoices, and Personal Care will be required to undergo state and national, fingerprint-based criminal background checks and central registry checks and repeat those checks on a regular basis consistent with state law.
- Provider certification requirements for ARChoices are amended to require all providers to recertify annually.
- ARChoices is amended to clarify when an environmental accessibility adaptation/adaptive equipment provider is required to submit a plumbing or electrical license with a bid, and to require bids to specify what work, if any, requires such a license.
- Providers of frozen home-delivered meals under ARChoices must contact each client daily, Monday through Friday, in person or by phone, to ensure the individual's safety and well-being, unless the client receives attendant care or personal care services more than three times per week, or the client receives only weekend meals.
- DHS will require providers of Attendant Care Services, Respite Care, and Home-Delivered Meals under ARChoices to participate in Electronic Visit Verification (EVV), consistent with new federal requirements.
- For Living Choices, DPSQA will be authorized to temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers, consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the approval of the federal Centers for Medicare and Medicaid Services (CMS). All Living Choices providers will be required to be certified by DPSQA.
- Living Choices providers will be required to immediately report to DHS any changes in a beneficiary's condition, rather than the current requirement of quarterly monitoring. The quarterly monitoring requirements are eliminated.
- For IndependentChoices, backup caregivers will now be required to enroll as caregivers with DPSQA.
- For Personal Care, current language permitting Level II Assisted Living Facilities (Level II ALFs) and Division of Developmental Disabilities Services Community Providers to enroll as personal care providers and to provide personal care services is repealed.
- All Personal Care providers will be required to be certified by DPSQA.
- Form/documentation requirements for Personal Care individualized service plans, requests submitted by providers, and service logs are clarified and revised. Service plan revisions will be required to be submitted as amended prior authorization requests.
- Reimbursement provisions and methodologies for residential care facilities (RCF) and assisted living facilities (ALF) are revised to use the term "Payment Level" in place of the term "Level of Care," and to incorporate the THS into the determination of the Payment Level.
- PACE is clarified to make explicit that failure to submit a PACE provider application to DAABHS at the same time or prior to submitting the application to CMS shall constitute grounds for DAABHS denying or delaying approval of the application.

Payment Changes:

- For ARChoices, the unit of service for Personal Emergency Response System (PERS) is changed from 1 day to 1 month, with a limit of 12 units per year.

- For Living Choices, the existing four-tier payment structure for assisted living facilities is eliminated and replaced with a single, statewide daily rate for all beneficiaries.

Taken together, all of the proposed changes outlined above will impact beneficiaries. Individual beneficiaries may see an increase or reduction in the amount, level, duration, frequency, type, and mix of services available to them, or their services may remain the same. Initial or continued eligibility for or enrollment in the ARChoices or Living Choices waiver programs or PACE, or eligibility for coverage of Personal Care Services or IndependentChoices services may be positively or adversely affected in individual cases.

Taken together, all of the proposed changes outlined above will also impact the providers of services, including, without limitation, provider operations, finances, billing practices, staffing, and compliance.

The ARChoices Waiver Amendment, Living Choices Waiver Amendment, Personal Care State Plan Amendment, and IndependentChoices State Plan Amendment are further subject to review and approval by the federal Centers for Medicare and Medicaid Services (CMS).

DHS estimates that the proposed changes outlined above are expected to result in a net decrease in aggregate Medicaid expenditures of $9.27 million in State Fiscal Year 2019 and $13.92 million in State Fiscal Year 2020.

The rules will be effective January 1, 2019.

Public hearings will be held on these changes on the following dates, times, and locations:

- Monday, October 15, 2018, 5pm, Arkansas College of Osteopathic Medicine, 7000 Chad Colley Blvd, Fort Smith, AR;
- Thursday, October 18, 2018, 5pm, Drew Memorial Hospital Conf. A., 778 Scoggin Dr., Monticello, AR;
- Thursday, October 22, 2018, 5pm, UA Hope Hempstead Hall, 2500 South Main St., Hope, AR;
- Tuesday, October 29, 2018, 5pm, Arkansas Enterprises for the Developmentally Disabled, 105 E Roosevelt Rd., Little Rock, AR; and
- Wednesday, November 7, 2018, 5pm, St. Bernard's Medical Center Auditorium, 225 E. Jackson Ave., Jonesboro, AR.