ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable

Previous Agency Name, If Applicable

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Name of Rule SPA #2020-0011; ARChoices Medicaid Provider Manual, Personal Care Medicaid Provider Manual, and Targeted Case Management Medicaid Provider Manual.

Newspaper Name Arkansas Democrat-Gazette

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Final Date for Public Comment April 20, 2020

Location and Time of Public Meeting No public meeting is scheduled.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective July 1, 2020:

The Department of Human Services (DHS) proposes to amend the ARChoices and Personal Care Medicaid Provider Manuals to implement regulatory reform which will allow the Manuals to mirror the Arkansas Department of Health (ADH) requirements while at the same time reducing administrative costs for providers and eliminating duplicative requirements. These revisions will allow DHS to make needed technical changes and corrections while bringing DHS into compliance with new ADH rules.

Revisions of the Personal Care Medicaid Provider Manual include the following:

- Section 220.100 of the Personal Care Manual requires an agency RN Supervisor to make an in-home visit for every beneficiary served by the agency at least once every 62 days. This requirement is based on an identical requirement contained in the Arkansas Department of Health (ADH) Rules and Regulations for Private Care Agencies in Arkansas. Act 811 of 2019 repealed the ADH requirement and replaced it with a requirement that each beneficiary be visited at least annually by a supervisor who may either be an RN or an individual with at least two years of full-time study in an institution of higher education. DHS is proposing to eliminate the parallel requirement contained in Section 220.100 and replace it with language that mirrors the new requirements. The Act requires supervisory visits to be made at a frequency that is "based on the specific needs of the patient."
- Section 215.200 has been updated to require that, before furnishing any personal care services to an individual, the provider must prepare a complete and accurate Individualized Service Plan with proposed hours and minutes and frequency of needed tasks consistent with the Task and Hour Standards. The service plan must be prepared, certified, and signed by a supervisor or registered nurse. Documentation of the service plan and all revisions must be kept by the personal care provider.
- Section 215.320 has been inserted to require in-person supervisory visits at least annually but at a frequency determined by a registered nurse, the personal care provider, and the beneficiary or the beneficiary's legal representative. The section states that the risk factors identified by the service plan must include any relevant medical diagnoses; the beneficiary's mental status; the presence of family or other residents in the beneficiary's home, and the frequency of their presence; and the beneficiary's physical dependency needs, including the activities of daily living (ADL) with which the beneficiary needs assistance. If the beneficiary has a significant change of condition affecting a risk factor, the registered nurse shall review the frequency of in-person visits and recommend changes as appropriate. Parts of sections 215.330, 216.000, and 220.100 were revised to provide clarity for certain requirements. The revisions include updates to monthly hours provided, qualifications and restrictions for supervisory individuals, and specifications of annual visits. The revisions include a duty to observe, document, and report. The manual requires documentation of consultation in the beneficiary's records and includes a new subsection regarding early recognition and reporting of changes in a client's condition.
- Changes are made throughout the rule to remove the requirement that a supervisor must be an RN. (Sections 216.000, 220.100, 221.000, 222.110, 222.120)

- DHS is reducing the amount of information required to be submitted by providers to request authorization to provide personal care services. DHS proposes to require only the following information:
  - Beneficiary and provider information;
  - Identification of alternative sources of personal assistance available to the beneficiary (family or friends, AAA, VA, Medicare, or other insurance, etc.);
  - Certification that the beneficiary's service plan will not duplicate any other in-home services of which the provider is aware;
  - The total number of hours per month which the provider seeks to offer for the beneficiary;
  - The frequency of in-person supervisory visits to be made by an agency supervisor, including information on the risk factors specific to the beneficiary and a justification for the frequency; and
  - The signed approval of the beneficiary or beneficiary's representative. (Section 215.200)

- DHS is also proposing changes to the Personal Care Manual regarding beneficiaries' individualized service plans:
  - Revising the Manual to clarify that a service plan is effective for one year from the date of the client's last Independent Assessment;
  - Eliminating the requirement that providers submit the beneficiary's individualized service plan to DHS. However, providers are required to maintain copies of all current and prior service plans for audit purposes; and
  - Requiring approval of a revised service plan only if the provider requests to provide more total monthly hours than are allocated in the current prior authorization. However, providers would still be required to maintain documentation of the medical need for any revisions made to the service plan. (Sections 214.200, 214.300, 215.200, 215.330, 215.351, and 244.000 of the Personal Care Manual)
  - DHS is revising Section 215.360 regarding documentation and reporting of a significant change in a beneficiary's condition. The individualized service plan must identify individualized, beneficiary-specific standards, based on the identified risk factors, for when a caregiver or supervisor must document and report any significant change in the beneficiary's condition. If a caregiver or supervisor observes a significant change of condition, they must document and report the change of condition as required by the change-reporting standards contained in the beneficiary's individualized service plan. Documentation must include the time and date the change was identified by the caregiver and a full description of the change. Within twenty-four (24) hours of a significant change of condition being reported, a registered nurse must evaluate and document an assessment of the beneficiary.

Revisions of ARChoices Targeted Case Management Medicaid Provider Manual and the Arkansas Medicaid Provider Manual include the following:

- Section 204.000(I)(3) of the Targeted Case Management Manual and page 6 of Supplement 1 to Attachment 3.1-A of the Arkansas Medicaid State Pan are revised to loosen the educational qualifications for ARChoices Targeted Case Managers by requiring them to have a bachelor's degree from an accredited institution in a health and human services field, or two years' experience in the delivery of human services to the elderly.

Revisions of the ARChoices Medicaid Provider Manual include the following:

- Section 262.100 of the ARChoices Manual is revised to eliminate an obsolete procedure code/modifier combination, S5125 with no modifier. This combination was used in the waiver program that preceded ARChoices, and the combination is no longer in use or needed.
- Added Section 262.312 regarding of quotients with decimals to mirror the Personal Care Provider Manual.

Revisions of the Arkansas Medicaid State Plan include the following:

- Supplement 1 to Attachment 3.1-A, Page 5 is revised to show that case management providers must now be certified by the Division of Provider Services and Quality Assurance.
- Supplement 1 to Attachment 3.1-A, Page 6 is revised to reflect the participation requirements for providers of TCM that are listed in the Targeted Case Management Medicaid Provider Manual.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule on the Medicaid website at https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **April 20, 2020**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6164.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. **4501888131**

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Janet Mann, Director
Division of Medical Services