

DHS Responses to Public Comments Regarding the Long Term Services Support (LTSS) Transformation Package

Mary McLain (alexiaelizabeth05@yahoo.com)

Comment: As an activity director in an assisted living facility, I am opposing these proposed cuts. These cuts will have a large negative affect on the residents in all of these facilities. These cuts will affect the quality of care the residents will receive. Most of these residents being elderly. They deserve to be cared for above and beyond.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Ron Cloud

Comment: I appose the 21.7% CUT to the Reimbursement to Asst. Living Waver.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

James L. Scott

Comment: I would like to state that I am strongly against the proposed 21.7% reimbursement cut for the aged. Please reconsider the proposal.

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

rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Marilyn Blair

Comment: I am a person who has paid taxes for years without any social services benefits. My 94 year old mother is currently living in the Oaks assisted living facility. I have learned that the budget for such services is scheduled to be dramatically cut. I think rather than a huge reduction in the state budget, why can't excess expenditures within the budget be eliminated? The Oaks facility provides an excellent solution for those who cannot care for their elderly personally. I think other budgets could be cut instead of going after the most vulnerable in our society. Why should healthy, vigorous young people who prefer not to work have the best insurance, food stamps, free or reduced housing while those least able to help themselves suffer deprivation of help during their final years?

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Margaret Brett, Steven Hubbard, Sandy Lyle, Renae Powell, Anita Sue Willborg, Judy Newcomb, Ova Doris Lott, Brandon Burk, Kayla Davis, Claudia Brown, Tammy Odom, Talanda Anglin, Jennifer Howard, Janet Van Deist, Bonnie Murphy, Renee Young, Bonnie Medlin, Pamela Barron, Morrissa Tibbs, Joanne Coogan, Sharon Nix, Naomi J. Stuart, Jennifer James, Stephanie Tapley, Terry Thomas, Lura Powell, Charlie Baker, Phyllis Simon, James, Vivian Orr, Betty McBryde; Kevin William, Priscilla Adams, Courtney Crawford, Danita Crawford, Brittany Price, Emily Smith, Patricia Jenkins, Julie Allen, Matthew Norm, Pilar Javier (all writing separately)

Comment: As a concerned citizen of our state, it has come to my attention of the possible Medicaid funding cuts that will adversely affect the lives of numerous elderlies in our community. I am writing to you today to ask for your help in finding alternative means to keep this from happening.

Not only will this displace hundreds of elderlies who are not ready to enter nursing homes, but it will cause the loss of employment for people who depend on this funding to raise their families and be productive entities in society.

I understand the reasoning to cut spending, but cutting this fund is not an option. I am sure if you will take the time to research this matter further you can assist in coming up with an amicable alternative.

Thank you for your prompt response to this urgent matter.

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

Sheila Yancey, RN

Comment: I work as a case manager through Kindred Healthcare, Inc. in North West Arkansas. Just a note to say that some of the people we service live in very rural places. The only caregiver available will be a relative. I sincerely hope that this rule of no relative allowed to care for a patient will be changed as some aging adult need the care of their child or grandchild and the child or grandchild still must have a job to pay the electric bill. Just My two cents as I have seen this first hand and it does work out for both the client and the caregiver so that the client gets to remain in the home for a longer period of time.

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

Emiko Hennings

Comment: I have a 94 year old grandmother who is in a wonderful assisted living facility. Due to her specific needs none of her family is able to give her the care that she needs in our homes. Medicaid does pay the majority of her bill. She and my grandfather worked and paid taxes their entire lives and NEVER received or asked for government help.

It angers me that DHS is willing to cut funding that will result in this assisted living facility and others like it around the state closing.

Why are potential cuts being made to hurt our most vulnerable citizens? The elderly and those who are mentally ill or developmentally delayed? Let's make cuts instead to those who are taking advantage of the system. You and I both know that those exist. I have been behind people in line with their EBT cards who are able to buy food that my family certainly can't afford. They are big, healthy people- let them get out and work. Unless a person is truly disabled, they need to work or they can learn to do without.

These DHS cuts aren't hurting those who can take care of themselves and won't...it's hurting those who actually need our help. Please do everything in your power to stop these cuts and encourage cuts being made where it won't hurt our vulnerable citizens.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was

on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Sharon Nettles

Comment: About the proposed 21.7% DHS cuts to Assisted Living Facilities and other facilities that help our most vulnerable people; and the Assisted Living Waiting List —

Please help to stop these cuts and to remove the waiting list to open up the Medicaid beds for Assisted Living Facilities. If you do not help with these issues, it will drastically reduce the ability of these homes to care for their patients and to maintain the facilities.

Even worse, some of the assisted living homes — such as The Oaks, where my 94-year-old mother lives — are in danger of closing altogether.

I do not know how we could manage my mother's care if this happens. My sister and I are in our middle 70s and we cared for her in my sister's house as long as we could; we have our own disabilities and are simply physically unable to do it anymore. We were so grateful for her to be able to live at The Oaks, which has a dedicated staff and takes wonderful care of its residents.

There aren't all that many nursing home/assisted living facilities available in our area anyway, and closing even one of them would be a huge loss to the entire community, not just to our family. Turning these places into hellholes for lack of staff and maintenance should also NOT be an option.

Please help improve conditions for our most vulnerable citizens, not make them worse!

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Karen Joiner

Comment: I am writing to let my concerns be known regarding the proposed changes to the AR Choices process. My concerns are regarding the addition of Optum to the process. While I understand cost-containment must be a part of decisions, the addition of this process, as I know it from the Medicaid Personal Care current process, is wrong and will only serve to expedite the entrance of these people into the skilled nursing facility rolls.

In summary, the Medicaid Personal Care referral/admission process now includes Optum and it has been nothing short of a disaster to many of our clients. We have no reason to believe their inclusion in any AR Choices process will be any different. The problems are many but the biggest issues are:

1. We are constantly told our clients should be able to get through the process within 2 weeks. This rarely happens. Consequently, by the time we hear anything our client is back in the SNF/hospital. The blame was originally Optum staffing but we don't know what is the problem now. We have been assured Optum is staffed to a level that can handle the referral volume.
2. Optum closes cases without going into the home because they reportedly can't get in touch with the client. Yet we always seem to be able to. We can only assume this is because of the sheer volume they currently attempt to handle.
3. As nurses, one of our biggest issue with the Optum process is that the final say for number of hours our clients get is not based on a skilled clinical assessment. I personally verified with DHS that the Optum nurses do not assess but rather perform an interview type question period. This interview overrides our actual RN assessment. When I asked Mr. Cloud about this I questioned him about whether he understood an elderly person is not going to always willingly divulge to a total stranger asking questions whether or not they wet their pants or need help caring for themselves. Therefore, the questionnaire approach is faulty for determining care. He told me we could always send staff out to be present during the interview. Obviously that is not something we can do.

I respectfully request consideration for the needs of this vulnerable population are in the forefront of future decisions. The current direction is not in the best interest of those dependent on personal and attendant care

Response: Comment considered. DHS understands that many providers are concerned about the viability of the independent assessment process and its relationship to the prior authorization process. Optum has now performed more than 50,000 independent assessments in Arkansas. The results have supported the accuracy and validity of the IA system. Independent assessments are a federal requirement for Medicaid waivers for home and community-based services. To be clear, although Optum is responsible for conducting independent assessments, Optum does not perform the function of prior authorization. DHS has worked to improve its internal processes in handling prior authorization requests and will continue to implement changes to improve the reliability of those processes.

Helen D. Smith

Comment: I. Wry concernd about proposed changes that would prevent family members from working as paid care attendants for Medicaid recipients. Especially in rural areas, it is sometimes impossible to staff people in need. Family members are doubly stressed if they have to decide between caring for a relative and earning a living. By being able to be paid to care for a family member who would otherwise go unstaffed, they are able to take care of those in need as well as meet their own financial needs. It often is the best solution for all parties involved. Please consider this in your decision making process. The proposed changes are detrimental to a number of people in need of care services.

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

Kim Faulk

Comment: At the direction of recent correspondence received on Medicaid changes regarding the care of my mother, Wanda Nickell please find attached my letter objecting to such changes as it would have a detrimental impact on the present care of my mother. I am not able to attend any of the meetings due to her care but am available to discuss any questions by phone that may surface from you or committee members in consideration of this proposed change. After reading the letter, I would ask careful & thoughtful consideration be made understanding it is not only impactful to my mother but other family members who sole responsibility is the care of a loved one impacted by the proposed changes in this program. (See attached Letter below)

I am writing you on behalf of my 84-year-old mother, Wanda Nickell afflicted with Alzheimer's in order to object on the upcoming proposed changes that will have a profound impact on the care of my mother and family. I have been the primary caregiver for my mother, Wanda Nickell for the last 4 years and under the Medicaid program for a short time since June, 2017. I was distressed to learn of the upcoming proposed changes related to her care as proposed under Section 26. Personal Care, Paragraph C, Section 1 & 3 and Paragraph G:

- C. 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:
 - 1. Reside (permanently, seasonally, or occasionally) in the same premises as the client;
 - 2. Have a business partnership or financial or fiduciary relationship of any kind with the client or the client's legal representative; or
 - 3. Be related to the client by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.
- G. Personal care services for adults 21 years of age or older are limited to a maximum of 64 hours per calendar month.

As to Section 26 it is my understanding, I will not longer be eligible to be paid as the primary caregiver for my mother. Like other individuals in similar circumstances have left opportunities in the employment market in order to take care of a mother / father 24 hours a day, 7 days a week, I would like to put this in context, Medicaid only reimburses me for a total of 137 hours out of 720 hours (24 hours x 30 days) a month. Along with not being paid, Paragraph G now will limit those hours further to 64 hours a month.

Medicaid in the proposed changes have also placed limitations based on new modeling to assess patients (RESPA) hours along with placing a moratorium on memory care beds made available. The only intention of these actions I can see is to place a greater burden on family care. It is also not lost on our family the public comment time for such changes is made past the election date in order to surface such concerns for additional legislative corrective action.

We moved my mother in with our family after her hip fracture, which is now under my direct supervision for 24/7 care. As most sons and daughters who take on this 24/7 responsibility, it is out of love and eternal gratitude of what a parent has provided in our lives.

As Wanda is under a monitored 24/7 care supervision, as a reminder to DHS at this level of Alzheimer's she is unable to perform normal rudimentary functions such as:

- 1) Hygiene, including bathing, hair & makeup
- 2) Toilet, with Depend changes
- 3) Dietary & Meal preparation

- 4) Walking without assistance
- 5) Physical therapy
- 6) Eating without assistance

These events start at 7:00AM in the morning and do not end until 2:00AM at night. Anyone afflicted with Alzheimer's in advanced stages are not self-sustained and needs 24/7 care. The only support which is available is DHS which now will be diminished along with Wanda ability to be properly cared for. In order to make the DHS less punitive on our and other families in which this will have a profound impact, we are requesting no changes be made in the present reimbursement structure made to families for assistance and the maximum 64 hours to be eliminated.

If these changes cannot be made, please allow or consider in adding a "grand-father amendment" in which families under the DHS present program guidelines would be allowed to continue to be paid by a 3rd party agency in order to monitor the care and the hours remain the same.

This would at least allow a continuation for the same level of care for families that the DHS agency now provides.

It saddens me greatly that my 84-year old mother and her generation that has paid the greatest amount of money into the Medicaid system will now suffer such punitive effects based on these proposed changes. Thank you in advance for your consideration on behalf of my mother, Wanda Nickell.

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

Sue Bartholomew

Comment: I am writing you this letter in regards to the upcoming amendment change to the current Medicaid waiver program. As I understand this amendment would reduce rates for seniors living in assisted living facilities. I am asking no, pleading with you to do all you can to stop this from happening. My 93-year-old mother is living in an assisted living facility. My father passed away in 2006 and mother lived alone until I could get her in an assisted living. Mother has a very clear mind and only needs help with her baths. She does not require the level of care that she would receive in a nursing home. I can't begin to tell you the relief to her family that she is in such a safe place. I had a son who was permanently brain damaged due to a drunk driver. He spent thirteen years in a nursing home. During those years I watched as residents came into the home. One of the hardest things for them was having to share a room. They never had a private moment after that for the rest of their lives. Please help us.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019,

will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Brittany L Thompson Little

Comment: I was recently notified there is a request for an amendment change to the current Medicaid waiver program that would drastically reduce Medicaid rates for those in assisted living facilities. I am asking that you postpone the assisted living rate reduction until more research is done. The elderly depends on this and by cutting costs, you are ultimately hurting them. I urge you to strongly consider my request. Let me know if you have any questions.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Rhonda Pifer Kirk

Comment: I would like to express my opposition to the proposed amendment change to the current Medicaid waiver program that drastically reduces Medicaid rates for those in assisted living facilities. Please stop the assisted living rate reduction. This amendment affects those in our society that cannot help their selves. Many of the residents in assisted living facilities have worked their entire lives and due to circumstances beyond their control have no other options for care. It is cruel and dehumanizing to reduce the level of care they will receive. My mother was widowed young and raised two children as a single parent. She worked and sacrificed her whole life to provide for others. She has mid stage Alzheimer's and cannot live alone and needs a safe living environment. She currently resides in an assisted living facility and depends on Medicaid for her care. It would be extremely cruel to reduce the level of care she receives. Please stop the assisted living rate reduction.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Mlt00t.mt@gmail.com

Comment: There is currently a request for an amendment to change the current Medicaid waiver program. This amendment would drastically reduce Medicaid rates for those living facilities. The

proposed cuts will make it impossible for some of our elderly and disabled residents to continue to live in assisted living facilities. If these individuals do not meet nursing home criteria they will have no where to live. Please have compassion for our fellow Arkansas citizens. Please do not allow the Medicare waiver program to be cut.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Marla Moran LPN

Comment: I would like to talk to you about the proposed Medicaid cuts. This will have a direct impact on the quality of care that the residents receive. It will also negatively impact employment in Mena and many other small communities. Our residents receive wonderful care. Our seniors have worked hard through out their lives and deserve the best!! This will be devastating to the care and compassion that exists in our assisted living homes. I ask you to please reconsider cutting the reimbursement. Moving out of a home like setting does not sent the appropriate messages to the citizens of Arkansas. Some people may feel like I'm fighting for this because I, myself work at a Assisted Living. However, this is not the case. I'm a nurse and will be able to find another job if the worst possibly happens. I care because of the magnitude of these residents being up-rooted and not able to have a choice in where they can reside. For most of the residents they have already had to give up so much just to come live at a Assisted Living. Once they get established here they realize that if they cant go back home this is the next best thing. To have to take that away or reduce the care they get is simply not fair! Thank you so much for your time, I sincerely hope you will reconsider and understand the importance of this.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Lenora Riedel

Comment: I am writing to you again to ask a few more questions. If you do the proposed rate reduction, how do you expect facilities to be able to sustain that loss? We would have to cut around 10 jobs to be able to overcome that hit. That would mean 10 less employees taking care of those who need our

services. The level of care that we provide for our residents would be drastically lower. As a facility, our #1 job is to provide adequate care for our residents. It will be near impossible to do so with your proposed rates.

Next, in the amendment change it says that 6 providers were sent surveys and only 3 providers responded. Is there a reason why only 6 providers in the entire state of Arkansas were surveyed? Because I know we would have loved to have given our input on the matter.

Finally, here is a little food for thought. Each year, the Military, Social Security Administration, Medicaid, and other government entities gives a Cost of Living Adjustment (COLA) depending on certain statistics, etc. I believe it's fair to say that it is usually between 1%-2% per year. I'd say that's a safe enough increase per year to keep budgets in order, correct? Now say we demand an increase of 21.7% COLA for one single year. Every single entity would crumble. Every. Single. One. But, at 1% here, 2% there, or some years where there are none, it makes that total amount a little more reasonable.

I truly think that if someone would've come up with a better plan, and not such a drastic cut, this wouldn't be such a devastating blow. Please rethink this and please do not push this amendment through right now.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Judy Foster

Comment: I am writhing concerning the drastic reduction in Medicaid rates for those in assisted living facilities. My father in law is in Countryside Assisted Living and this would impact him terribly. He would not be able to stay there if something happened to his Medicaid. When he first went to this facility he had to share a small room and was very dissatisfied. He is 91 yrs old and it would be so very sad to see his life disrupted again. I beg of you to please reconsider this matter.

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

assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Jane Martin

Comment: I would like to encourage you to stop the process to cut the Medicaid reimbursement to Assisted Living Facilities. I am a retired RN after 26 years with the state, 16 of which was doing assessments to help eligible Arkansas elderly and disabled receive services in their home or in an Assisted Living to prevent or delay Nursing Home placement. These cuts will force our most vulnerable into Nursing Homes and greatly diminish their quality of life. Our goal should be to care for our elderly and disabled in the LEAST restrictive environment, not in the most restrictive. Thank you for listening, it was a pleasure working with you.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Shay Stevens

Comment: I left a message on Mr. White's voicemail on October 24, 2018 requesting a very short meeting to detail the effects of the interruption of ARChoices and proposed changes that was discussed on the last webinar. As I stated to Mr. White, I hope this meeting request is not inappropriate, although I plan to attend the public forum on Monday evening. I realize you two are VERY busy men, and even 15 minutes of your time may even seem impossible. But perhaps if I briefly detail my concerns here, you both may have a chance to consider and revisit the concerns over the next few months before the proposed changes are implemented. The 0.12 cents reduction in pay can potentially result in a few hundred dollars less monthly.

Kindly consider Salaries, Insurance (Professional Liability, Workman's Comp), food costs, TAXES!! On a side note, in an effort to deter a high employee turnover rate (consider the importance of familiarity and dementia), my four employees are paid \$11 per hour, and the Program Director is paid \$15 per hour (4 employees at Millennium 1, 2 employees at Millennium 2). Also our food cost is in excess of 1500 per month (we are NOT interested in the food program). Kindly allow me to provide an example of the effects. If average billing were 552 hours per week (14 residentsx7hoursx5days); the .12 reduction would be an \$86 reduction, or a minimum of \$344 per month. Being a small business, this \$344 is very much needed. Removing transportation from Adult Day Cares

Kindly consider that many of our residents live with their elderly spouses or working children. Neither of whom are always able to provide transportation. If adult day cares purchase vans, it would result in more expenses of gas, commercial vehicle insurance (average is 1200 per month), or an abandonment of the adult day care program. Although each client at Millennium is automatically enrolled in Links Paratransit for our fieldtrips, Southeast Trans has already informed us that it will no longer reimburse for Links effective January 1. My other concerns were already addressed during the webinar in regard to home care, so I dare not waste your time with redundancy.

Adult Day Care operations are quite an undertaking, gentleman. I pray I am able to shed light on the perspective of the provider and operations. I look forward to seeing you on Monday, and as always, I feel SO honored to be able to partner with you and our beautiful state as we provide care for the vulnerable adults of our community. There is not a second that goes by that I ever it for granted.

Response: Comment considered. The proposed rate is based on an actuarial study that included a review of licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule.

Mike Riley

Comment: I am writing to you due to my concern for the many senior citizens in Arkansas which includes my own mother and mother-in-law. I have heard that there is a proposed 21.7% cut in Medicaid rates which will negatively impact all of the senior citizens. Starting January 1, 2019 all assisted living facilities will start to lose roughly \$500.00 per month due to these cuts in Medicaid. This impact will cause many assisted living facilities to close which will live a great many Arkansas seniors without a place to live as well as impacting the many employees of these facilities in the loss of their employment. My mother is 86 years old had sufferers from severe dementia and like the many seniors that suffer from this condition she requires 27/7 care and oversight that only an assisted living facility can provide. I know that in your heart you would not want not support these cuts and implore your immediate attention to this matter.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Garry Thompson

Comment: I have a family member that works in an assisted living facility. She goes above and beyond each and every day for the care of the residents. She loves going to work every day to help make a difference in their lives. Her help makes the resident's quality of life extend and gives them confidence in their independence. Why would you want to cut funding that helps a resident's quality of life? They thrive at assisted living facilities because they are not ready for the skilled care a nursing home provides. I know from a personal aspect of how many lives this would affect if you cut the Medicaid rates. Please

consider the importance of this letter I am writing you. Do your research and see how important assisted living facilities are to our elderly and how cutting their rates will only hurt them.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Brooklyn Sloan

Comment: I currently work at an assisted living facility. I see every day how happy our residents are and how proud they are to be living here. Our residents thrive here because they know they can receive help with tasks that are just a little bit too hard for them, but still retain some independency. They might not be able to take a shower on their own or they might not be able to bend over and wash their body or hold their hands up long enough to wash their hair; this is where we step in and help. There are some residents that cannot cook three meals a day or simply go to the bathroom on their own without assistance. These residents need the security of knowing that they have help with these daily tasks. They do not need to be put in a nursing home with extensive care. If you cut the Medicaid rates, the residents will not get the quality of care they are receiving today. We will have to cut our staffing and activities that we provide to the residents. This is where their quality of life will start to go downhill. Our residents are happy and safe because we provide a place like home with assistance for the tasks they cannot independently do each day. I would hate to see this be taken away from our residents and other assisted livings across Arkansas.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Lenora Riedel

Comment: I am writing to you in regards to the proposed reductions in Medicaid reimbursements to facilities. I have worked with our assisted living for over 5 years now and have dealt with helping Medicaid residents for all of that time, too. I know the quality of life that our residents receive here. If you were to cut reimbursement rates, the care they receive would drastically drop. We would have to cut staffing and nursing to try and sustain the reduction. I cannot look at my residents and tell them that they aren't worth us giving 110% of our effort to them. But I can't ask our owner to go bankrupt doing so

either. So, what do we do? Also, regarding the slots and wait list that has been an ongoing issue, I get calls daily of potential residents needing Medicaid. Sadly, I have to tell them of the wait list and how I can't help them when they need it right then. It truly breaks my heart. We need more slots! But not at the expense of reducing reimbursements. There is no point in that. Please tell me how that is going to help facilities if they cannot afford to pay their bills? It helps no one. There is no point in taking on more people at a reduced rate. I know that nursing homes receive federal money and that helps out with how much it costs to run their facilities. But please don't punish assisted living facilities because we don't receive the same funding. There are so many residents who cannot live home alone (even with assistance), but do not need a skilled nursing facility. They need us! This is why I love my job and do the best I can. I invite you to come visit us! Come see the difference we are making with our residents. I guarantee that you would have no hesitation in knowing where you would reside if you had to go somewhere right now. And I guarantee it wouldn't be a nursing home. Thank you for your time.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Ben Von Sprecken

Comment: Hello my name is ben von sprecken iam writing you today about the major cut to the dhs Medicaid ar choice program.. Iam not happy about this change at all.. I am very concerned as a caregiver why you and all the stupid Republicans think you need to cut back on Medicaid you cannot by law for somebody out of their home into a nursing home this is crazy you guys are discriminating against people and their diagnosis there are 8300 people on this program who want to stay in their homes who do not want to be in a nursing home to suffer and die to live out the rest of their life because your nursing homes are suffering they have horrible care they're nasty they stink it's ridiculous people have the right to stay in their home they should be forced out of their home because nursing home to charge ten to twenty thousand a month for horrible care you guys should have never change this program to our choices it should have remained aapd where people were getting their full hours... My mother is diagnosed with multiple sclerosis she is wheelchair-bound she is catheterized she has tremors she is verbal and it's still all there she just can't walk because of the diagnosis she was receiving care 7 days a week 57 hours a week I am her son I am providing care to her now you guys are enforcing family can't take care of their loved ones who says I'm sorry but no other aides coming up in my house I would

sacrifice myself before another Aid walks up into my home taking care of my mother you all reduced her hours to 36 hours that is 4 days of care and all y'all say is well if you can't take care of yourself go to nursing home why should she she is an adult she has the right to live in her home she paid for it not you or not the thestate you guys keep cutting everybody's hours and you're screwing people like me out of a job you have reduced my pay since you guys switch from aapd to AR choices I'm now having to work two jobs with another Home Health agency just to get a 40 to 45 hour paycheck this is ridiculous because you guys want embezzled money and screw people out of their care I don't understand why you are just attacking this program there are other waiver Services out there where people are getting 24 to 48 hour care and they have a mental condition why aren't you cutting their hours... Hmmm and why is there service is not being cut... I'm sorry from experience in the nursing home facility before I went into Home Health I would never work for nursing home again just like Bentonville Manor in Bentonville Arkansas was sued and today it is demolished it was all over the news that lady suffered from big bed sores she was starving and the family pay for a private room with crappy care and the nursing home was always in state trouble daily when I first started in the nursing facility I'm sorry but I don't think people should be forced out of the home because nursing homes and ASA Hutchinson in the rest of you wanting bezel money behind closed doors shame shame on all of you you guys have to stand before God just like the rest of us now I'm not here to talk religion but I know what the Bible says I think this is unfair what you are doing to people and you guys should be ashamed of yourself people should be able to live in their home enjoy their freedom until they die no one should be forced out of their home and why in the world would I want to switch to Palco and take a low pay I've done this for 11 years and I'm only making \$11 an hour I am underpaid is your company going to back pay me and all the other caregivers are money for the last 4 years for screwing us out of our services I mean you guys were well up putting in false information on that stupid AR Choice program computer DHS busted y'all on that one I think me and all the other caregiver should file lawsuit for 4 years of back pay anyways I think this program is ridiculous and my mother will never be forced out of her home I would take a bullet for her ain't no other caregiver going to come in my home and take care of my mother Over My Dead Body I provide excellent care to her and she's very satisfied if you guys think you're going to cut people that are family related to stop providing care for their loved ones good luck with that one that's a lawsuit fixing to burst out the door and yes I will file a lawsuit if I have to well I hope you have a great day but once again you and all the other people that are behind this shame on you all of you should be ashamed of what you doing to these innocent people taking their Care away and forcing them to something they don't want to do I'm sorry but my mother will never be forced in the nursing home how about you and ASA Hutchinson and the rest of you people behind this go to a nursing home for 4 days and living there and tell me how miserable you will be

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

Bo Gerbig

Comment: This is a little lengthy but please read! I have heard that that there is a request to the amendment change to the current Medicaid waiver program. & I would like to know more about it because I heard that the changes maybe in the reduction of income going to assisted living facilities! I am Bo Gerbig from Elkins Arkansas & I'm curious about this change because it maybe affecting my mother that has been residing at Country Side assisted Living in Huntsville Ar. and it has me very worried to say the least ! About My Mother : Norma Loretta Howard (Age 82) My mother worked her tail off

working at a bank & selling real estate after work ect. she had a 4 bedroom 2 bath house paid for, money in stocks and cash in her account. She was diagnosed with dementia & the state of Arkansas found her unable to live in her own home alone so she was pulled from her house after living there for so many years, she was needing a 24 hour lockdown facility due to her condition so my older sister found a place in Maumelle Ar. which cost about 5,000.00 a month - needless to say after selling my moms stocks, house and using all her money up at Elmcroft@Maumelle I had found a place in Huntsville called Countryside that took medicare wavers ! I wished I would have found this place to begin with for this facility actually is a place that really does care about the elderly & has a great crew of loving staff members- As I sit and visit with my Mom I sit in the lobby of residents @ times and watch this crew handle all these elders with care I notice how hard it is for them to lift people up to there walkers or just help them up (this puts lots of wear & tear on the staff) some of the residents out weigh them by at least twice their weight if not more." No Graig" cutting staff would not be a good option & either would double occupancy in a room for the rooms are about the size for one.. You see Graig my mother still has some mind left & that is her own little apartment & although she is in her (last stage) of this horrible disease I feel she gets to keep a little dignity there-sitting in her own little apartment with a loving staff providing for her & I have a little piece of mind knowing she is being taken care of! I have visited nursing homes before and its very sad because they just shove these elders in a home with very little crew that is so unkind almost inhumane! Graig , bottom line is if there needs to be cuts some where please don't take cuts which will effect the elders , & thank you for the read!

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Bo Gerbig

Comment: I should proof read before I Hit send so my apologies for typing Graig instead of Craig, also I must say I very much dislike Elmcroft in Maumelle, the day my sister & I moved my mom we could not find one associate to unlock the door to move my mothers furniture out and heard several elders yelling for help , I don't know much about different facilities but was so blessed to find Countryside in Huntsville, they are a fraction of the cost of Elmcroft but I don't think they could handle cost cuts at an already low fee they charge without loosing quality care-just a thought! Have a great day

Response: Comment considered and accepted in part. Please refer to response above.

April Gillmore

Comment: I would like to take this time to express my concerns about the changes to go into effect January 1. My "client" suffers on a daily basis from Cerebral Palsy, Mental Retardation, Epilepsy, and also Cortical Blindness. I have been his caregiver as well as his personal care aide for 16 years. My client can't walk or talk, has a set schedule that we go by, doesn't like to be out of his "routine", and is used to certain things and people in his daily living. Our "clients" are family to us, whether it's been for 16 years or 6 months. Hindering the little abilities that he does have by switching his aides, or even his hours of

aide will not and can't help in his daily living. The goal is to make life easier for them, these "Clients" did NOT ask for the mental, physical or emotional trials of their everyday living, why would you make them suffer even more, by taking away someone that they are used to, or their hours away for care.

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

Jamie Cardenzana

Comment: As a provider for the Arkansas Medicaid AR Choices and Personal Care programs, I see several issues with the proposed changes in regulations for these programs. These proposed changes need further evaluation and reconsideration. Many of the people who need attendant care, respite care, and/or personal care services under these Medicaid programs are the oldest and frailest or disabled Arkansans. These services are essential in enabling them to live out their lives with dignity and support in their own home if that is their preference. The alternative to receiving home care services is a nursing home or to go without the care they need. Home and Community Based Services must allow beneficiaries to choose among setting options and the choice must be based on their individual needs and preferences. HCBS must also ensure beneficiaries' rights of privacy, dignity and respect and freedom from coercion and restraint as well as optimize autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact. They must also facilitate individual choice regarding services and supports and who provides them.

Several of the proposed changes to the regulations for these programs will hurt Medicaid beneficiaries receiving the services and their families. These changes limit the beneficiaries' freedom of choice and limit their ability to utilize the home and community based services. There is currently a caregiver shortage in the NW A area, which limits agency providers from effectively staffing all clients in need, especially those who live in rural areas. The proposed changes in definitions of attendant care services to exclude companionship and socialization will decrease beneficiaries' quality of life and mental wellness, which science has shown can decrease a person's overall health and wellbeing. Many beneficiaries do not have family, friends, or regular adequate support so they depend on agency provided caregivers to meet all of their needs. The purpose of the proposed changes are to create a more person-centered approach to long-term services and supports by allowing greater flexibility and discretion for nurses to create service plans that are targeted to each beneficiary's individual needs, which is great. It is also intends to do this by focusing beneficiary decision-making on how best to protect the beneficiary's health and safety, however some of these changes do the opposite. The proposed changes are also supposed to better align L TSS services across Medicaid beneficiary needs by coordinating personal care, attendant care, and respite care services through more consistent definitions which has been accomplished with the proposed changes to the definitions. It is imperative to define the services and establish limitations on what the services are intended for; however, the current regulations for attendant care do not have specific regulations for what must be completed during each visit or how hours need to be allocated. This provides complete flexibility for the beneficiaries, yet a hardship for providers to require beneficiaries to allow aides to provide services other than housekeeping and errands. The intent of the programs are for beneficiaries to receive assistance in AD Ls (eating, bathing, dressing, personal hygiene, toileting and ambulating) and IADLs

(meal preparation, incidental housekeeping, and laundry). Current regulations do not specify how much time, if any, must be devoted to ADLs and many beneficiaries state that they want to use the hours however they want to since it is not prohibited. This enables them to use all of their attendant care hours for housekeeping and errands if they so choose. The proposed regulations exclude companion, socialization, entertainment, or recreational services. While it is important to place limitations on these types of services to prevent overuse and abuse by beneficiaries it is just as important to allow for a limited amount of socialization and entertainment to contribute to a higher quality of life and mental wellbeing. Changes to the current regulations are necessary to decrease the amount abuse, misuse, and fraud; however, the proposed changes will create additional problems and limit the options for beneficiaries to receive the care they need.

AR Choices Waiver Amendment:

- Waiver amendment says "Human assistance with medically necessary ADLs (such as toileting and mobility, and ambulating) remain covered both in the home setting and outside the home when a waiver participant wishes to participate in community activities or attend religious services and needs such assistance at those venues;" however, the proposed changes to the AR Choices provider manual removes errands and traveling. The scope for shopping has been updated to state for "food, clothing, and other essential items required specifically for the health and maintenance of the participant." The proposed changes for the provider manual also states that attendant care services will exclude:
"companion, socialization, entertainment, or recreational activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies and other activities pursued for pleasure, relaxation or fellowship."
 - These two proposed changes contradict each other. Waiver amendment states that services will be covered when the participant wants to participate in community activities, but the provider manual states that those services are excluded.

Response: Comment accepted. The proposed language will be revised to clarify that a caregiver may provide assistance with ADLs/IADLs outside the home and in community activities.

Comment:

- Waiver amendment states all new policies about provider service delivery which includes service definitions will go into effect with the amended waiver. "Specifically, any services authorized under a person-centered service plan in effect on the effective date of the amended waiver and promulgated provider manual must comply with the service definitions and limitations in the amended waiver. For example, providers must adhere to new service definitions and limitations concerning the types of activities that are covered under attendant care and respite care."
 - Will waiver participants be notified of these amended changes that providers will be required to follow prior to them becoming effective? As a provider, when we tell a client they can no longer do something because of regulation changes they do not believe that this is actually a regulation change that we're required to follow. They also complain that this is something that they have always been able to do.

Response: Yes, participants will be notified of the proposed service changes.

Comment:

- "At the time of assessment and re-assessment of the waiver participant, the DHS RN explains the services available through the ARChoices waiver, discusses the qualified ARChoices providers in the state, and develops an appropriate person-centered service plan."

- Will the DHS RN also be explaining what is included in these services and what is excluded? Will they explain the provider's limitations and requirement to follow the regulations?

Response: Yes.

Comment:

- Attendant care services are not available (not covered and not reimbursable) "when attendant care services delivered through a home health agency or private care agency are provided by any person who (i) resides (permanently, seasonally, or occasionally) in the same premises as the participant; (ii) has a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's guardian or legal representative; or (iii) is related to the participant by blood (i.e., a consanguinity relationship) or by marriage or adoption (i.e., an affinity relationship) to the fourth degree."
 - If family members or house hold members will no longer be able to be paid care providers through an agency, couldn't this negatively affect several participants? Who will provide the care when a participant does not want a 'stranger' to provide their care, yet the family member cannot afford to not work and be an unpaid caregiver? Many of the family members and house hold members that provide care through an agency are able to do so because they get paid to do so. If they cannot do this any longer, they would be forced to get a job outside the home which would limit the care the participant receives, especially when they do not feel comfortable with an outside person coming in to provide it.
 - How does this amendment allow for the participant to have their freedom of choice?
 - If the state does not allow for family and/or household members to provide aide services through an agency, but allows it through independent choices the state is essentially forcing these beneficiaries to go to independent choices which is limiting their freedom of choice. Many beneficiaries and aides prefer to work through an agency. Our experience with aides that have either worked through PALCO or attempted to work through PALCO have reported difficulties. Some complaints include: long process to get started for the caregiver to be eligible to get paid, less frequent pay, not being able to utilize all of their hours, difficult to work with and follow up is poor.
 - This change would affect approximately 65 of our Medicaid beneficiaries. Of these beneficiaries, there are 6 that we would have difficulty staffing due to language barriers. NWA has a large population of non-English speaking residents. Agencies have limited bi-lingual aides to utilize to provide home care services to these beneficiaries. 4 of the 6 clients speak Spanish, but there is a limited number of Spanish speaking aides available to send to these clients. The other 2 clients speak Arabic languages, which would be nearly impossible to staff with an aide who could effectively communicate with the beneficiary if family/household members were excluded from being a paid caregiver. 19 of these beneficiaries would be difficult to staff due to the location of their home. Many of these beneficiaries have had family members attend personal care aide training in order to be eligible to be a paid caregiver through an agency. A majority of these 65 beneficiaries decline a replacement aide if their family or household member who is their regular paid caregiver is unavailable and report not wanting people they do not know coming into their home or providing personal care services.

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

Comment:

- Attendant care services are not available on dates of service when the participant receives personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan for the same tasks.
 - o Does this mean that providers cannot schedule personal care services on the same day as attendant care services? Or would it be okay to do so as long as some of the tasks are being completed under PC and the others are being done during the attendant care hours?

Response: Comment accepted. The proposed language will be revised to clarify the relationship between personal care and attendant care.

Comment:

- Attendant care services are not available when the participant spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the DAABHS registered nurse.
 - o If both adult day services and attendant care are on the person-centered services plan authorized by the DAABHS RN, is this the written approval that is needed? Or does the provider need additional documentation for the approval?

Response: The provider must have written documentation specifically authorizing the additional hours, either in the service plan or in another document authorized by the DHS RN.

Comment:

- Attendant care services are not available through ARChoices on dates of service when the participant receives services from an inpatient hospital, nursing facility, assisted living facility, hospice facility, or residential care facility, unless approved in writing by a DAABHS registered nurse as reasonable and necessary given the time of day of the facility admission or discharge, the need for transition assistance, or an inpatient hospital admission incident to an emergency department visit or direct inpatient admission by the attending physician?
 - o Are the DAABHS RNs going to be able to approve and provide this in writing timely? There are times clients will call stating they are being discharged in a few hours and will need someone to help them get settled back in their home. Will providers be required to wait for the DAABHS to approve this in writing prior to being able to send an attendant on the day of discharge?
 - o How does this benefit the participant?

Response: Yes, DAABHS will work to approve requests timely, and approval should be obtained in advance. The purpose of this rule is to comply with federal restrictions on waiver services being provided at the same time as state plan services.

Comment:

- Respite care is to provide short term relief for the primary caregiver subject to "no other alternative caregiver (e.g., other member of household, other family member) or source of assistance is available to provide a respite for the primary caregiver(s)."

- o Will providers be required to determine that there is no alternate caregiver or source of assistance prior to scheduling respite for the participant's primary caregiver? Or will this responsibility be the DAABHS RNs' responsibility when developing the PCSP?

Response: Authorization and allocation of respite hours will be the responsibility of the DHS RN.

- Reimbursement is not permitted for Respite Care services provided by: 1. any person related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree; 2. A resident of the participant's home or place of residence (whether permanent, seasonal, or occasional); 3. Any of the participant's regular caregiver(s) for whom respite is being provided; 4. Any person who has a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's guardian or legal representative; or 5. Any provider organization that employs or contracts with any above individual.
 - o Does number 5 mean that if an agency employs someone that is family or lives with the participant then they would not be eligible to provide respite services?
 - o Would the participant be required to choose a different agency?
 - o Does this not limit the participant's freedom of choice?

Response: Please refer to response above regarding the provision of services by family members.

Comment:

- Respite care services are not covered to provide continuous or substitute care while the primary caregiver(s) is working, attending school, or incarcerated.
 - o Why can the primary caregiver not request respite care for them to get a break from caregiver to try and earn some money or further their education? If the participant requires 24/7 care, this might be the only time they would be able to get out of the home to do these things.

Response: The purpose of respite care is to preserve the availability of care during short-term, planned or emergency periods of time where an unpaid caregiver needs a break; work or school is not a respite period.

Comment:

- Task and Hour Standards
 - o Will the providers be given a copy of the individual THS for each participant?
 - o There are currently beneficiaries that want to max out their hours because they have been given up to a certain number of hours per month, however during the provider's assessment we could not justify 64 hours of personal care based on the tasks the beneficiary was requesting at the frequency they wanted them completed. Many times when the beneficiary realizes this does not add up to all 64 hours they are upset. It would be beneficial for the providers to have access to each beneficiary's THS for scheduling medically necessary hours that align with the independent assessment. It would also help make sure the provider is appropriately utilizing the approved hours based on the beneficiary's assessment. Providers would also be able to use this to help explain and justify the limitations on scheduling a certain number or hours per day or per week to the beneficiary instead of the beneficiary thinking they can use their monthly hours any way they choose.

Response: Yes, providers may be given the participant's THS.

Comment:

- Objection to the proposed changes on restrictions on who may provide ARChoices Services: Individuals providing attendant care, environmental accessibility adaptations/adaptive equipment, prevocational services, or respite care may not: 1. Reside (permanently, seasonally, or occasionally) in the same premises as the participant; 2. Have a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or 3. Be related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.
 - o Why are family and household members being prohibited from providing attendant care services?
 - o There are many clients who choose to have a family member (by the proposed definition) or household member provide care through an agency. This allows the caregiver to earn some income while also assisting their family/household member. If they are not allowed to do this, it could force them to find work outside the home. This exclusion limits the beneficiary's provider freedom of choice.
 - o If this proposed change does get approved and providers are required to comply with the new regulation on the effective date of the provider manual changes, will there be a transition process for these clients? It will be a major adjustment for several clients and attendants as well as providers. It will require having to hire several new attendants to provide this care, if the beneficiary will even allow it. Providers may not be able to effectively hire enough caregivers in such a short amount of time.
 - o This will negatively impact hard-to-staff rural areas as well. There are many clients that live in more rural areas where staffing is more difficult. Many of these have a family member or household member that provide the care since agencies cannot find another caregiver.
 - o If approved, who will be responsible for notifying the beneficiaries?
 - o Why would family be allowed to work through Independent Choices to provide the same type and amount of care that they would provide through an agency, but not be allowed to work for an agency?
 - o If approved, and participants choose to switch from agency to Independent Choices will they be able to by the time the changes become effective? Can PALCO handle that many enrollees at once?
 - o Agencies are required to follow guidelines in which family members must be trained, background checks ran, and provide TBST. There is less oversight through independent choices vs. agency provided care.

Response: Please refer to response above regarding the provision of services by family members.

Comment:

- Attendant care service definition changed to exclude companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship.
 - o What about the beneficiary's mental health and wellbeing? Some clients have no family support or friends. The only social interaction they receive is during their aide services. These activities can help improve quality of life. Meeting all of a person's needs provides holistic care.
 - o Research has shown that companionship and socialization can increase one's

quality of life. It is necessary to take care of the whole person using a holistic approach vs. just physically taking care of them. Many beneficiaries do not have family, friends, or regular adequate support to ensure that all of their needs are met, so they depend on agency provided caregivers to meet all of their needs including emotional, mental, social, and physical needs.

Response: Comment considered. Neither companionship nor socialization is recognized as an ADL or IADL, and the purpose of attendant care is to provide hands-on assistance with ADLs and IADLs.

Comment:

Personal Care Provider Manual:

- Personal care tasks - 213 .200 C. Personal care services are individually designed to assist with a beneficiary's assessed physical dependency needs related to the following routing activities of daily living and instrumental activities of daily living: 5. Incidental housekeeping 6. Laundry 7. Personal hygiene 8. Shopping for personal maintenance items.
 - u Why could you not define these tasks further like the service descriptions in the AR Choices regulations?

Response: Comment considered. The existing Personal Care provider manual already contains detailed information regarding the covered ADLs/IADLs, and DHS does not believe that the existing language needs clarification at this time.

Comment:

- 214.3210 If personal care services are not currently being provided when the DHS RN develops the AR Choices PCSP, the DHS RN will determine if personal care services are needed. If so, the service, amount, frequency, duration and the beneficiary's provider of choice will be included on the AR Choices PCSP.
 - o This is inconsistent with the AR Choices regulations, which states that state plan personal care will be utilized prior to attendant care services through the waiver. This statement in the proposed PC regulations makes it seem like the DHS RN could determine that personal care is not needed.
 - o When including the service, amount, frequency, and duration on the beneficiary's PCSP will this be weekly hours? Monthly hours? Will the frequency tell the provider the number of days per week the beneficiary is needing/wanting personal care? Will it tell the providers how many hours per day their assessed need is?

Response: Comment considered. Neither personal care nor attendant care is an automatic entitlement under the waiver program. The DHS nurse must first determine whether the beneficiary requires paid hands-on assistance with ADLs/IADLs. If so, the DHS nurse will first allocate personal care hours, and then attendant care hours if appropriate. The Task and Hour Standards will identify the aggregate number of care hours by week and month, and will identify the frequency. The provider and the beneficiary will determine the number of days per week that care is needed, or how hours are split between multiple days.

Comment:

- The proposed service plan, with proposed hours/minutes and frequency of needed tasks consistent with the Task and Hour Standards is to be submitted with the referral.
 - o If the ARIA assessment has not been done, then how does the provider know the needs intensity score to develop a service plan that is consistent with the task and hour standards?

Response: For ARChoices beneficiaries, no referral will be submitted by the provider, and the service plan will be developed after the ARIA assessment has been completed. For non-waiver beneficiaries, DHS will

work to streamline the DMS-618 form and reduce the amount of information required to be submitted by providers.

Comment:

- Will the process for submitting referrals be outlined for providers? There seem to have been a lot of changes to the approval process for personal care services over the last year. Many of the changes in procedure have not been effectively communicated with providers until the provider has done something incorrectly. We were initially told to do submit referrals in a particular way with certain information, but then as changes occurred providers were not notified. We found out by asking for an update on a referral submission or because a DHS RN told us that something had changed when submitted incorrectly.
 - o There is a lack of communication between the person's developing/changing the procedures, the DHS nurses, and the providers which makes it difficult for providers to follow current procedures for submissions.

Response: Later this year DHS will be offering additional training for providers.

Comment:

- Individualized Service Plan. The service plan must describe each routine or activity listed; the frequency and duration of service of each routine and activity, including: the number of days per week each routine or activity will be accomplished and the maximum and minimum estimated aggregate minutes the aide should spent on all authorized tasks each service day.
 - o The proposed regulations do not specify different requirements for personal care beneficiaries under 21 years of age and over the age of 21; however, AFMC who approves the individualized service plan and creates the prior authorization for beneficiaries under 21 have informed this provider to not include minimum and maximum (a range) of time for tasks. They have told us that no matter what they will always only approve the minimum number of hours listed on the DMS618. If AFMC will not allow providers to include these ranges on the individualized service plan, how are providers expected to follow the provider manual and maintain compliance with this regulation?
 - o If there is no differentiation in the process or the requirements of PC for those under 21, then how do providers know what needs to be done differently? Such as, approvals being done by AFMC.

Response: The maximum/minimum ranges in the Task and Hour Standards are used only to calculate the aggregate number of hours of care; they are not intended as limitations on actual performance of each individual instance of a task. DHS will work with AFMC to clarify requirements and process for under 21 beneficiaries.

Comment:

- As a condition of coverage and reimbursement, all personal care services must be: 3. Not available from another source (including, but not limited to, family members, a member of the beneficiary's household, or other unpaid caregivers; another Medicaid State Plan covered service; the Medicare program; the beneficiary's Medicare Advantage plan or Medicare prescription drug plan; or the beneficiary's private long-term care, disability, or supplemental insurance coverage.)
 - o Will a family member or household member that works outside of the home be enough reason to consider them unavailable to provide personal care?
 - o Will beneficiaries on the AR Choices program also be required to meet this

standard? If they have family members who are able to provide some or all of the personal care, will they still be eligible for personal care under the AR Choices waiver?

Response: Care from a family member is considered to be “available” only if the family member is capable and willing, and is either already providing the service, or has expressed a specific willingness to provide the service. This requirement applies to all Medicaid services, whether state plan or waiver.

Comment:

- Shopping is a covered service only when the beneficiary is purchasing items that are necessary for the beneficiary's health and maintenance in the home (such as food, clothing, and other essential items) and that are used primarily by the beneficiary.
 - It would help for the definition to include personal care items, such as soap and shampoo.
 - It would be helpful for "other essential items" to be further defined. There are several beneficiaries that would consider cigarettes, lottery tickets, pet food, etc. as essential items which may not be the intention of the state.

Response: Comment considered. DHS does not consider it practical to specifically list every item that might be considered essential. Whether an item is essential is an objective test, but it will vary from beneficiary to beneficiary depending on their specific needs.

Comment:

- 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: 1. Reside (permanently, seasonally, or occasionally) in the same premises as the beneficiary; 2. Have a business partnership or financial or fiduciary relationship of any kind with the beneficiary or the beneficiary's legal representative; or 3. Be related to the beneficiary by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.
 - If family members or house hold members will no longer be able to be paid care providers through an agency, couldn't this negatively affect several participants? Who will provide the care when a participant does not want a 'stranger' to provide their care, yet the family member cannot afford to not work and be an unpaid caregiver? Many of the family members and house hold members that provide care through an agency are able to do so because they get paid. If they cannot do this any longer, they would be forced to get a job outside the home which would limit the care the participant receives, especially when they do not feel comfortable with an outside person coming in to provide personal care services.
 - How does this amendment allow for the participant to have their freedom of choice?
 - There are many beneficiaries that have a family member or household member providing the paid caregiving services through an agency because of their preference to work for an agency. These aides generally provide quite a bit more care than what they are paid because the beneficiary is someone that they care for and lives in their home or is a relative. While some caregiving should be expected from family members many could not provide the amount of care that they do without compensation.

Response: Please refer to response above regarding the provision of services by family members.

Comment:

- Task and Hours standards in the proposed changes to the personal care provider manual refers to the standardized process for calculating the amount of reasonable, medically necessary attendant care services hours. The number of attendant care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN or the contractor(s) consistent with the THS grid.
 - o Shouldn't this be referring to the number of personal care hours instead of attendant care?

Response: Comment accepted. This language will be clarified.

Comment:

- Will providers be getting a copy of the task and hour standards assessment and determination for each individual client to see how the hours were determined and where they were allocated to?
 - o Receiving this information is imperative in assisting providers in scheduling aides for the beneficiaries for the appropriate, assessed medically necessary amount of hours for each task. It will also help maintain consistency between provider and DHS approvals.

Response: Please refer to response above regarding this issue as applied to ARChoices.

Comment:

- If a personal care recipient will receive an ARIA assessment by the independent contractor and have an individualized service plan meeting with the DHS, why does the provider need to go out and do an assessment prior approval of attendant care hours?
 - o Many clients have told providers that certain tasks take them a certain amount of time, but then the prior authorization that gets approved has a different approved amount of time.

Response: DHS will work to streamline the DMS-618 form and reduce the amount of information required to be submitted by providers.

Comment:

- Provider Notification Process. Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.
 - o 15 working days = 3 weeks. This is a long time for a beneficiary to wait for personal care services to be approved when they are in desperate need for personal care services.
 - o Currently, some prior authorization requests taking 1-2 months for approval. The beneficiaries are calling on a daily or every couple day basis to find out if their hours have been approved. There has been some lack of communication regarding some of the beneficiaries. After a couple of weeks without receiving an approval, we will attempt to contact the DHS RN to follow up on the request. Many times we do not get a response to these questions. It is difficult to follow up to see if there is something else the provider is needing to do or if the beneficiary is potentially on the unable to contact list or if there is something else entirely going on preventing us from receiving an approval or denial. This makes it difficult for the provider because we are consistently having to tell the beneficiary that we

have not received the approval, but that we have not been able to find out why the request has either not been approved or denied.

Response: Comment considered. DHS understands that many providers are concerned about the viability of the independent assessment process and its relationship to the prior authorization process. Optum has now performed more than 50,000 independent assessments in Arkansas. The results have supported the accuracy and validity of the IA system. Independent assessments are a federal requirement for Medicaid waivers for home and community-based services. To be clear, although Optum is responsible for conducting independent assessments, Optum does not perform the function of prior authorization. DHS has worked to improve its internal processes in handling prior authorization requests and will continue to implement changes to improve the reliability of those processes.

Stephen Malcolm Parlier II

Comment: Are you people smoking crack?! Has everyone at DHS lost their minds, or just sold their soul to the Devil. First you good folks violate a court order. then you're held in contempt of court. and yet no one is held accountable for this. if any other citizen of the great state of Arkansas would've done this they would be in prison!!!! So does DHS have a license to break the law???!!!! If you instate this abomination of a system you are not only doing a disservice to the people of Arkansas, you are doing a disservice to yourselves as well. I promise you I intend to boycott this new system. on social media, to video and print media, and I intend to also contact my lawyer at legal aid. this gross incompetence and willful Negligence will not be tolerated by the people of the great state of Arkansas! Also something else you may want to remember you are an employee of the aforementioned people. You are handing out a Death Sentence to myself as well as countless Arkansans. So DHS is basically a death squad similar to the ones Hitler had instated. I assure you if I should die due to the willful Negligence of this abomination of a system you want to instate, My wife and family will sue for wrongful death and WILL receive punitive damages, as well as seeking indictments for Criminal Charges.

Response: Comment considered.

treparlier1997@gmail.com

Comment: Do you people have no sense of responsibility, you would just rather a machine did the work of an actual person? If that's the case why don't we get machines to do your job? As a result of ARIA , not only will my dad most likely lose all of his hours, but since all family caregivers will no longer be able to work through an agency, I will lose my job since I take care of my dad, I know that I am not the only family caregiver that this affects. This needs to be stopped. ARIA is almost the exact same as the RUG's system and since the RUG's system was found unconstitutional in a court of law, I can almost guarantee that ARIA is as well. Do you realize how many people will die as a result of this? Many people would rather stay in their homes and be taken care of by someone that they trust and who understands their needs instead of being forced to be in a nursing home and with ARIA there are so many people that will be forced to be in a nursing home or will die because without the help that people get from their loved one being on in home care. We need to go back to the nurse's having the discretion as to how much care clients need because that is the only way people like my dad will get the services and care he needs. Would you let a machine decide the fate of your parents, if the answer is yes, then I have a great idea, since you're so comfortable with machines making decisions let's let the people of the great state of Arkansas devise a machine to decide annually who get's your job.

Response: Comment considered. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for

flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary.

Marilyn Richerson

Comment: I'm appalled that you would even consider touching our seniors care during this political time. Our seniors deserve SECURITY and RESPECT. They do understand and they do worry about their care. SHAME on you. Our forefathers and our country would be saddened by this action. And you're Arkansas' Director of Provider Services & Quality Assurance? Step down.

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

Sarita Gerbig

Comment: Mam I am writing because I understand there is an amendment change to the current Medicaid waiver program, specifically an assisted living rate reduction coming up fast. I'm really asking that this change be postponed at the very least – and ultimately left alone. I hope that you can help me.

Please, please hear my reasoning. My mother who is now 82 years old is residing in an assisted living facility in Huntsville where her needs are being cared for and looked after. My mother has dementia and can't live alone. She can't remember where the bathroom is or how to brush her hair, her teeth or the location of her former home. She does though still have traces of the woman that raised me – humor, dignity, caring, respect for others and love. We don't talk about the same things we used to but carry on different conversations. She never – ever - took a handout and worked two jobs, low pay in fact, to pay for the house I was forced to remove her from and sell. If she knew Medicaid was supporting her life now, she'd rather be living under an overpass than "take" a hand-out.

I will forever carry the guilt of selling a house she loved, for selling its entire contents, emptying her bank account of every single penny, selling off stocks she dreamed of using to retire comfortably, all to pay for her time in assisted living facilities because there was no other way. We moved her three times. It went so fast. After every single material thing was spent and/or sold, I was forced to find a nursing home that could accommodate a strong woman not "gone" but in the process of "losing herself" and essential short term memories. I visited several nursing homes but just couldn't see her going from an assisted living scenario to a single bed - in a shared nursing home room - that looks like a hospital stay. There was divine intervention though... my brother decided to check out an assisted living facility very close to him in Huntsville, Arkansas: Countryside Assisted Living. He found they accepted social security with some help from Medicaid via waivers. We immediately placed her on a waiting list. My brother went by every day or two to check to see where she was on the list until finally her/our day came.

I promised my mother the day my brother and I delivered her there, we would never move her again. Of course, she still wanted to go home. And still does today. Except today, she can't remember where home is. She is as comfortable as anyone in this condition. Her current state can be only be attributed to the care this assisted living's staff and workers provide. The work is strenuous, fast pasted

and always on. Right now they are keeping their patients' needs at hand. I just can't imagine what would happen if staff cuts were affected by a reduction in Medicaid rates for assisted living facilities, especially this one! Please, please postpone this amendment or just drop it. Our elders have earned the care. Our state, our country, just can't just toss those who raised us aside – can they?

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Kathryn Sue Wilson

Comment: Dear Sir & madam who represent DHS: The governor and his staff plan to cut Medicaid rates by 21.77%. Each assisted living residence will have to lay off 5 to 6 employees. We need to express our feelings on the issue of what they plan to do with Medicaid. I'm sorry to hear that our dear governor plans to take away from what we have honestly earned. I do not wish to live on the street or anywhere else that the governor would not live. I do oppose sending our representatives to other places to go. Pushing American Seniors to save budget is not the way to go. Women need to be educated so they could be governor, senator or representative-someone who could run a clear office and keep things on the straight and narrow. Please vote for the good of our country and our assisted living facilities.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Jude Box

Comment: I have a family member that lives in an assisted living. They are not able to live at home due to not being able to make their own meals and take care of themselves. She needs assistance on bathing, dressing, and personal care in the bathroom. She loves living in an assisted living facility. She says it's a home away from home! And if she needs help with anything they are there for her. She was hesitant at first in moving into a facility, but when we went and toured she fell in love with not only the facility, but the people. It wasn't dark or sad to be in, it felt like a home that was bright and happy. You have no idea how big of a relief it is for me not to worry about her being depressed and enjoy where she is living. I love to go visit her almost daily and see all the new crafts she has made in activities and visit with all her friends. You see, she is not sitting at home alone anymore, she has her friends that become

family when you are with them each day. I have security knowing that she is safe. She is no where close to having to live in a nursing home because she is too high functioning and she cannot stay at home. She might have some good days where as she might not need as much help, but there are some days where she just might need help washing her hair or going to the bathroom. Please see that assisted living facilities are wonderful for our friends and families. They give them the care that they need. To take this away from our elderly, the desperate ones who cannot work or stay by themselves, would be a disservice to everything they have worked for.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Anonymous

Comment: I recently received and read about the Governors proposal to cut Medicaid 21.7%. Seven years ago when I found I could no longer live alone, I was very unhappy. But When I found Countryside assisted living I was relieved. I have been living here for four years. They furnish me with a very nice living area, I get three good meals a day. They do my laundry. They keep my room clean. They keep me entertained and occupied with activities. I have help at the press of a button if I fall or am sick. I don't know what I would do without this facility. And I would be very disappointed to hve any of these activities cut.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Melissa Zabecki

Comment: I am writing on behalf of my best friend, Marilyn Knapp. Her parents, Wayne (90 yrs. old) and Norma Rossow (84 yrs. old) entered an Assisted Living Facility (ALF) on April 13, 2018 through the Medicaid wavier program. Since they have lived there, their quality of life has improved and it has helped them live with dignity as they near the end of their lives. Their daughter and my friend, Marilyn, has had a much easier time since her parents have been placed, rather than worry about them every minute while they were at home. We have great concern that the proposed DHS amendment changing the rules concerning provider care, rates, and changes in the assisted living homes will greatly adversely

impact not just her parents, but also thousands of elders across our state. This amendment is being pushed too quickly. Too many many people and families will be affected by these changes without enough impact studies done beforehand. While these changes may save money, the cost on people's lives is not worth it. So I am asking that you do not pass this amendment as is.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Marilyn Knapp

Comment: I am writing on behalf of my parents, Wayne (90 yrs. old) and Norma Rossow (84 yrs. old) (Photo attached). They entered an Assisted Living Facility (ALF) on April 13, 2018 through the Medicaid wavier program. Since they have lived there, their quality of life has improved and it has helped them live with dignity as they near the end of their lives.

I have great concern that the proposed DHS amendment changing the rules concerning provider care, rates and changes in the assisted living homes will greatly adversely impact not just my parents, but also thousands of elders across our state.

I believe that this amendment, which is 600 pages long, is being pushed in an extremely short timeline. Do you know how many people and families will be affected by these changes? Has there been an impact study done? I ask you to take a moment and think about how the repercussions these changes will have on not only individuals and families, but also communities.

Sure, maybe these changes save the state tons of money, but what other unexpected costs may come of it? I implore you; do not pass this amendment as is.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Christy Bennett

Comment: I am writing to request that you postpone the assisted living rate reduction. This change will negatively affect several of my loved one's care they receive in assisted living facilities. I believe you need to research this matter further before making a decision that will affect many in a negative way. I have family members in Countryside Assisted Living in Huntsville. That facility is ran by two of my great friends and they do amazing things for the people there but can not operate with this reduction in funds. Those family members will be forced to move to a nursing home or worse, move back home, where they can't care for themselves. We need to take care of our elderly! Thanks for your consideration.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Nancy and Robert Holmes

Comment: We are Nancy and Robert Holmes and are writing on behalf of Nancy's elderly mother, Dolores Reuland, who is a resident at Legacy Village Assisted Living under a Medicaid Waiver.

We have great concern that the proposed changes to DHS rules concerning provider care, rates and changes to assisted living homes arrangement with the state Medicaid Waiver Program is being pushed to be reviewed and revised in an extremely short timeline in order to cut the Arkansas state budget.

The documents are nearly 600 pages of changes, edits and overhauls, It is critical for our lawmakers, senior care providers and affected seniors to understand the changes being sought by the Department of Human Services and the current timeline does not allow this.

Under these proposed rule changes, not only will vulnerable seniors currently living in assisted living facilities under the Medicaid Waiver program be adversely affected, the facilities themselves will be providing the same required level of care while receiving -21.7% cut in cost per day rate.

We respectfully request your help in ensuring that these changes are not passed as is or at the very least help delay the adoption of these rule changes until the Administrative Rules and Regulations Committee has fully considered all the long-term ramifications of how they will affect Arkansas citizens and care facilities.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019,

will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Stephen Holman

Comment: I am writing on behalf of Bobbi Gray & Osage Gardens Assisted Living Community located in Bentonville, AR.

I have great concern that the proposed DHS rules concerning provider care (Living Choices Assisted Living, Section 200.100, Qualifying Criteria\ for Living Choices Assisted Living Providers), rates and changes to the assisted living home arrangement with the state is being pushed to be revised and reviewed in an extremely short timeline as the document is nearly 600 pages of changes, edits and overhauls. It is critical for our Seniors and Senior care providers to understand the changes being sought by the Department of Human Service and the current timeline does not allow for this proper review.

I respectfully request you help delay the adoption of this rule change until after the elections and holiday so that our Seniors and care providers have time to understand the implication so the proposed rule. (NOTE: "Delay" is the request that our care provider group has agreed to unify around.)

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Michelle Martin

Comment: Greetings from Berryville, Arkansas! I write to you today in regards to a topic that is near and dear to my heart. I have worked in two assisted living facilities and have been amazed at the level of care these facilities have provided our aging population. I have also worked in the geriatric ward of a mental health facility and understand the demands on staff caring for individuals suffering from dementia and the detriment to patients that can happen due to inadequate staffing. While most of our elderly do not require much attention or assistance with activities of daily living, those individuals are not typically the ones utilizing the resources within a skilled facility and are certainly not the ones who qualify for Medicaid in order to do so. Those individuals are ones that are able to age in place within their own homes with minor assistance from friends and family. The individuals we skillfully care for are ones who require various levels of assistance- some more physical while others need more assistance with memory care in order to stay safe and healthy. Either way, it takes a tremendous amount of time and attention to properly care for these individuals. The proposal to cut Medicaid rates for our aging Arkansans to relieve budgetary stresses is not the answer.

Our seniors deserve the best care. In order to provide that care, these facilities need funds to fully enlist the best nursing staff by providing competitive salaries, hiring enough aides to properly cover shifts, and providing wholesome, nutritional ingredients for complete diets. The impact of these cuts is far more reaching than you may have initially considered. These facilities, including the one in which I am

currently employed, would have to choose how these cuts would have to be handled- from laying off good employees to rethinking menus to cut costs-ultimately providing a lower quality or quantity of food. Both would greatly impact our residents! I am blessed to work in a facility who does its absolute best to staff above state requirements so that we are able to take a little extra time with our residents. For instance, the one who needs undivided attention to make sure he eats all of his food so he can maintain his weight or the resident in memory care who is reliving a traumatic time in her life and needs one of us to stay by her side to talk her through breathing techniques to calm down. With budget cuts, our facility is looking at having to lay off five to six compassionate employees. I am one of the most recent hires and therefore that puts me in the position of being laid off. As such, these cuts also impact my family greatly. I am currently the primary income for our household of seven. We have five children under the age of ten. I implore you to please reconsider your request for an amendment change- for our seniors as well as my children. Our seniors deserve the best. My children deserve the best. Please help me to provide the best for both. Please reconsider your proposal. Thank you for your time. Thank you for continually putting Arkansans first.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

mitch.lankford@sbcglobal.net

Comment: I want to tell you of my disapproval of the proposed cuts in Medicaid funding for the low income people in Arkansas. The October 2017 amendment by the Department of Human Services of the Assisted Living Medicaid program to limit the number of participants approved is currently hurting these low income residents. To cap this benefit to 1200 for the entire state is unrealistic. Then, to extend this cap to 2020 would be jeopardizing the existence of many of the facilities that these residents depend on. What are these low income residents to do without a place to live? Most, if not all, have only their social security as income. Do you expect this small amount of money to pay for private care and a place to live too? I urge you to NOT support these cuts. I will be anxiously awaiting your comments

Response: Comment considered and accepted in part. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. As for assisted living, the current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on

evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Nancy Holmes

Comment: What: Rally

When: Friday, November 2, 2018

Time: 5:30 PM

Where: Gardens at Osage Terrace

3317 SE L Street

Bentonville, AR 72712

You are invited to attend a rally held by concerned Assisted Living residents, family members and community to stop the Administrative Rules And Regulations Committee from passing the proposed current New Rule Changes to AR Choices/Medicaid Waiver Program. Come out and visit with the people these changes will affect and hear their concerns. You can ask for me and I will connect you with resident seniors and family members. I am the daughter of Dolores Reuland a resident at Legacy Village Assisted Living on the Medicaid Wavier Program

Response: Comment considered.

Mike Shepard (Fort Smith Public Hearing 10/15/2018)

Comment: Good evening. My name is Mike Shepard, I'm an Assisted Living provider here in Arkansas. We own and manage four facilities, three of them are rural, one of them is urban, and we're partners in five others. I'm the past chair of the National Center of Assisted Living in Washington, D.C., and I sat on their board for over ten years. I have great knowledge about Medicaid and Assisted Living throughout the United States, and I wish to speak in opposition to the Assisted Living proposed changes, most particularly, having to do with the rate. I was part of the original negotiating team representing Assisted Living in 2002, and I sat with the state as we promulgated all of the various regulations that would ensue. At that time --for those of you that are not familiar with Assisted Living, Assisted Living must meet nursing home admission standards in order to comply as a level two facility. At that time, the plan that was submitted and approved by CMS included a number of provisions, one of which was a cost of living increase similar to the cost of living increase every year that Medicare recipients receive. In about 2014, the state indicated that they thought that that was excessive, and that Assisted Living was getting too expensive for the state. Although it is less in cost than nursing homes due to the reimbursement from the federal government, the state believed that Assisted Living was more expensive than the nursing home. At that time, the cost of living increase was taken out of the plan. We knew at that time that we would face five years of no cost of living increase and those providers that were active in the association decided that we could live with that, as long as things continued without, additional cuts. The state came to us in 2016 indicating that there were budget issues, and would we please talk to them about cuts to Assisted Living. At that point, we said, yes, that we would. Now, they have come forward with a 21 percent cut in Assisted Living rates. The average rate of Assisted Living is \$80.00 a day, and they are proposing a \$62.00 cut., Basically, what that means is since 2002 they are trying to take back everything that Assisted Living has done for their senior, frail, Arkansas residents. When I say that, that's because our cost of living increase allowed us to get our employees health insurance, it allowed us to increase our employees' wages every year at two or three percent.

And there was only one year in that period that we did not receive that cost of living increase. I think that was 2013. As a result of that, our costs have risen every year. Now the state is asking us to come forward, take a 21 percent reduction, which will include serious problems, not in urban markets, because in urban markets there are plenty of private pay residents. But in rural markets, there is not a significant amount of private pay residents, and Medicaid is a very, very valued resource to those folks that need nursing home and Assisted Living care. The basic reason that I think that we all need to oppose this rate is because in the study, the Milliman study, they've used three facilities to establish a benchmark, or a baseline for their recommended rate cut. There are over 65 facilities. That makes the study statistically invalid, that you would only use three facilities to look at an entire 65-facility urban and rural market. Therefore, I would like to enter my objection on the basis of that that study is statistically invalid. It needs to be reopened and to include costs from all the other facilities. One of the reasons that I think that's important is, in all the facilities in Arkansas, the acuity, or level of care, varies dramatically by county, and you can't put into one bag what happens in Bentonville or what happens in Pope County or whatever. But I can speak honestly that if this rate goes through, you will see a significant number of rural facilities close. They will not be able to live at a \$62.00 rate. We have raised that issue with the state, and the comment consistently is this, Well, you will just move them to the nursing home. And if that's what we want for our residents, then I'm sorry to say that that's not what Assisted Living folks want. Thank you for your time.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Linda Short (Fort Smith Public Hearing 10/15/2018)

Comment: Good afternoon. My name is Linda Short, and I have been in the healthcare 40 years. I own facilities that are called licensed residential care facilities, and we care for persons with mental health issues. There are 2,000, approximately, mental health beds that are residential care in the State of Arkansas. To me, it is a crime for DHS to want us to take care of residents for \$30.00 a day. The cuts to Personal Care are \$30.00 a day. No matter what tier you tier out at, it's \$30.00 a day. And so, I am here on behalf of not just my facility, but the other remaining residential care facilities, 2,000 of them, in the State of Arkansas. We have not had a raise in 15 years. Fifteen years. And that is unconscionable to me. To take care of persons with mental health issues, it would be a disaster, a

nightmare to have 11, 12-percent cut. It's also an understanding that we are going to go into the PASSE. For those of you that aren't familiar with the PASSE, that DHS will channel everything over to the PASSE. I'm not against the PASSE. I think the PASSE can be a vital asset. But to even think that we would have to even think of a cut, it is unbearable. So, I'm here to speak on behalf that we are totally against a cut in Personal Care. Thank you.

Response: Comment considered. DHS is not proposing a rate cut for personal care services at this time.

Todd Hightower (Fort Smith Public Hearing 10/15/2018)

Comment: Good evening, I'm Todd Hightower. I'm also an Assisted Living operator in the state. I would like to pose my objection to the changes in the cuts that we have seen. Much like Mike Shepard said, a 21.7 percent rate cut in Assisted Living is just going to be untenable for us. My biggest fear is, when you combine that with the changes disallowing Personal Care in a Licensed Assisted Living level two facility, and on top of that that right now in Assisted Living we have 1,300 slots available statewide, 1,200 of those are nonduplicatable, meaning on February 1st when the program opens, if somebody moves into that slot and were to come off the program February 5th, that slot is tied up for the remainder of the year until the following February. You take those into account, the 22 percent rate cut and some of the other changes we're seeing to Personal Care and ARChoices, and my fear and my opposition is that we are limiting services and availability of healthcare to our seniors[and our developmentally disabled adults. That would be my opposition.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Ed Holman (Fort Smith Public Hearing 10/15/2018)

Comment: Hi, I'm Ed Holman, I'm a provider, I'm out of Little Rock. We've got an Assisted Living facility in Fairfield Bay. I'm going to read from my notes here just because I couldn't remember all this stuff. But Assisted Living was started kind of late in Arkansas. It had been a trend throughout the country, but we got it approved in Act 1230 in 2001. I will repeat some of what Mike said. But up until that point we only had residential care, which was a lower level of care, and skilled nursing, which we all know what that is. I'm an operator, I especially know. Assisted Living was a place for the elderly to live with dignity, a lot more comfort, they were getting freedom. It was in an apartment, more home-like setting. We hear

how home and community-based wants a home-like setting. All the elderly I know say, "I want to live in a home-like setting." When I built a nursing home in Little Rock years ago, my mom and dad came up and they said, "It's beautiful, but we never want to live here." But Assisted Living, you could live there. It's pretty nice. The state went on to encourage us to do this program. They gave us a sort of good rate to start with, and then when it wasn't really taking off, they started to improve our rates, and they made it where it was actually something you could build and •. operate and run successfully. We did get, annual rates, as Mike said, and that helped. But we have the rates frozen in 2014, and since then, we have had to absorb mandatory insurance, health insurance, we have had minimum wage, which back then, when it started, was about six and a quarter an hour, now we are -- minimum wage is whatever Wal-Mart is paying. I can't ask somebody to do a job in my facility when they -- for \$6.00 or \$7.00 an hour when they tell me they can go get \$13.00 or \$14.00 at Wal-Mart. So, that's minimum wage. Amazon said their starting wage now is \$15.00 an hour. So, I've got to compete with that when the new facility opens down the road from me. We can't absorb these cuts. From the highest rate we are getting now it's a 26 percent cut. It just doesn't work. I can't afford that. We've got 52 facilities in the state that are on the Waiver right now. he caps are limiting us terribly. We used to consistently have 20 plus residents that are on the Waiver. Now we are lucky to have ten. There just aren't enough slots available. So, I'm very opposed to this. I want us to re-look at this Milliman study and get more accurate data in there. Otherwise, as it has been heard, you are going to have a lot of facilities that are going to have a lot of problems. Interest rates are going up --for a medium-sized Assisted Living, just the interest rates f going up a couple of percent raise their cost of doing business \$5,000.00 to \$6,000.00 a month. For a more expensive building might be \$10,000.00 or \$12,000.00. They can't absorb a cut on top of that. Banks and other lenders loan to build these facilities based on the feasibility and these rates that we have. If somebody goes to their bank and says, "Oh, by the way, my rate just got cut 20 percent," they might have trouble on their loan renewal. So, I'm opposed. I want you guys to be thinking about this, because you are going to see some facilities filing for bankruptcy if this goes through, I can promise that. And I can't --you know, you are putting this on the elderly's backs. Their choices are going to be very limited here, and I think it's something we've got to work with. Thank you.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Charlie Willbanks (Fort Smith Public Hearing 10/15/2018)

Comment: Everybody, my name is Charlie, I'm with Home Instead Senior Care of Northwest Arkansas. We are an in-home, non-medical care provider. We just have several questions after reading the Notice of Rule-making, so I just want to go through all those. And these are really just questions that we feel -- this is going to negatively affect not only what we have seen with the Assisted Living, but where are they going to go when they don't want to go there, they can't go there, they come to us. This is going to affect what we can do for them, and that's what these questions are related to. So, with the Personal Care service changes where the ARChoices program is pushing all your hours to be Personal Care instead of attendant care as a secondary asset, long term care facilities, Assisted Living facilities are encompassing an entire well-being for a beneficiary, for a recipient; mental health, physical health, and social psychosocial. With the changes to push everything to Personal Care and what the Task and Hour standards are, it feels like we are focusing solely on the physical well-being of a beneficiary in the state. And so, our question that we want an answer to, is in the state's view, these 9,000 or so recipients that are in the home, are we only to focus on their physical well-being? Is it all we have to do now? Is that good, enough? That's the answer we want. In regards to the Task and Hour standards for our beneficiaries, we are looking at time, task, frequency, duration for every medically necessary service. And so, DHS' RNs are going to be going out, making notes in there -- or not going out, but the subcontractor that goes out, does the assessment, turns those over to DHS; and DHS' RN will then take that and make these time/task frequency. Are those going to be shared with the provider RN? What we don't want is our assessment to not match your assessment, and then a provider is held responsible for something that could have been prevented had we had all the information. Let's see, here. The Personal Care program, once again, has requirements for task, time frequency and duration of each service. With the push from attendant care over to Personal Care, even though you are still in the ARChoices program, not the Personal Care services program, are you held to the same standard as far as task, time, frequency, and duration. Do we want that to go along with that? Let's see. And then, the cap is going to affect attendant care, respite care, personal care. I just want to say, personally with us, we currently have clients that are receiving hours above the new cap that is going to be closed out effective January 1, 2019. Due to the cap, it's going to cut their hours down. If they are -- which supposedly there is a cap on long-term care bits. They can't get into these Assisted Living facilities because there is not a bed available or they don't meet a standard available or the Assisted Living facility just can't take them because they are not getting the resource for taking them. Due to these physical limitations, where are they going to go, what do we do with them, how do we help them? To qualify for the \$30,000.00 annually, the participant requires total dependency or extensive assistance from all three areas, mobility, feeding, toileting. As a nurse, I know what mobility is, I know what toileting is. But for the ISB, what we want to know is, is meal preparation going to be included in that feeding assistance or are we talking about only feeding them fork and spoon? That's a big change for us. And also, we want a clarification on Medicaid's definition for extensive assistance from another person listed in the definition for those caps, what are we looking at as far as extensive? Is that to each their own kind of call on that? So, we want a definitive answer there. And that's all I have. Thank you for listening. I just personally, I feel like this is negative, so I would oppose as a person of this state, as somebody who works for an agency in this state. I don't know. It's hard ground to stand on and go to my client's house and tell them, "Hey, I've got to pull out. I can't take care of you the way I want to take care of you because I'm not allowed." I just don't agree with that. Thank you.

Response: Comment considered and accepted in part. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of

savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. To answer the remaining questions: The Task & Hour Standards grid completed by the DHS RN may be shared with providers, and the proposed rules contain definitions for “total dependence” and “extensive assistance.” Feeding does not include meal preparation, and DHS is not recommending any changes to the coverage of meal preparation as an IADL.

Tim Taylor (Fort Smith Public Hearing 10/15/2018)

Comment: I gave a copy of the majority of these to the court reporter. My name is Tim Taylor. My company is Superior Senior Care, and I have been in this business for 23 years now, a long time. I have always felt like that our objective, and at the time, the state's objective, was to try to care for our elderly and disabled people in the best way possible, with the most dignity possible. It's important to preface the rest of my remarks, and I have a bunch of pretty specific questions to be answered, just by saying that all of these changes take the ARChoices program, the Personal Care program and just cuts the legs right out from under them. As the young man that preceded me said, you can't get into an Assisted Living. And I will tell you right now, I have an aunt right now that is in Assisted Living, she is running out of money, and the state -- she is going to go on Medicaid. The state won't release a bed for that Assisted Living to take her. So, we are going to be faced with a real tough decision. She is going to go in a nursing facility. I don't want that to happen. But, you know, we will have to see. I find many inconsistencies in these rule changes, things that just don't make sense, not just from a personal standpoint or from a business standpoint, if we want to call our businesses that. I mean, they are, let's face it, you have to make a fair profit to be able to stay and serve people. But there are some questions that I would like the State of Arkansas to answer, which is, what is the real purpose of all of these ARChoices program changes? To address the quality of care. Do-we really think that these changes will improve quality of care for our elderly and disabled? I don't. I mean, I just don't see how that's possible. I would like them to answer, you know, what is the cost impact of all these changes on a per capita basis, dollars and a percentage? I mean, my assumption right now, it's, "Hey, we just don't want to pay as much. But I could be wrong. So, that's why I'm asking the question. Why is Arkansas proposing, for example, with regard to the attendant care program and the drastic cut that many, many recipients will face, why is it that it is suggested that everyone be funneled into an Independent Choices program that doesn't have the oversight that an agency provides, that allows unqualified, untrained caregivers to provide care just because they are family? But family is being excluded from working through an agency from this point forward. I don't understand why. I mean, it just doesn't make sense unless there is some other motive for trying to cut --move the agencies out of the equation. I think these changes are going to destroy the safety net for Arkansas elderly and disabled that aren't ill enough that they require skilled nursing care. And I'm going to move on to some comments, and I have to kind of read through here, because the young man preceding me, he addressed a couple of them. The majority of clients have the ability to self-direct their care. And if they can, you know, once again, why do they have to move them to Independent Choices? I'm just a little bit curious why is --is there a discrimination issue to tell a certified nursing assistant that she can't work for a family member through an agency, but she can if they go through Independent Choices. There are a bunch of caregivers that do appreciate the support that they receive from agencies. We understand that this is modeled after the Texas ACBS program. And their program reimburses attendant care \$13.50 an hour to agencies. And so, basically, they pay all caregivers minimum wage. One of the things that was referenced in the proposed rule changes was a suggestion that caregivers' pay be reduced? from that that they receive through agencies or many agencies, from \$11.00 to \$12.00 an hour to only \$8.50 an hour. And as a gentleman that spoke earlier, you know, that's below what Wal-Mart pays. You can't get anybody to work for \$8.50 an hour, you just can't do it. So, I don't understand why just because of the promulgation of a rule, that we believe someone would

actually do that. We have had a lot of changes in the last year. There hasn't been enough time for everyone, agencies, DHS, Optum to react to them. And yet, here we are changing everything again. You know, there has been a lot of famous businessmen, not myself, say things like, "Look, give us a set of rules, stick with it, and then maybe we can figure out a way to make it work." The State of Arkansas hasn't stuck with anything for the last ten years. It has just been one cascading set of rules changes after another. For example, we still haven't received any information on the electronic visit verification system, what is really supposed to happen. We would like to know about it. You know, when is it going to happen? We would like more details about the individual service budget so we have a better understanding about what fits in. There is another issue that has cropped up over the past few years, and that has been caregivers have been limited to working 40 hours --billing Medicaid for 40 hours of services. Once again, in the proposed rule changes, we talked about, "Oh, they could still get 60 hours of services if they would just work for \$8.50 an hour." Well, if it's a family member and the family wants a member to do it all, all 62 hours, well, ho, they can only bill 40. So, that's inconsistent. It just really seems to us that all these proposed rule changes have not given the thought, the care, the analysis that they need. And there has got to be a better way. So, I'm asking the state to do so, not just for Attendant Care and Personal Care Services and Respite Services, but the I. entire spectrum has to work together. That includes Assisted Living. So, thank you very much.

Exhibit One

LTSS Reforms Public Hearing Questions

1. The majority of our clients have the ability to self-direct their care. I'm sure this is the case for other agencies as well. Why does DHS think it's fair that after Jan 1st, if a beneficiary wants their family member to care for them, they cannot do so through an agency, but can through Independent Choices? Does the beneficiary not deserve the RN oversight and pool of vetted fill-in caregivers available when their family member needs to be off work? If the family member is a CNA or PCA, with a clean criminal background check and drug screen, and participates in continuing education and chooses to work through an agency for the benefits afforded by the agency, why shouldn't they be allowed to care for their loved one in this setting with an RN supervisor?
2. Please explain how it is not discrimination to say that a CNA cannot work for a family member under the agency model, but can work for that same family member under Independent Choices? Why does the state feel that, even though it is the same people and the same money, this scenario is only acceptable under Independent Choices? Family members working through an agency haven't already made the choice and commitment to become certified so that they do not have to work through Independent Choices. Their efforts will have been wasted and their choice taken away.
3. We understand the proposed budget amounts would be the same for agency as for Independent Choices, so what is the reasoning for having a different set of rules for the two options?
4. We understand that this is modeled after the Texas HCBS program. Their HCBS program reimburses attendant care at \$13.50/hr. The only way for a client to receive help is through a caregiver willing to accept minimum wage. Many agencies cannot work within these parameters. Texas ranks extremely low when comparing HCBS programs. Do you think they were the best to model our system after?
5. Who was involved in the creation of these proposed rules? Were any current HCBS providers invited to discuss before completing the amendments? We have asked around and not a single person was aware of these changes. Who was consulted to ensure that these changes, such as

- eliminating meal preparation and companionship, would not have a negative impact on our senior population and end up costing the state more money in the long run?
6. As taxpayers who ultimately incur the costs of expensive state contracts, such as the one given to Optum, are we not entitled to see the results of our money before agreeing to further changes? Instead of eliminating our seniors' services and taking away their family member caregivers, maybe we should implement the independent assessment on our current program and gauge the results before making the next move.
 7. It has taken Optum almost a year to get on track performing independent assessments for the PC population. We need to examine the results before agreeing to more changes. Many provider offices continue to experience a disconnect between OHS and Optum which in turn causes delay after delay in starting services for the Medicaid beneficiaries.
 8. There have been numerous changes in the last year and there hasn't been enough time for everyone, including DHS staff to adapt to them. Rather than add even more changes to a chaotic system, it seems best to work on what we've done so far and then build from a more stable foundation. OHS staff is more inconsistent and more uniformed than ever. There needs to be more time to adjust to the recent changes the ARChoices and PC programs have already experienced.
 9. Before deciding on these proposals, we would like to see 10 scenarios of actual beneficiaries and how their current services would be affected if the new changes were applied.
 10. If beneficiaries receive an annual budget, and currently providers are allowed to bill for service up to one year in the past, how will providers know the amount of budget left if/when a beneficiary switches provider?
 11. We still haven't received any information on EVV. When is this expected to be required?
 12. What exactly does the Individual Service Budget cover? Please list all services that could fall under this budget.
 13. Why would a primary caregiver not be allowed respite if they are asked to work longer hours at their place of employment or if they decide to take a class and further their education? It seems these would be two of the most ideal reasons for receiving relief from their care duties. What can a person do if their job depends on them working whatever schedule is needed? If they are a family member and are unable to work or attend school, they are double-penalized because these rules would also prevent them from being paid for their loved one's care. Shouldn't we be encouraging primary caregivers to use their respite service as a means to better their lives and their community?

Response: Comment considered and accepted in part. Nothing in the proposed rules requires beneficiaries to choose self-direction, and the proposed rules treat self-direction and agency care equally in terms of the proposed service budgets and service planning. DHS originally proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules. DHS has worked with a variety of stakeholders in developing these proposals. In the spring and summer of 2016, DHS conducted a webinar and five public meetings around the state, attended by hundreds of providers, to outline these proposed changes. As for the independent assessment, the proposed changes do not "implement" an IA, as the IA has long been required by federal law and is currently administered using the Arpath platform. The proposal only changes the platform for the IA, not the requirement of an IA. DHS understands that many providers are concerned about the viability of the independent assessment process and its relationship to the prior authorization process. Optum has now performed more than 50,000 independent assessments in Arkansas. The results have supported the accuracy and validity of the IA system. Independent assessments

are a federal requirement for Medicaid waivers for home and community-based services. To be clear, although Optum is responsible for conducting independent assessments, Optum does not perform the function of prior authorization. DHS has worked to improve its internal processes in handling prior authorization requests and will continue to implement changes to improve the reliability of those processes. As for the individual service budgets, the budgets will be set and governed on the basis of the contents of the person-centered service plan. DHS will be responsible for ensuring that the services authorized under the plan remain within the ISB amounts. The ISB will not apply to personal care services or to other Medicaid state plan services. The ISB will apply only to waiver services other than environmental accessibility adaptations. As for EVV, DHS does not expect a full implementation of EVV until mid-2019. As for respite, the purpose of respite care is to preserve the availability of care during short-term, planned or emergency periods of time where an unpaid caregiver needs a break; work or school is not a respite period.

Cherry Long (Fort Smith Public Hearing 10/15/2018)

Comment: I'm the regional ombudsman for Region Eight in western Arkansas. And I am here not so much as an ombudsman but as a taxpayer who does not want to see these cuts in the least expensive way to take care of our seniors. It cuts the pay of the workers, and so you get a more apathetic worker that is working in these facilities instead of competing for the jobs. We are rapidly hitting the peak of our baby boomers that we are going to have 30 percent --potentially 30 percent of our population could be looking for places to stay. I work cases where people are slipping in between those nets of being functional at a minimal assistance would fit in Assisted Living, I've got to keep them in a more expensive setting to make sure that they are safe and taken care of. If we get them out of the expensive setting, they are at-risk individuals in the community, and I can't get placement for them. There are a lot of things about this, we are seeing my community members affected by a lack of Medicaid beds available in this medium range setting, and the support we need for the workers that we are going to have to entice into this area because our senior population is growing so fast. Thank you.

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

Mike Shepard (Public Hearing 10/18/2018)

Comment: Good evening, folks. My name is Mike Shepard, I'm a provider of Assisted Living here in Arkansas. I would like to speak in opposition to the proposed changes to the Living Choices waiver program. My concern has a lot to do with Assisted Living in rural communities. We have identified 18 facilities that if these rate reductions go into effect will be at risk for closing. Now, it's not so much that there are seniors that are vulnerable and frail in these facilities, as much as it is where are they going to go? Well, everybody says, let them go to the nursing home. Certainly the quality of life in a nursing home is not as good as it is in Assisted Living, but more importantly is, if half of those facilities close, there are 25 or 30 jobs that go along with that. And in small, rural communities 25 or 30 jobs is significant. And what happens to those employees? One of the things I think the state failed to recognize was, those employees will go on unemployment. Did they computer the cost of the unemployment benefit claims into their analysis of cost? I doubt it. But I'm hoping that they can answer those questions. There is one additional question. Under the Olmstead Act, I think it's a violation if you change your rules to cause people -- to cause facilities to go out of business. I would like to further examine that

to see if we can either slow this process and get some additional review as to what is going on, and try and create a rate that is going to be fair to all the facilities, and not unreasonably punish rural facilities.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Mike Akin (Public Hearing 10/18/2018)

Comment: Well, I would go on record to echo everything that has been said here. How are you supposed to take a 21 percent cut and still abide by the standards that the state -- that the regs say you are supposed to adhere to? So, what do we need to do? We need to go lean on our legislators, I guess. I mean, I know there is a mandate, or there is a push, effort to reduce Medicaid spending, cut Medicaid. And where are you going to do it? And I'm sure this is just a piece of the puzzle. I'm sorry.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Jeanette Harris (Public Hearing 10/22/2018)

Comment: My name is Jeanette Harris. I work for Martin Family Support and at the Webinar that we had here a few days ago, they were discussing (family members for Personal Care not working. And we are stationed in Bradley, Arkansas, which is a very small community, and it is mostly based on family members. And it is kind of hard to get aides without them being some type of family. I had asked in the Webinar, you know, what consists of family, and it was a wide range until you get to the cousins. And I was just wondering would that be considered in that -- in that change that they are

trying to make.

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

Samantha Gummenson (Public Hearing 10/22/2018)

Comment: Can I also comment on that? Samantha Gummenson. I am with Elite Care out of Malvern. We looked at it, and we went over it. We have close to 150 clients, and 41 percent of our clients, they have family members that take care of them. And we cover 18 counties in the State of Arkansas. And some of those counties are just like Bradley, Arkansas. I mean, they are very, very small areas, and everybody is related to everybody, or -- I mean, some of these clients, you know, they have been through a lot of caregivers. And I don't know the best way to word this, but sometimes the family members are going to be the ones that can care for them the best and can do what needs to be done, versus somebody else, you know, outside the home or outside the family.

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

Bonise Rish

Comment: My name is Bonise Rish. I am permanently disabled and rely on several caregivers for assistance for everyday living. I request that you will please consider continuing payment to the family caregivers. The information came to me through the Visiting Angels agency saying the Department of Human Services may not continue to allow family members to be paid to help their disabled family members as of January 2019. You cannot realize how critical this is to me. Why? I have been disabled for 28 years with Multiple Sclerosis and used three different agencies. All three have struggled to find a CNA to come put me to bed in the evening. All that was resolved when our son agreed to transfer me to bed at night. It is a great incentive to him to be paid for his services. It is also more convenient, less invasive of privacy, and works easier into our schedules.

My son has been transferring me to bed for 12 months and life has been so much simpler. Please continue this paid service for the future. Even though they are family members, their job as caregiver can be challenging and time consuming. Their efforts should be rewarded. Even the Bible says, "The labourer is worthy of his hire" (Luke 10:7)

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

Wayne and Bobbie Riffle

Comment: These are my comments in response to the public hearing on proposed changes to be effective Jan. 1, 2019 to AR Choices, Living Choices Assisted Living, Independent Choices, Medicaid Personal Care Services, and PACE as discussed at the Public hearing at 105 Roosevelt Rd., Little Rock on October 29, 2018 at 5:00 p.m.

1. My daughter just changed to a new program on July 30, 2018; because of the multiple titles to programs (for example Living Choices, also called HCBS Waiver Program) it is hard to know which program you are really on and which of these changes will affect you. I have called the PASSE person, UCP, Carolyn Ford at DHS, our old Case Manager on the previous program, and tried to talk with the Agency head we used to use in an effort to find out if we are affected and no one seems to know for sure. For example, Carolyn Ford with DHS said we were on HCBS Waiver, however Mark White who was in charge of the public hearing didn't seem to know for sure either, he said he didn't think the changes affected us. If everyone is as confused as I am, it is bound to cause some to not come to a public hearing or know what comments to make.

2. Also, for clients, as far as I know, the only notice they could have gotten of the public hearing was if they happened to read the Newspaper on the one Sunday that it was published. I don't know why DHS didn't ask Case Managers to let clients know about these meetings; or have the Palco people tell clients.

3. I continue to be amazed at how much state agency's in Arkansas hire outside contractors and pay them thousands of dollars to do a job that their own employees could do and have sometimes already done in the past. This is a gross waste of dollars that could be used for services that are desperately needed by clients. You know we are really not barefoot idiots here-we have a lot of competent and intelligent people in this state and we should stop shipping the tax money out of state for services we can do for ourselves.

4. I question whether the "outside independent assessment contractor" is independent at all. I am guessing that his amount of pay and continued contractual service depends upon them

5. There was not a full explanation of how the ARIA would work-it said it would be "used to develop the beneficiary's person-centered service plan"-HOW? Also, in what way will this be different from the RUG process? Also, will the beneficiary (client) be given a copy of the assessment answers at the time the assessment is done? This failure to document to the client at the time of assessment has resulted in many wrong assessments with the client being left to appeal, which takes months.

6. The estimated reductions in costs for 2019 and 2020 -are these on top of the reductions made by putting RUG assessments in for two years?

7. DHS states they want to allow people to stay in their own homes and in the community instead of having to go to a nursing home. However, with these reductions and limitations you will be forcing many people to not be able to do that or really have a choice. When they go to the nursing home, you will definitely not be saving Medicaid money.

8. Apparently there have been a lot of "assumptions" made which have not been backed up by facts; such as fraud assumptions with family member providers. Do you have any proof that family providers commit fraud any more than contracted providers?

9. Our experience over about 17 years of self-directed hiring of caregivers is that it is

EXTREMELY DIFFICULT to hire a competent and caring caregiver for the amount DHS pays. We have had them work for a couple of weeks and then go to work for Walmart. I don't see how you will be able to obtain enough (good or bad) caregivers to meet the need if you remove family caregivers. I am not saying this for personal benefit for my family-we never intended when we got on the DHS program to be a paid caregiver-we thought the money could be used better by others, because my husband already had a job. We just needed a hired caregiver. We were sort of forced into him becoming a caregiver on the prior program because our paid caregiver missed so much that DHS was threatening to cut our hours even though it wasn't our fault and my husband was having to pick up the slack when she missed anyway.

10. Your proposal of cutting out help with Managing Finances, communication and traveling is not reasonable. Many people need this help. In the past I thought that was one of the important goals was to get the people out into the community and not make them be restricted indoors and made to feel handicapped and 'imprisoned'. The exclusion of socialization, entertainment, and recreational services or activities is unreasonable.

11. The daily rate for Assisted Living is not documented as to how this is reasonable. In fact it seems very UNREASONABLE. This rate should be documented by need and fact.

Response: Comment considered and accepted in part. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary. As for assisted living, the current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Linda Rowe

Comment: The Oaks is a very valuable asset to families in our small community. It provides excellent care and living quarters for those who cannot live alone, but don't need to be in a nursing facility. If it is forced to close due to funding, the residents will have no choice but to go to a nursing home - and there could very well not be enough beds for them here. Employees would also be displaced and lose their jobs. This would be tragic for them and for the entire community.

Please do everything you can to help them keep their doors open and keep them providing living assistance for the clients and jobs for the staff. Thank you for your time and consideration.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Phyllis Sirmon

Comment: I'm sending the email because of my concerns for the cuts that are being proposed for the Assisted Living Waivers with Medicaid. My mother is in The Oaks in Mena, AR and this will affect her as well as so many other residents and also the employees. Since she has been in the Oaks her life has been so much better. She is happier and not depressed and has made so many friends her age. The Oaks takes awesome care of the residents and they all feel at home. Please don't make the cuts to where these residents have to leave their home and have to worry about where they will live out the rest of their lives. Our elderly have worked hard their whole lives and deserve our respect.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Rene' Taylor (Voicemail)

Comment: My name is Rene' Taylor in Northwest Arkansas. We are protesting the proposed cuts to Medicaid for those on the Waiver program. You're going to be putting my mother out on the street and other people who have no family to go to and please delay your decision so you guys can review the ramifications of making an approval as such.

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

appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program.

William C. Jenkins

Comment: Our daughter Lynnette M. Jenkins is physically handicapped. We believe that the State of Arkansas with the help of DHS is doing an injustice and mistreating these citizens of Arkansas by trying to save money by denying or seriously reducing services for those that truly need for their care. These individuals are unable to care for themselves or defend for their selves against such actions taken by DHS and or the State of Arkansas. It appears that the DHS or the State of Arkansas through the proposed rules presented of DHS for 2019 you would prefer these citizens be put into a state approved institution. There is no way in HELL would we ever allow our daughter be put in an institution.

1. There would be too many patients for the staff to give their full attention.
2. Most institutions are under staffed therefore patients aren't given the full care needed.
3. I have heard about patients been mistreated.

I know there are many more individuals in the state that need much more attention than daughter, with that being said she still needs 24 hours a day care. My wife or I are up several times every night to help her to the bathroom or she will wet her bed, when this happens then my wife has to wash the sheets the next day. It appears to me that the State of Arkansas has given the DHS a free hand to do whatever to the handicapped of the state. In my opinion this is a wrong approach to the needs of the handicapped citizens of the great State of Arkansas. My wife and I believe that if these new changes are passed we will be forced to leave Arkansas to a state that is willing to support the needs of the handicapped. I thank you taking the time to read this, I do pray that this serious issue will be corrected.

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

Jean Smith

Comment: Division of Medical Services Director, This letter is to urge you to reconsider proposed changes to the Medicaid waiver program for assisted living facilities. These changes adversely affect individuals who do not have resources for necessary care. Our elderly and disabled individuals deserve to have adequate care and services! Please consider cancellation of these changes that will harm our most vulnerable citizens!

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

rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Fred and Lois Adler

Comment: Our mother is in an assisted living facility in Huntsville Arkansas. We have been told DHS has threatened not to keep funding Medicaid unless their per person reimbursement was lowered. They say neighboring states are lower. I don't know that but I do know it's way cheaper to buy land there too. Our cost of living is higher here in NW Arkansas. Our father spent 4 years overseas during WWII and his wife of 77 years will be affected by this change. He has passed away, but gave what the country needed at the time. We all pay our fair share of taxes. To cut the quality of life for people who have always done what government asked them to do. Paid social security, paid Medicaid along with state and federal taxes. We have known for years the government has taken money given to social security to fund things that are their agenda is and always has been a law made by government to find itself. It is criminal to me to say it's failing, when it's been stolen from by legal thievery. It looks like the same kind of rhetoric is going on now with Medicaid. If we give an inch on this issue, it will soon be said to be a failed system also. We will not continue to vote or sponsor any candidate that fight for big government by stealing from everyday workers by making laws to benefit them! It would even be a little easier to swallow if politicians had to live by the same systems we do, but they voted away a better package for themselves to survive after retirement then they've allowed everyone else to have available

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Roger Douglas

Comment: I am NOT for the proposed Medicaid changes. I do NOT believe spending should be capped for care. People have paid into system their whole working life, should not be forced out of their homes so the state can save money. I am Not for the new evaluation method because it could change preexisting care already in place for someone. Most importantly they will not receive the level of care they get at home, if it was your family how would you feel?

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

Nancy Desonie

Comment: I would like to address several items on the LLTS Reform webinar.

1. I have a large percentage of my clients (49%) that currently utilize a trained family member to provide their care. I have never had a family member attempt to summit hours they were not their providing care. However I have had non relatives attempt this several times. It is very difficult to find qualified CNAs that can pass all the current standards, background checks, experience and drug test. This would increase the shortage even more.

2. How are clients who live alone going to be able to get to the store for food and personal care supplies.

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

Tara Box

Comment: I am writing in response to the devastating assisted living Medicaid cuts. I am a facility owner. We are about half Medicaid and half private pay. We need Medicaid in assisted living. Although, with the proposed 21.7% Medicaid cuts there will be no way to accept Medicaid residents. You are violating their bill of rights. They have a freedom of choice. We are the only facility in our small rural town. These residents will not have a choice. You all have preached that they need to be in the "least restrictive environment". Well you are just forcing them to the nursing homes. Although, most of these people would not qualify for the nursing homes. You are basically forcing these people out into the streets. Especially with you cuts to in home care. Who is going to take care of our elderly that took care of you as kids. Imagine your grandparents with no option of living. Living in an apartment covered in feces because no one is able to take care of them and the higher ups say they can not live in assisted living because we don't want to pay them for their care. If someone told you that tomorrow your wages were going to be cut 20% how do you think you would feel? Then add on top of that these are people's lives you are dealing with that is a disgrace to the elderly population. You do not go and say tomorrow we are going to raise the cost of living 20% nor reduce it 20%. Then I hear of people talking about phasing it in. Not sure how this is going to help unless you wanting to give these people time to find a nursing home to live in or a street corner to take up residency. I would like for everyone of you making these decisions to come to our facility. You come and see what you would be taking away from these residents. You would be taking away staffing. This would be compromising care. You would be taking away activities. What if someone told you to just go to a facility and never get out and do something fun. Imagine that. That is what you are taking away with these cuts. I am sure your pocket book is not going to be adjusted by these cuts. Or maybe it is. Maybe you took a bonus because you are saving the governor more money. It's probably illegal but you all don't care what you are taking away from the elderly. We take great pride in knowing our elders are properly seen about. You are just wishing for them to die off. I would be ashamed. Also, you said you did an actuary study. Oh my, you surveyed 3 facilities across the state to come up with your rate reduction. Lets just go by the seat of our pants and do something half way. So if I went and surveyed 3 facilities I would get a feel as to what rate reductions need to be done. If this company told you it was ok to only survey 3 facilities then they are wrong and I would make them dig a little deeper. They might of surveyed 3 facilities in south arkansas that do not have the same wages as northwest arkansas. They apparently do not know the industry. They might of even surveyed 3 facilities that don't do a good job of caring for the elderly. They apparently do not know what it takes to take care of the elderly. You come and live in our facility and we will show you how we staff now and how you want us to staff. I doubt you

come because you are probably out shopping spending all the money you are taking away from our elderly. I hope you all can sleep good at night because I sure don't. I am worried about how I am going to keep a facility running on your low standards and what the state says we have to do and what I know needs to be to run a good facility.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Lisa Douglas

Comment: I am writing to you today to voice my objections to the initiative before the state legislature of Arkansas, this week. The proposed Medicaid changes will cut spending limits and cap amounts allotted for care of people who have paid into the system for life. The people who have paid in all their lives are to be forced out of the comfort of their homes in order for the state to save money. It is not fair, nor is it right for the citizens to suffer at the hands of the legislature. The citizen has worked and paid into the system to get care in their home. Many currently receive these benefits and to alter the process now would not be beneficial. The new evaluation method will alter the current method of preexisting care for our elderly and disabled. I am against the measures and will be speaking to my congressman and representative today. I am available and will speak to you personally if you would like to reach out to me.

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

Drussilla M. Sorey

Comment: In regards to the recent letter from DHS addressing my mom's personal care from Home Instead is rather alarming. She's been at senior housing for about 5 years. Prior to that she lived with us

10 years but needed to move to flatter ground so she could walk more and get healthier. Not knowing her heart valve needed replaced and how badly it was leaking. She's had COPD and has been on oxygen 24/7 for 8 years or more. Having someone help shop for her has been a big blessing since I'm the other person that helps with that and takes her to doctor visits. Not to mention all the home health care for her. She's unable to do all that we younger people can do and isn't that part of our health care system? Providing care for people so they can stay at home longer? Nursing care facilities are short staffed and expensive. Our government knows that so I question their wisdom and sincere care about our seniors. Is someone getting bought off by these facilities? Our seniors deserve respect and honor for all the years they've lived and worked in our nation. Your assessment standards sound impersonal and uncaring. You can't standardize the assessment since every individual's situation is different. These clients are living human beings not a number. Micro managing human beings especially those taking care of our seniors is never good. We're not robots but human beings. DHS staff are not medical doctors, so they are not trained to determine what is medically needed for that patient just by an assessment. If you still think nursing homes and assisted living are cheaper, again I ask, "who is being bought off by these big conglomerates?" Your taking the CARE out of health care. It's not the local representatives of your department and our nation that are uncaring, sadly it's the higher up you go people get bought off in different ways. The Meals on Wheels people don't have time to check on a person's well being with all the meals they need to deliver daily. There doing good to get them all delivered. One last note health care should be handled by the private sector since our political representatives waste our money and then say, "oh we don't have enough money and resources to go around!". Hobby Lobby, Chic-Fila and other companies don't seem to have that problem!!!!!!!!!!!!!!!!!!!!!!

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

Mark Sillings

Comment: I am writing to you regarding the proposed 22% cut in Medicaid reimbursement rates for seniors in assisted living. My mother has lived in Arkansas for decades and is now in an assisted living facility in the small town of Mena. Although she is not a Medicaid patient herself many of the other residents where she lives fall into that category. I fear the reduction in reimbursement rates will have a negative impact on all residents in her assisted living home, regardless of whether they are on Medicaid or not, if staffing and service levels must be cut to cope with the reduced revenue. I understand there is a need to manage public funds in the most responsible manner possible, but it does not say much about our society when we do so at the expense of our most vulnerable citizens. Like others where she lives my mother is suffering from dementia. I am sure she would be outraged if she understood what was going on and how it might diminish the quality care she and her friends now receive. Although it is unlikely my mother and her assisted living friends will ever again be able to venture into a voting booth, it will be a mistake to assume their voices no longer count or will not be heard. Their friends and family out in the community can and will vote on their behalf and they have long memories should these proposed rules actually go into effect in the coming year. I hope and pray that all the public officials and elected representatives who will determine the fate of these proposed rule changes will have an

opportunity to rethink what they are planning, do the right thing, and find another more charitable way to control costs.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Michelle Welch

Comment: I am writing on behalf of my elderly Mother, Betty Welch. I have great concern that the proposed DHS rules concerning provider care, rates and changes in the assisted living homes arrangement with the state is being pushed to be revised and reviewed in an extremely short timeline. It is critical for our Seniors and Senior care providers to understand the changes being sought by the Department of Human Services and the current timeline does not allow this. I respectfully request your help in delaying the adoption of this rule change until after the elections and holidays so that our Seniors and care providers have time to understand the implications of the proposed rule.

If this change passes as it is, my Mother will not be able to stay in her Assisted Living facility. She is 95 years old and has dementia. Please consider this. She does not need Nursing Home care, but she does need a safe place to be, with someone available all day and night. If she has more needs than you will allow for Assisted Living, but not enough need for Nursing care, where do you propose I place her?

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Dana Wolf (RUG's or ARIA)

Comment: I have been a client of the Department of Human Resources Division of Aging and Adult Services since June, 2000. Prior to the implementation of the RUGS algorithm, the DHS nurse did my annual assessments and determined I was eligible for the maximum 8 hours per day or 56 hours per week.

I am a C4-5 quadriplegic, full assist, living alone in my home. I wear a Foley catheter and have home health nursing care. When I was assessed by a DHS nurse for the years 2000-2008, I was living with family. Family is no longer an option for my needs as they are full-time employed elsewhere. From

2009 to current, I have been living alone in my personal residence in Mountain Home, AR with the help of this program.

Over the last three years, I have incurred serious health issues, such as pneumonia, which required manual assistance for coughing from an attendant throughout the day and night. I had a tracheotomy for 2 of the years that required suctioning throughout each 24-hour day. Although my tracheotomy has been reversed, I still have had pressure ulcers after my RUG's assessment which reduced my hours in 2016. Current care includes a Trilogy (CPAP), a suction machine, and regular updrafts as needed to keep my airways clear. I have Medicare and Medicaid which allows home health nurse visits bi-weekly.

For the months of May through October, 2016 I have tried living with the reduced hours. The isolation and lack of care hours left me vulnerable to bed sores, on bowel program nights I had to lay in my feces between shifts, and my diminished respiratory issues required me to contact 911. While on appeal my hours were reinstated to the previous level of 8 hours per day.

My current situation allows me to sit no more than 8 hours per day. I am in bed approximately 16 hours per day and require an attendant to perform all my basic needs as I am unable to use my hands. I have done my best to utilize technology, such as a self-dialing telephone, a button I can trigger in bed for emergencies, and voice-activated Echo-Dot to control my television and other devices. Without going into specifics of my daily routine of attendant care, the facts are: I require an attendant for 2 hours per visit, 4 times per 24-hour period, just for the basics of life. Any reduction in hours would be detrimental to health and living independently in my home.

I hope you consider a client's individual basic necessities in living when determining how you implement any form of hourly assessment.

Response: Comment considered. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary.

Luther Douglas

Comment: I'm Luther Douglas and I am emailing you through my grandson's email as I do not have an email of my own. My wife, Juanita Douglas, is currently receiving in home help through Medicaid. She has advanced Alzheimers and there is no possibility of her health getting better. We currently have AR choice hours and respite hours. These combined allow me to do some of the shopping while I know that my wife is take care of. Without these aids, I would not be able to take care of my wife. I do not approve of the proposed legislation. While working my entire career, I paid into Medicaid so that we would be able to use it if needed. Now the state is wanting to save money and cut my possibility of my wife remaining in our home of 50 years. I do not agree with the new evaluation process because my wife has currently been evaluated and been given hours of care. I do not want any new evaluation method that could in any way change the hours she receives now. I also do not agree in the spending caps for personal care hours, AR choice hours, or anything else. I have paid into Medicaid and want to keep my wife at home until she passes peacefully in the home where we raised two kids and have spent time

with numerous grandkids. ONCE AGAIN, I DO NOT SUPPORT ANY PORTION OF THE PROPOSED LEGISLATIVE CHANGES TO MEDICAID!

Response: Comment considered. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program.

Gary Douglas

Comment: I'm Gary Douglas and my mother, Juanita Douglas, is currently receiving in home help through Medicaid. She has advanced Alzheimers and there is no possibility of her health getting better. She currently receives care hours that assist my father in her care when we are not able to be there because of our jobs. I do not approve of the proposed legislation. I currently pay into Medicaid as an Arkansas resident and do not want to see my mother's care affected. The state is wanting to save money and my mother's care may never be increased as she deteriorates into the final stages of Alzheimers. I do not agree with the new evaluation process because my mother has currently been evaluated and been given hours of care. I do not want any new evaluation method that could in any way change the hours she receives now. I also do not agree in the spending caps for personal care hours, AR choice hours, or anything else. As a current Medicaid tax payer, I am appalled and would try to bring suit against the state to receive my Medicaid money back to pay for whatever care I might need down the road because obviously the state is too ignorant to have the working tax payers interest in mind! ONCE AGAIN, I DO NOT SUPPORT ANY PORTION OF THE PROPOSED LEGISLATIVE CHANGES TO MEDICAID!

Response: Comment considered. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program.

Shelley Lee

Comment: I have the following comments on the proposed changes to the ARChoices HCBS Program and other L TSS Reform issues:

1. The inability to hire family members will be detrimental to people's ability to use HCBS services and will force them into higher-priced nursing facility care. Deletion of family as paid staff conflicts with the intent of the Olmstead decision.
2. As to the hiring of family members, consanguinity to the 4th degree is needlessly restrictive .. This degree will be detrimental to people's ability to use HCBS services. disagree that family members of any consanguinity should be restricted as paid staff but, if implemented, first degree of consanguinity is sufficient. Restrictive consanguinity rules conflict with the intent of the Olmstead decision.
3. DHS should post each person's Individual Service Budget (ISB) online by a preassigned case number. How do people know what they are spending now? Which DHS form tells people that? How can people plan without their ISB information?
4. When a person appeals a decrease in their ISB, OHS should maintain their service level until the matter is decided.
5. A cap of \$30,000 is unrealistic, discriminatory and dangerous for those service users at the high end of need. According to slide 10 of the L TSS Webinar, 280 people served by the waivers have an ISB over \$30,000. Specifically, 221 people need \$30,000 to \$40,000, 48 people need \$40,000 to \$50,000, and 11 people require \$50,000 to \$75,000. How will OHS guarantee the health and safety of these 280 people with a proposed ISB of only \$30,000? Capping the ISB at \$30,000 will be detrimental to the ability of high-need persons to use HCBS services and will force individuals into higher-priced nursing facility care. Capping at \$30,000 conflicts with the intent of the Olmstead decision.
6. A transition period to decrease the ISB does not address a 60% decrease in funding from \$75,000 to \$30,000. Time will not erase the inequity and insufficiency of such a decrease.
7. The rationale for capping the ISB at \$30,000 was stated as "2,873 people need \$5,000 or less". Lower need and less spend by 2,873 people may be a fact but is not a rationale for discriminating against 280 people with higher need and more spend.
8. A cap of \$30,000 will effectively disenroll and endanger nearly 5% of the HCBS population. Does CMS require the Waivers to have a quota for the number of high need, high spend users?
9. The "Notes" on the bottom of the L TSS Webinar slide 1 O states that "ARChoices spending estimates adjusted assuming (a) the up to 64 hours per month allowed in SPPCS are used before ACWS and (b) 10% fewer Attendant Care hours are used in the aggregate due to service definitions and program integrity protections." Which service definitions were included in this 10% reduction and why? Which program integrity protections were included in this 10% reduction and why?
10. "Traveling" has been omitted as an IADL but travel is a complicated activity, requiring the performance of many ADLs (transfer, balance, ambulation, toileting, meal prep, etc.). How does the deletion of "traveling" impact transportation into the community? Without transportation assistance, how can an ARChoices recipient go into the community? Deletion of "traveling" conflicts with the Olmstead decision.
11. How many licensed and certified nursing facility beds are vacant as of the date DHS prepares responses for these comments? Are these HCBS changes designed to remove those people with high needs from the ARChoices program to fill vacant nursing facility beds?
12. Will OHS allow the staff and provider that perform personal care under the SPA to also perform attendant care under ARChoices? If not, people have the upheaval of a second person entering and leaving their home each day and additional bureaucracy.
13. A single Level of Care Tier for all of the people who use L TSS is unrealistic. Since Tiers 0, 1, and 3, are not eligible for ArChoices, Tier 2 should be divided into 2a low need, 2b mid-need, and 2c high need to

more realistically reflect the needs of the persons served by the L TSS programs and levels of care already in effect in nursing facilities.

14. The 3 proposed ISB levels (Preventative \$5,000, Intermediate \$20,000, and Intensive \$30,000) should correspond financially to the 3 sub-skilled levels within a nursing facility (Intermediate I, II, and III) to more adequately reflect L TSS levels of need. The base level for a NF stay is well above \$5,000.

15. A lifetime benefit of \$7500 for environmental modification is unrealistic. OHS should offer an annual benefit amount, similar to that of the DDS Waiver.

16. DHS should make public its documentation for the testing of the Task and Hour Standards algorithm. With how many persons needing services were the Standards (algorithm) tested and over what period of time? What data did DAABHS use to validate the algorithm? How is this algorithm more valid than RUGS?

17. DHS should standardize and modernize its term for the people using its services. The use of the term "beneficiary" is contrary to people-first language and is scorned by most people served and their families.

Response: Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. The Task and Hour Standards is not an algorithm. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary. Nothing in current rules nor in the proposed rules would prohibit one provider from providing both attendant care and personal care to a beneficiary. DHS will work with providers to develop procedures for implementation of the ISBs.

Lydia Douglas

Comment: I am highly disappointed in the proposed Medicaid changes. This will leave thousands of people, who have paid into Medicaid throughout their careers, without the proper care. Healthcare should not be capped for people who are in need and have completed their civic duties. Arkansas citizens should not be deforced out of the comfort of their own home for the state to save money. This is a selfish and unethical act of justice. The state can afford budget cuts, if necessary, in other areas. Recipients of Medicaid have worked to get the care they currently have, just to have their well-being stripped from them with the proposed new Medicaid changes. I am currently obtaining a healthcare degree and I fully understand how the evaluation process works, as I complete on average one diagnostic evaluation a week. While some people abuse the privilege, it is the health care professional's responsibility to see that patients are getting the proper number of at home care hours and the care they deserve. Personally, my grandmother has advanced Alzheimer's, which if you are educated, you

know she will make no progress and will need proper care in order to sustain enjoyable life within the few years she does have left. While we know she will make no progress our number one goal for her is to be happy and enjoy the life she is living at home with my grandfather who she has been with since she was fourteen years old. While she does not recognize anyone, she still recognizes him. She deserves to be happy in the home that her and her husband built, raised two children, four grandchildren, and five great-grandchildren. She has lived in her home for 50 years and is about to have the life as she knows it taken away if she cannot receive the hours she currently has, as my grandfather cannot care for her alone. I don't think the state realizes the toll it takes on the caregivers and families, as they do not have a healthcare background. I believe that patients already in the Medicaid system should receive the care that they currently have. The proposed revisions to Medicaid could result in changes to preexisting care. The day we start putting the cost of healthcare above people's well-being is the day we fail as ethical human beings. I DO NOT SUPPORT ANY PORTION OF THE PROPOSED LEGISLATIVE CHANGES TO MEDICAID.

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

Michelle Joyner

Comment: I'm writing today in response to the new daily rate proposal of \$62.89 per day per resident that resides in Assisted Living Facilities. The rate is a 21.9% decrease. In any business that drops 21% of its revenue it would be devastating to that business. Most would close or would be looking at cutting operations. Assisted livings are not your average business. We can not just simply close our doors. We cannot cut staffing. We are responsible for the safety and well being of a population that can not function without assistance.

A response from DHS has been sickening regarding the ability to operate "we'll find them placement elsewhere". The beneficiaries of this program are not cattle to be hauled away from their homes. The point of this program was to promote personal choice. This rate is taking that choice away from them and in many cases causing displacement.

These beneficiaries are blue collar workers. They know grit and hard work. Truck drivers, farmers, school teachers, preachers and their wives, veterans that don't fall in the appropriate time line, factory workers, and many people that have kept this state going for generations. And now they may have been apart of this program for a decade and being told their home is at risk.

The staffing at these facilities are at risk. Jeopardizing hundreds of jobs of another generation of blue-collar workers. These workers come to work rain, shine, sleet, snow, holidays, etc. And now in some cases, after years of labor their jobs are in jeopardy.

The past 5 years facilities have not seen a rate increase. Meanwhile the cost of food, personal care items, and utilities have continued to increase. I can't imagine ANY of the "three" facilities used in the hand picked processed would agree to this rate to have a functioning facility.

An independent non-biased assessment including all facilities would need to be done to accurately determine an appropriate rate.

In 2011 the lowest level of care for a Tier 1 rate was \$62.98/day. Think about the increased cost we as providers have absorbed annually since 2011. Precedent exists from the beginning of the program. Can't change rules in the middle of the game.

The new proposed rate of \$62.89 per day is an arbitrary number based on many assumptions and overhead loads in other states along with three responses from assisted living facilities of which were provided to the Milliman group. The word assumption is listed 20 times in this four page report. That's a lot of assumptions used to come up with this daily rate. The validity of this actuary using a 75% overhead load should be challenged since there are no details of what was included in the operational cost. What is the cost of doing business and performing ADL services in an Assisted Living Facility in addition to the Overhead Rate used? Taxes, Capital Expenditures and Capital Maintenance Costs, Business Loan Costs, Insurance costs – building and liability, profit margin- which is why any business is in existence whether private or non-profit. Assisted Living Services must be priced just like a product that we all purchase daily, weekly, etc. For Example: Eggs. Say it cost 1.00 per dozen to produce and deliver the eggs to a retail store. The retail store then buys them from the egg distributor for \$1.75 per dozen. The retail store then sells them to you and me for \$2.67 per dozen. What is going on here? NO ONE purchased the eggs at cost. It could not happen or the company producing the eggs would go out of business. The moral to the story is that Assisted Living facilities cannot take a rate based on costs only as that is not usual, customary or ethically or morally correct as mentioned in the example given. So why is Assisted Living Services any different? Why should we as providers be forced to sell our AL services at cost? Only explanation is to drive us out of business if we take Medicaid. We all have business loans and tremendous obligations that must be met and this would be devastating not only to the AL industry but also to the individual Medicaid recipients

Furthermore, this proposal is nursing home biased and forfeits Medicaid recipient's right to options of whether they want the care in an institution, or in an assisted living facility and places them in a position where their independence is not supported and eliminates their choice of access to care by cutting the per diem rate so low that no assisted living facility could feasibly operate on a \$62.89/day budget. This proposed budget compromises quality and continuity of care for Arkansas Medicaid recipients who meet the eligibility standards for assisted living options. I think of the Waiver program as a shared expense between the recipient and the state for care services that could not be afforded in a private pay setting. The people represented in with this waiver program are your teachers, professors, factory workers, farmers, I even had a CIA agent one time. My point is that these people were hard working individuals who paid their share of taxes and voted. These recipients still reserve their right to vote and are active in this process. Under the current pay structure, the four tier levels are based on care of need with a rate structure of \$70.00-\$85.00 a day developed by DHS own nurse's assessments using ArPath. How can DHS support a \$62.89/day rate that is less than the lowest tier of need? Assisted Living Facilities have been proven a valuable resource for Medicaid recipients who want to maintain their independence and be involved in choices of their medical care.

The timing in the release of the rate for the proposed 2019 budget give participating providers no time to plan for the devastating loss in revenue and will have grave consequences that will include closure of some facilities who are 50% to 100% dependent on Medicaid Waiver. DHS's response to this... well, they will find alternative placement. This disrupts the recipient's continuity of care and environment. To

further insult facilities budgets, a new minimum wage increase is on the ballot in November and will also be effective January 2019. This also was not included in the proposed budget for 2019.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Charlie Millikin

Comment: My name is Charlie Millikin and I am an RN Client Care Manager for Absolute Care Management Corporation, in Russellville Arkansas. I would like to take this opportunity to be an advocate and voice for our clients and all Medicaid recipients who are at risk for losing a large portion of their benefits, as well as their right to make their own choices in their healthcare management. Many of our clients will be adversely affected by the proposed changes and I would like to request that more time be given for the proposals to be brought before the public, so they can have input, and also have the opportunity for those of us in the health care community, to provide cost saving proposals that will save Medicaid money and not have such an enormous impact on the health, well- being and quality of life of our clients. I would like for you to read the following examples of just how some of our Medicaid recipients can be adversely affected by these changes as they have been proposed.

Example 1:

We have many clients who have chosen a family member to be their paid care provider to manage their health care in their homes. These clients and caregivers have voiced to me the importance of being able to provide care to their family members, (some of whose time on earth may be limited due to their disease process) and still be able to have an income to support their household, as well as to still be able to have needed insurance benefits to manage their own health care needs.

It will be a devastating blow to these clients and caregivers affected, to have no choice but to go to the Independent choices program to continue as care providers for their loved ones, as they will lose these benefits. Many will be unable to continue as the clients care provider, because they have a condition that makes it vital that they be able to have health insurance, to afford the medications required for them to stay healthy themselves. They will essentially have no choice but to go find jobs in the community where health insurance is available to them and leave the care of their loved one to strangers. This also makes the medically fragile client responsible for finding caregivers, a primary and

secondary caregiver, to provide their care. They are not required to have any personal care training and there may be an increase in accidents that require hospitalization based on lack of caregiver training and an RN as a resource to make referrals for health issues before they become major, costly problems. Additionally, even if the caregiver is able to be without insurance and can continue working for their loved one through Independent choices, there will no longer be an RN monitoring the care of the client or a Targeted Case Manager to assist in finding other needed resources in the community. This will inevitably lead to an increase in hospitalizations, in-house rehabilitation stays and surgeries that will cost Medicaid thousands and thousands more dollars than would be spent, if early intervention were used to prevent these adverse outcomes. Ultimately, the client has had their freedom to choose how their own health care is managed taken away. There is no monetary value that can be placed on the peace of mind a client gains by having a loving family member be their caregiver. Maintaining and improving a clients' health status is the number one way to reduce costs to Medicaid. There is no better advocate for the maintaining and improving of a client's health, than one that is motivated by love.

Example 2:

I have a young man whom is our client that was born with Muscular Dystrophy. He lost his ability to walk at the age of 8 years old and has continued to have disease progression over the years, that has now led him to be able to only move his head and his hands. He is a remarkable young man, and he and his mother have managed his care at home with the assistance of non-skilled in home services Agency caregivers. He has surpassed his life expectancy of 18 years old and is now 30 years old and is an inspiration to so many. He is a high school graduate and has also graduated from college with a degree in marketing. He takes pride in the fact that though he was born with a severe disadvantage in life, he has still been able to participate in life and become accomplished in spite of his limitations. He has been able to do these things with the assistance of his devoted mother and the loving caregivers that have provided him with care at home through Agencies that utilize the AR Choices Waiver program. He is so proud that he and his mother have been able to "keep me at home with my family" by having the assistance of Agency caregivers, and is terrified that with the proposed changes and cuts in benefits, he will no longer have the choice of staying in his home with his mother, but be forced to live in a nursing home setting due to the cuts in hours and budget that will adversely affect his care and as such his choice to live at home. The proposed "cap" is 30,000 dollars per year for clients that qualify under the highest acuity tier, or most intensive group, which is where he falls. He now receives 66 hours of care weekly to manage his care at home. This means that he will potentially only receive 32 hours per week of paid care according to the proposed budget. Without the help of Agency caregivers, his mother cannot manage his care alone, due to her own medical problems that have developed over the years. He fears he will have no choice but to go live in a nursing home and feels that if this happens then he has survived this disease and the death sentence it brings for nothing, that "it will have won and stolen my freedom to choose".

He was born with Muscular Dystrophy. He had no choice. He deserves the right to choose. He has determined not to let his disease define who he is and what he does with his life. He is an inspiration and has a better outlook on life than most people that I know, who are completely able bodied and free of disease. He is a hero and I am asking you to please reconsider these proposals and give us time to help find ways to reduce Medicaid costs, without robbing Arkansans of the right to choose where they live, who provides their care and ultimately, take away from their quality of life.

Response: Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this

rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

Patricia Parlier

Comment: Do you take care of anyone besides yourself? Maybe a family member or kids? If you do then you will understand the importance that the ARIA assessment is not conducive to helping independent people in their homes. I work outside the home to take care of people so that their family can have a break and a little less stress in their lives. The new assessment will put the lives of many Arkansans in danger. They will have to decide if they get to choose the quality care they have been receiving or sub-par care by many unfamiliar faces. This can cause them a lot of stress. Their doctor(s) bills will go up because they will have to go the doctor(s) more often for anti-anxiety medication. Many of these people have been doing the same way of life for a long time. It would be wrong and detrimental to their health to expect them to change. The RUG's assessment was flawed from the beginning with the nurses not being able to do their jobs. This new assessment-ARIA- will take even more away from the human equation of health care. Nurses are needed to evaluate a person, in person, not a machine doing the thinking for them. DHS can not expect an algorithm to do the thinking that can only be done by a well-trained human being. When you cut costs, you cut care. There must be another way to find a solution to this problem. My clients depend on me to do the job that I am skilled, prepared, and trained to do. The companies that will lose employees due to no more family caregivers are going to be put in an unfair disposition. These companies will have to go through the grueling process of hiring new people, some with little to no experience. The nurses that do the assessments need to be able to do the job that they are hired for, not a computer doing a logical algorithm for them. I know a little about math since I have an associate's in accounting and I know that logic and math do not always work together. I am working a career that I love and I know that cutting care does not work out well for cutting cost. To cut \$10 million in a year of cost for care is not only astounding, it is appalling. When people have to decide if their care is more important than their family's sanity, then there is something wrong with the new assessment. I have said several times before and I will say it again and again. You can not cut care to cut costs. The reality, in fact, is that when you cut care to cut costs, you will ultimately create more costs. By cutting costs, you cut care and this does not work out well for those involved. The new assessment will cut care and cause many Arkansans to suffer, if not perish.

Response: Comment considered. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary. Although the Independent Assessment is a tool used in the eligibility and service planning process, the final decisions on eligibility and hour allocation are made by nurses.

Anne Barcus

Comment: Your considered benefit cuts could drastically affect my wellbeing! I am not taking my requesting your help lightly. Asking for help has been very difficult these past 4 years. But now I must ask again. There is a legal phrase "Throw yourself on the mercy of the courts." I am "throwing myself" to your mercy! Why is it so hard to ask for help? My lifestyle has been making contributions to Society. I had a 30 year career of working with Chemically dependent-Mentally ill-Homeless people in the Public Sector. When disability forced my retirement I changed to "faith based" provision through the Church

of the Nazarene: In 2014 medical crisis closed that opportunity,. That service had been 12 years. At that time I as forced to turn to Arkansas DHS. You have provided for me very well and I thank you.

And now I must come to you and ask for your mercy. I have no family residence options. I have at The Oaks at Mena. This facility is not just "my address"- it is my HOME!! These are the people that care for ALL of my needs! If they are forced to close my options are FEW! I am most sad when I look around me and realize that I am not the ONLY resident facing this crisis!! As your discuss this in your committees please remember this pleas and search your soul.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Lisa J. Callahan

Comment: I am writing on behalf of my Mom, June Kesterson and the elderly residents and staff of the Oaks Assisted Living Center Mena, AR. I hope you take and have the time to read all these email, letters as well as listen to the phone comment. I understand that the Oaks in Mena is in jeopardy of closing due to cuts in the Ar Medicaid program. The government is turning out or re located the citizens that when they was bring up their families in the 1950s & 1960s without ANY assistance from the government. My Mom worked long hours in a factory as well as having to work at our chicken houses. She also raised a son who had spina bifida in 1963 until he passed in 2011. I have seen my Mom be so tired at times and would have welcomed the services the young get now for having several children and not work. My Mom had 5 children and the jobs she held outside the home and then come home and take care of HER children. So please consider what this group of elderly did for their government and now it is TIME for them to enjoy what is left of their life. I know their has to be cuts somewhere, a good place to start is with your 18-55 years that are not working and don't plan on working as long as the government rewards them for having children and drug and alcohol problems that we have to supplement. I work as a Juvenile Officer and probably 95 % of my clients parents are on welfare/disabilities due to their lifestyle. I am praying hard as well as everyone else, that this cut will not displace many of our elderly who DESERVE a nice place to live out their lives in decent places.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019,

will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Patricia (Patty) Goethals

Comment: My mother's assisted living facility administrator has informed me that should this cut to the budget pass their facility would be forced to close their doors. It is an outrage that this is even being considered while illegal immigrants are having huge amounts spent on their care through the state Health Department. My father was a World War 2 veteran who never accepted government handouts even though he was eligible for them. Now that my mother is in need of more care than the family can provide, politicians want to cut the budget at the expense of our most vulnerable citizens. Norma LHow about cutting benefits to the illegals instead? How about cutting benefits to those who are healthy and able to work and would rather just collect a government paycheck? There are plenty of other areas to cut expenses without affecting our elderly citizens. My mother told me that the daily topic now at the dining room is "Where will we go if this place closes?" These are citizens in their 80's and 90's. Please don't forget about these elderly citizens who have paid into the system all their lives. I would appreciate any help you can give in defeating this measure.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Norma J. Lott

Comment: Please reconsider the proposed changes to the Medicaid Program concerning the cap on Medicaid Assisted Living admissions and reducing the reimbursement rate by 22% daily. My 90 year old mother lived on her own and worked as a foster grandparent at Ouachita River School until last year when her eyesight became so bad that she could not drive or safely care for herself. These deserving older folks should be well cared for and well nourished, as their children and grandchildren are working and paying taxes to keep our economy strong. The residents of these facilities did their part to build this great state as they farmed, worked in factories or operated businesses.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Luke Mattingly with The Central Arkansas Area Agency on Aging/dba Carelink

Comment: In 2018 there were legal challenges to the current ARChoices waiver assessment tool. DHS is proposing a new tool, and numerous policy changes, to be effective January 1, 2019. The voluminous provisions were posted October 5 and public comment closes November 7. DHS intends on submitting the proposed changes to CMS and the Arkansas Legislature November 15, 2018. It appears that these changes will go through Public Health, Rules and Regs and ACL committees between Nov 16 and Dec 31.

Our major concerns:

- 1) The details of how the new tool will assess individuals, place them in Tiers and the resulting service level is not apparent from the filings. It is extremely difficult for a care recipient, their family or their service provider to ascertain what the resulting level of care will be with the new assessment tool. There is no clear answer as to how the new Tier assignment and Task and Hour assessment will affect current recipients of care.

CHANGE NEEDED: Before approval of the new waiver and policies, an educated review of the impact of the new process on our frail elderly and adults with physical disabilities should be conducted. DHS should perform a comparison study prior to any rule changes. This study should conduct assessments with the new tool using a statistically valid sample number from current care recipients to produce an adequate analysis. The comparison results, including the impact on service levels, should be made available to the public and the Legislature for review to determine the overall estimated impact on care and funding. Care recipients deserve to know in relative terms how the changes will impact them.

Response: Comment considered. The eligibility tiers are based on existing standards for eligibility, as DHS is not recommending any change to the underlying eligibility standards. Because the standards are not changing, and because eligibility is ultimately determined not by ARIA but by OLTC, there is no need for additional testing. The Task and Hour Standards are based on standards used in another state for more than 20 years, providing long-term validation for the tool.

Comment:

- 2) New definition of a relative that can be paid by an agency to provide Medicaid Personal Care or ARChoices Attendant Care. The current definition prevents an agency from hiring a spouse, parent or legal guardian. The new change will enlarge that group to the 4th degree of consanguinity. That eliminates all the way down to a great-great grandchild, a great niece/nephew or a first cousin. CareLink has 125 caregivers that will fit into this new definition and will be prohibited from serving their loved ones on Jan 1. In some of our small rural counties this practically eliminates all potential care providers from being employees. Additionally, this new definition only applies to Home and Community Based Services providers. It does not apply to the Independent Choices/Consumer Directed Care program, nor the Developmentally Disabled community nor facility-based care.

Home Care Aides are in short supply in Arkansas and nationally and increasing difficult to find. Additional restrictions on agencies ability to hire caregivers will needless impact our frail seniors that need care to stay at home instead of being placed in a facility.

CHANGE NEEDED: DHS should remove this new definition from the ARChoices waiver documents and the Medicaid Personal Care Policy revisions. Current restrictions in the policy are adequate.

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

Comment:

- 3) Assisted Living rate reimbursement is being reduced by 22% on January 1, 2019. A few Assisted Living facilities are Medicaid only and this reduction will essentially put them out of business. The facilities that have a mix of clientele will likely, over time, convert Medicaid rooms to private pay, restricting options of Medicaid recipients. Even private pay clients may spend down to the point of Medicaid eligibility only to be told there are now no Medicaid rooms available. Additionally, DHS is striking a provision that allows Assisted Living facilities to provide and bill for Personal Care Services.

CHANGE NEEDED: DHS should take a more reasonable approach to the Assisted Living rate restructuring. Most businesses cannot withstand a sudden 22% reduction in revenue. Leave the current policy in place which allows Assisted Living Providers to bill for Personal Care Services.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Comment:

- 4) Minimum wage increase. This ballot initiative is likely to pass. The last time the issue was on the ballot, 2014, it passed handily. Polls conducted by some news agencies for the current issue indicate is likely to be overwhelmingly approved. If the Arkansas Medicaid Personal Care and ARChoices Attendant Care rates are not adjusted to reflect these increases, providers will not be able to offer the service and will have to get out of the Medicaid business. The results of the election will be known on November 7, 2018. DHS intends to incorporate other public comments into the Waiver submission between November 7 and November 15. They could also easily revise the rate in the waiver submission to reflect an increase to offset the minimum wage increase.

CHANGE NEEDED: DHS should include rates in the waiver request that take into account the new Arkansas minimum wage requirements if passed on November 6. Also, DHS should simultaneously change to Medicaid Personal Care rate to reflect the same.

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

Comment:

- 5) We do not oppose the third-party assessment, however, there is a concern with injecting OPTUM into the eligibility process for ARChoices. The roll out this year of this same process with this same vendor for Medicaid Personal Care has been fraught with delays, miscommunication, confusion and undue anxiety and hardship for the older Arkansans on the program. We are concerned that they are not prepared, by Jan 1, to absorb another 8,500 cases for a frail population that is dependent on timely accurate service assessments.

CHANGE NEEDED: DHS needs to analyze and improve process flow for eligibility within DHS itself and between OPTUM, applicants/recipients and providers. This should occur before adding ARChoices eligibility assessment responsibilities to OPTUM.

Response: Comment considered. DHS understands that many providers are concerned about the viability of the independent assessment process and its relationship to the prior authorization process. Optum has now performed more than 50,000 independent assessments in Arkansas. The results have supported the accuracy and validity of the IA system. Independent assessments are a federal requirement for Medicaid waivers for home and community-based services. To be clear, although Optum is responsible for conducting independent assessments, Optum does not perform the function of prior authorization. DHS has worked to improve its internal processes in handling prior authorization requests and will continue to implement changes to improve the reliability of those processes.

Comment:

- 6) The individual Tiered budget CAPS are of concern. Once assessed and placed in a Tier older Arkansans and adults with physical disabilities will be locked into a maximum annual expenditure for services. Those tiers are \$5,000, \$20,000 or \$30,000 depending on health dependencies. Maximum available services may not be adequate to maintain someone in the community where they prefer to reside.

CHANGE NEEDED: If the new system is implemented, DHS should review the CAPS annually for adjustment, after again evaluating the market factors the CAPS are initially based upon.

Response: Comment considered. The proposed ISB amounts will be in place for only two years, as the ARChoices waiver expires after two years and must be renewed. DHS will review the cap amounts in connection with the renewal of the waiver.

Comment:

- 7) One of the problems that the recent ARChoices legal challenge pointed out was that DHS did not keep adequate records of the impact of changes on individuals when the assessment process was last changed. How many recipients lost services, how many gained services, what was the percentage of service gain vs service loss? This requires a year of data collection as recipients are reassessed once every 12 months. Additionally, what is the overall average service level of

new applicants coming into the system under the new assessment vs the average service level of participants before the new process, etc.

CHANGE NEEDED: If the new system is implemented, DHS needs to maintain comparative records on individual service plan adjustments for the first 12 months of implementation and produce qualitative comparison data for review.

Response: Comment considered. DHS intends to maintain records on implementation of the changes.

Peggy Garrett

Comment: I am contacting you today to ask you to postpone the living rate reduction for seniors in assisted living. My mother had her 90th birthday last week but because she has Alzheimer's, she didn't know it. She is currently a resident at Countryside Assisted Living and receives Medicaid. She and my dad worked hard all of their lives but after he died, my mother struggled with paying her bills and her medications. I was her caregiver until she just could not stay home any longer with her condition. We were blessed to find her a place at Countryside, but if her Medicaid benefits are cut, she may not be able to remain there or be moved in with other residents. Our seniors in residential care deserve to be taken care of with dignity and compassion. Reducing the medicaid rates will have an extremely negative effect on my mother's care and each one of the other residents at Countryside as well as other facilities. I urge you to take the time to research the impact this decision will have on so many people who have lost their voice and rely on others to do what is right so they can live out their lives in peace and with the care that they deserve.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Deborah Luker

Comment: My opinion to this form what I can understand of this letter it goes back and forth not to be understanding at all. This very unjust for all of us disabled individuals which I am totally disabled cannot even stand on feet, toileting and bathing plus get clothed by myself. This program is very unjust and not caring at all. How can you make a plan for our care with a computer it is not right. Is our country and state turning to this for our elderly care I worked all my life and now this I never planned one this happening to me. I have no choice I need help. Please reconsider this it is not right period.

Response: Comment considered. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary.

Rickey Gibson

Comment: I, Love living at Countryside Assisted Living. They fix 3 healthy meals here daily. My medication is given to me at meals regularly by a nurse. I have a medical alert devise on me that's a blessing to have. They clean my room once every week. They also do all my laundry every week, too. They also have a fire alarm for all residents. The activities are for the enjoyment of all residents. They also have crafts for all residents, too. The activities director is knowledgeable about the games played, and the crafts that are built. She is also compassionate and helpful with all the residents. For protection and security, for many of the residents, they (themselves), their property (furniture, TV, Telephone, computer, etc.) and other valuables. This room protection and security is done either by a key to the entrance door of the room or a coded lock device known only by the resident who olives in that room All the halls are fully carpeted. The rooms are generally roomy, and the floors have a wood look but the floors of the rooms are plastic. The employees usually clean your room daily; take out trash, mop every other day, put soap in dispenser for sink when needed, disinfect with liquid on cloth the counter and sink possibly the toilet seat too. My room for instance, has a fairly large bedroom the bedroom is sealed off from all other rooms by its own door It also has one wood clothes rod on each side of a queen size bed. These clothes rods go the entire length of the queen size bed and longer to the walls, of the head of the bed and foot of the bed. I also have a chest of bedroom drawers in there too, plus twelve inch wide shelves extending the length of the room on both sides. Plus a smaller shelf twelve inches wide that extends to about half of the length of the others.

Page 2- It's about half way down the wall, underneath one of the longer shelves. Then, by the entrance door, I have a small room that is a kitchenette with a sink, a counter, with a lot of storage above and below the counter. There's a mirror on one of the ketch3enette doors, where I shave daily. There's another large mirror on the opposite wall that could be used for trying on clothes, etc. they're several pictures around that mirror, too. The living room is an ex-large room. Some of the items prove to you that it is, there is a large screen TV, sitting on an old but not an antique piece of furniture, I think that this was for a queen size bed. There is also a chair that reclines, an office type of desk but made of wood, a love seat that reclines and rocks, a small refrigerator, a desk lamp, a throw rug, and sink. I have another small room that has a toilet and a shower. Now back to the many things that Countryside Assisted Living has to offer its residents: there are water sprinkler in my room as well as the other residents in case of fire. They have two dining rooms to eat in. Both dining rooms have large screen TV's in them, to watch our favorite TV program while you eat your meal. On the walls in both dining rooms and in the hallways of the resident's rooms there are many glass and wooden antiques plus pictures. During, before and maybe afterward too, I'm sorry I forget, for instance the holiday might be Christmas or Easter, or maybe Valentine's Day. You can see all the place. When its Christmas, the owner Tara, buys many of the residents a Christmas boot, displaying their Christmas boots on a selected place on a certain wall close to the office. All of the boots have candy, Christmas cards, pens, etc. All from Countryside Assisted Living.

Page 3 -The owner Tara, as a Christmas treat then takes many of us out for supper at a Dairy Queen or a business similar to that just before Christmas. Tara, the owner even buys all of the residents Christmas presents too. She makes sure that those that didn't get Christmas boots and also didn't go out to eat; those less fortunate residents, (disabled, wheelchair victims, etc.,) she made sure they were treated fairly, by getting them more Christmas presents. Tara, the owner sent a paper around before Christmas asking all the residents what they wanted for Christmas, but to keep their presents to a certain dollar amount. On a point, where two walls meet, a bulletin board is displayed having the birthdays of the resident or residents of that particular month. This happens every month of the year. At a certain time every the activities director shows movies on a selected day for a set time period. They also serve

popcorn during those movies too. At another set time period they serve to all the residents homemade ice cream. Once a month, every month all of the residents have their blood pressure taken another weight taken. When there is a health problem, it might be taken a lot more often. She, Tara, some time ago had built an Alzheimer's unit strictly for Alzheimer patients. The landscaping for Countryside Assisted Living is breathtaking. It's really second to none, you ought to see it, it's amazing. A lot of thought, a lot of planning was done by someone. The landscaping also has a sprinkler system arranged in it that waters all the plants and trees. This was a hospital in the 1990's but Dr. Box bought the place in 1994 and turned the place into an Assisted Living establishment. Dr Box sold the place to Tara, present owner in 2011.

Page 4 -Tara, the present owner, has turned the place into what it is today. She has built on the old building a wing having a total of 70 residents in countryside Assisted Living and 22 residents in the Alzheimers building across the street. Tara, the owner, has gotten 24 years of experience that he bought into, when he bought the hospital in 1994 and started his own Assisted Living program. She, Tara, also has a degree in nursing and a degree in administration. She's very hard working, and she seldom takes no as the answer or you can't do it. I'm proud of her for what she has done from 2011 to 2018 to this place and anyone else who might know her should too. Now back to some of the benefits of living at Countryside Assisted Living. When you're a resident here, the same Dr. Box that bought the Huntsville, hospital in 1994 and started his own Assisted Living program in that old Huntsville hospital. Dr. Box has over 50 years of experience at being a doctor he has agreed with Tara to come up every morning to Countryside Assisted Living and look over the reports and check out cases of ill or sickly people at Countryside. Tara, the owner, plus remember she has a degree in nursing and Countryside has 3 highly qualified nurses. Therefore, Tara and one of the three nurses will always be there to help assist Dr. Box in determining the proper treatment, etc. yes, the facts are there before them. They are the right people, they just need a solution. Dr. box has done this doctoring faithfully since Countryside Assisted Living started back in 2011. This lessens your expense of daily living in your room.

Page 5-Tara, the owner, buys all the residents toilet paper regularly, and she keeps stocked hand soap, and we try to keep our soap dispensers full, thanks to her for having it and the toilet paper she give us. We as residents have need like candy bars, pop, clothing, shoes DVDS, etc., to buy and Wal-Mart here in the Huntsville supplies us with those needs. A bus holding 13 residents that's also wheelchair accessible. I think, but I'm not sure of the number of wheelchair residents it will hold is 2. They have another bus, both buses are pretty new, plus both buses are taken on daily trips no longer but I'm not for sure if both buses are used for these day trips. But I'm pretty certain that both buses are used when many of the Countryside residents are treated in eating supper out by Tara, the owner, of Countryside Assisted Living. After eating the meal as a Christmas Holiday treat. We take the time to see the Christmas lights of the city of where we're at and some of its homes. I'm a firm believer that there is only one living and true God and His son is Jesus Christ. Hebrews 13:8 says this, "Jesus Christ is the same yesterday, today, and forever." I'm blessed that Countryside let's me attend church on Sundays. We have church services at Countryside 3 Sundays a month if it's a normal month of having 4 Sundays in it. The 2nd Sunday of every month the Midianites come and sing at Countryside. All of the residents enjoy their beautiful singing. When we have church services at Countryside, I always try to set up the chairs for the services plus I make sure we have plenty of song books out too. I also set up all of the seating that's done in the activity room when the Midianites come and sing for the residents, and their friends and loved ones. I'm just another resident but I do like to help when I can. The activity director lets me help her with some of the games, bean bag and bingo.

Page 6- They are letting me go and work on Tuesdays of every week to a place called the Food Pantry, that serves the needy and the poor with food, books, fresh produce, lawn laundry detergent, toothpaste, health medications, and much more. Before the people get their food and other things, the person who checks the family in needing the food, etc. will gladly pray for them and their needs. We also have toys for the kids. Down the hall from us at different hours, theres an organization that gives away free clothes. Back to the funding reduction by Medicaid Services. I'm totally against it. I wrote this article.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Phyllis Acord

Comment: We have several clients here at Absolute Care that these new changes to Ar Choices and PC will effect, it will possibly force some families to put their loved one in a nursing home, or put a caregiver in their home to take care of them that they don't know, and with some older people that is very scary if they are not social beings. I feel like leaving the people that they are comfortable with caring for them is the best thing that can be done for our elderly. Stop pulling everything from them and making things harder on them most of them live on a limited income and struggle to make ends meet as it is and to add this stress on top is all un-necessary.

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

Trish and Mark Love

Comment: This is to let you know that we are very concerned about the proposed DHS rule changes and want to see them delayed and re-written so as not to ruin the safety and security of those who depend on the funds. My husband Mark's mother is in assisted living at Legacy Village in Bentonville, a non-profit facility. Reba is 93 and is in relatively good health, physically. However, she has Alzheimer's and her care has ramped-up as this disease had progressed. Once the executive secretary for Daisy BB VP Bob Wesley, then secretary for Daisy BB President Dick Daniel, and reportedly the highest paid secretary in Rogers, Reba now does not recognize her family, has no idea where she is and cannot care for herself. When she retired in the early 90's she had ample savings and a good pension to take her through the end of her life---and then suddenly everything changed. We have been able to provide for her care through her own funds so far, but in about a year she will run out of money and we will have to apply for Medicaid. It is our understanding that she will no longer qualify for those funds through the new rules, leaving her on the doorstep at a time when stability and security are critical in her world. Physically, Reba is in reasonably good health and may live for many more years. The question is where

will she live and who will care for her? She requires 24-hour care for her own safety and well-being. That is impossible for us to provide. What are we expected to do? Where is she expected to go? We ask that you look more closely at how this 600-page document will affect REAL PEOPLE and get your eyes of the bottom line. This is not the place to create surplus for tax cuts. Everyone in the state will be affected by this in one way or another, including you--if not now, then eventually. These changes have been hastily tossed out for review without sufficient time to understand their ramifications. In fact, there has been little transparency in the process. We urge you to withdraw this proposal and try again. Do NOT vote in favor of the rule changes.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. As for transparency, DHS first previewed these changes in the spring and summer through a publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input.

Shirley Ann Johnson

Comment: I chose not to agree or be punish to me or to my family while I'm living in my assisted living home. Nor do I chose to have our help taken away for your selfish needs. We are a family and need to stay the way we are. Not live up to your selfish way to gain more money for you. I live in a very helpful and caring home and wish to continue to do the same.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Brenda Parks

Comment: My name is Brenda Parks and I am a caregiver for my 88 year old mother in law. I have received some disturbing news concerning relatives that work for relatives, and someone thinks it's not in the best interest of elderly clients to be cared for by family members. I am totally in disagreement with that opinion. My mother in law has progressive dementia and only trusts the people she knows. She requires help with some personal care needs and should not be subjected to strangers for her need for help. I really appreciate the money I earn taking care of her. I took care of her without compensation

until we learned about the area agency on aging here in search county. My main concern though is her inability to accept change and she's afraid to let strangers come into her home. She is totally dependent on me. Her short-term memory is very bad. I check on her throughout the day even after my shift ends. Please don't let this happen.! It's always better for family to care for their own.!! If there's anything I can do or someone I can call PLEASE let me know. My cell # is 479 263 0738. Please let me know. This is too important to sweep under the rug.

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

Ashley Simms

Comment: Hi, my name is Ashley Simms. I'm writing you today to discuss the concerning changes that medicaid is facing. I've been an Activity Director at a small assisted living facility here in Arkansas for a little over three years now. Many of these people who are just statistical numbers to the rest of the world, have become like family to me. I see them happy. I see them sad. I comfort them when they have no one else and are facing crippling illnesses. I assure them that everything will be alright and they need not worry about their future. My job and my passion is to see these residents happy and healthy. The proposed rate cut will negatively impact the care of our Arkansas seniors. Any one can see that. The only way to deal with the Medicaid cut is to reduce staffing, which in turn limits the quality of care any facility can provide. Don't the seniors of Arkansas deserve the best that we can offer? Don't they deserve the care that they have worked their whole lives for? Facing the proposed changes, one can only assume that the Department of Health Services doesn't care for health quality or for the elderly who have fought so hard to make this state what it is. I only pray that eyes will be opened and that we can provide for our loved ones the way they should be cared for, the way you would want to see your family cared for.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Herb Sanderson

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

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

based on inadequate data and incorrect assumptions.

- 5) They hurt families. There are an estimated 452,000 family caregivers in Arkansas; estimated value of their caregiving services being over \$4.7 million. Families provide the most care to frail elderly, far greater than Medicaid. While families make herculean efforts to care for their loved ones, sometimes they need help. The proposed changes will reduce help available to families, making it more difficult for them to continue in their caregiving roles.

Response: Comment considered and accepted in part. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. As to the issue of transparency, DHS first previewed these changes in the spring and summer through a publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input. Because the comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement. As to the issue of family caregivers, DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver’s family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

Marla Moran (2nd Comment)

Comment: Hi, My name is Marla Moran and I’m the Director of Care at Peachtree Assisted Living in Mena. I have worked at Peachtree for 9 years this month. This facility and the residents here are like a second family to me. I want to state that the proposed rate cut will cause a loss of 25% of employment in Assisted Living facilities. Such a loss of employment will negatively impact unemployment compensation, and community employment health. It will have a direct impact on the quality of care that the residents receive. It will also negatively impact employment in Mena and many other small communities like I stated above. Our residents at Peachtree receive wonderful care. Our seniors have worked hard through out their lives and deserve the best. This will be devastating to the care and compassion that exists in our assisted living homes. The residents having to move out of a home like setting does not send the appropriate messages to the citizens of Arkansas. Some people may feel like I’m fighting for this because I work at one of the potentially affected facilities, the truth is, I’m a nurse and will find another job. I care because of the magnitude of these residents being up-rooted and not able to have a choice in where they can reside. For most of the residents they have already had to give up so much just to come live at an Assisted Living. Once they get established here they realize that if they can not go back home this is the next best thing. To have to take that away or reduce the care they get is simply not fair. Thank you for your time.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was

on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Carla Tenbrook

Comment: My name is Carla Tenbrook, I am the executive director of Peachtree Assisted living in Mena, Arkansas a small community of 5700 people. I have been a nurse since 2005 and have worked at peachtree for 7 years. The care we provide has helped many residents and their families to provide them with a safe secure loving atmosphere in a less restrictive environment allowing them to be independent. These residents have worked hard throughout their lives and paid their taxes to be able to have the option of choosing a less restrictive environment. They gave up their homes and all assets to be able to qualify them for this program. The proposed rate cut will negatively impact rural communities where the Medicaid program is essential to rural residents. The potential for facilities closing will cause loss of jobs, loss of community support and no place for the care of vulnerable and frail Arkansas seniors who need the assisted living Medicaid program. Do the right thing for our seniors and the residence of Polk County. I oppose the proposed rate cut.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Crystal Spurling

Comment: Hello, my name is Crystal Spurling I have worked as a waitress part time at a local cafe and as a loan processor for a local bank for nearly 9 years. I have supported my family from these local businesses but I have taken a different turn in my life, I have just recently come into the assisted living facility as an office manager which I absolutely love. You get to know the residents as well as their families. They are not just residents but they become part of your family as well. I also volunteer and come up at least one Sunday a month with my kids and we play bingo and have a pretty great crowd. I have growing concerns that DHS claims that Assisted Living is more expensive than nursing home care. This is an absolute fabrication. Assisted Living continues to be less expensive to the state budget than nursing home care. To think that in our home town we have two Assisted Living Facilities that has the potential to be closing we have so many residents that have worked hard in their lifetimes just to be tossed out and to find a place to live, to some this is all they have. We are their families and it would be devastating to not know what would become of part of our extended family members. Not to mention all the jobs that will be lost in this transition. I have been in two bank transitions in my 9 years of banking and have lost employees and have witnessed the hard times it put on them. This is a huge mistake for our residents and staff of this community.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

David H. Cooper

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

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

Follow the Golden Rule.

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

James Cavner, Jim Harvill, Alissa Nead, Markeitha Gilliam, Gloria Swedeen, Barry Casey, Patricia Geraci, Linda Duncan, Mr. Leslie Martindale, Arthur Aldridge, Lance Taylor, Rickey Beggs, Hank Klein, Brian Rounsavall, Dawn Apple, Pamela Dodson, Bob Coonradt, Cheri Carden, Nan Selz, Ed Hancock, Rick Culver, Mary Hood, Rebecca Parker, Adrienne Forsythe, Katherine Stone, Karen Scarbrough, Mary Thames Bundy, Adrian Bussell, Jan Mafsen, Rosemary Fortner, Michael Parsons, Wendi Hickman, John Heath, Donald Terry, Charles Ryan, Jennie Harvey, David Witt, Richard Acquistapace, Gerome Hudson, Rich Stalter, John Arnett, Cynthia Vozel, Johnny Rummel, Dow Manuel, Lori Bowers, Bonnie Kent, Darryl Lasker,

Charles Page, Mark Wright, Judie Nickell, Marilyn Johnson, Diane Roush, William Carter, Kris Coleman, Steve Langsner, Crystal Faulkner, Jerry Thigpen, Joel Seaman, Dennis Miller, David Palmquist, Lou Schmedemann, Craig Stotts, Billy Roberts, Marie Boyce, Mary Johnson, Thelma Dunbar, James in Ruple, Gene Tweraser, Dolores Miller, Kraig McCluskey, Michael Moorman, Ira Crite, Christopher Cutler, Cheryl Zabroski, Daniel Broadwater, Bennie Lard, Bill Swafford, Gordon Stephan, Patricia Everman, Pat Hendrix, John Bonnett, Tina Carpenter, Ted Lasher, Douglas Gallemore, Roy Oswald, Philip Miley, Debbie Williamson, James Swain, Barbara Kriske, Lori Cooper, Franklin Garza, Stephan Pollard, Sara Mahoney, Monte Crofutt, Janet Bartos, Wanda Shockey, Kim Abbott, Linda Fritz, George Farquhar, Billie Henley, Diane Radcliff, Jeannie Wilson, Vallerie Waters, Deidre Martin, Margerit Fleischmann, Sandy Franks, John Sutherland, Kent Stubbs, David McCullough; Lynn Carter, Brian Humble, Chris Prevatt, Johnny McClure, Angela Glosenger, Karen Hughes, Steven Wright, Melvin Wallace, Robert Kinzel, Dorothy Stobaugh, Judy Ustey, Mae Agnew, Kym Gallagher, Marjorie Lacy, Stacy May, Joe Perryman, Sherry Stout, Donna Morey, Mitchell Scarborough, Judy Fehrenbach, Betty Patton, LR Brion, Clara Harper, Jerrell Dillaha, Brenda Johnson, John Bellwr, Marsha Caldwell Mildred Dixon, Virginia Luttrell, Linda Paluch, Daryl Love, Mark Strahan, Susan Igo, Rochie Bunton, David Corless, David Gates, Larry Onstott, Janet Gaines, Freya Guerra, Leslie Ward, Mary Henderson, Earnest Johnson, Robert Slaymaker, Wanda Jones, Ronald Franklin, Carolyn Kukendall, Jan Jordan, Hoyt Jones, Larry Ehrke (all writing separately)

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

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

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

Melvin Reiter

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing

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

I am a Disabled Veteran and my S/S just go's so far, So any cuts would make it very hard on me and my family.

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

Lou West

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

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

People do better, both physically and mentally, when they are able to stay at home THUS costing the state less money in the long run.

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

Barry Beard

Comment: I would ask that you please delay the proposed changes to the current Medicaid waiver program that would drastically reduce Medicaid rates for those in assisted living facilities. At least for this to be studied further. This action would create a large hardship to my family.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Dennington Moss

Comment: I am Dennington Moss, owner of Green Acre Lodge of Holiday Island assisted living facility, Holiday Island, AR. I am writing today to voice my concerns about the proposed Assisted Living Medicaid Rate Reduction. While I greatly appreciate the desire to lower costs to our great State, I believe that any major cut in the reimbursement rate will cause a multitude of unintentional consequences, both long and shortterm.

Green Acre Lodge's census is comprised of 52% Medicaid residents. We are very proud of the level of care we provide the Green Acre "family", but I am very concerned that with the drastically proposed reduction, we will have to make major changes in our delivery model. I believe this will prove to have a negative effect on our residents' quality of life, as we will immediately be forced to make comparable cuts. This will ultimately lead to reductions in the services we will be able to provide.

I also believe it is inevitable that one of the many long-term effects will be that many of our most vulnerable citizens will have no choice but to "switch" to a nursing home. This, in turn, will create a much greater long-term cost burden for the State and defeat the original purpose of reducing costs. As you are well aware, most of our assisted living residents need more care than they can get at home, yet, in most cases, much less than the costly minimum level of "round-the-clock" care a nursing home is required to provide.

I know as a state, we don't take the concern for our citizens' health care lightly, and it is a very difficult task to find the necessary balance(s). When we consider the total amount of short-term dollars we hope to save, it is clear to me, and many who provide this care, that these proposed savings are not worth the long-term costs, both financial and non-financial. Certainly there are other areas where the savings could be matched or greatly increased without sacrificing the quality of life for our vulnerable loved ones.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Mrs. Vicki Hobeck

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) These cuts hurt families. My sister is completely relies on some one to change bath feed move get up lay down dress clean wash put on makeup and brush her hair and teeth shave her pluck her eyebrows wash her butt give her enemas give her a drink her coffee put in and out of truck to take her to the dr or shopping and they after waiting for a year and her niece going broke from not being able to work because we don't won't her in a nursing home where she has had her leg broke her wheel chair taken away bed sores on more than one occasion she is being took care of she is only fifty and is totally disable because of a tarnado that cases her disability and I don't know who thinks all she needs is 3 hours a day 27 total a week but some of the people who made this stupid decision needs to come and take care of her and see if you can do it in 3 hours it takes 2hrs just to bath her with 2 people please check your data and give our caregivers there hours back

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

publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input. Because the comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement.

Linda Monroe

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

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

** Do you have a senior member who go to a memory care facility for Alzheimer's? If my mother had to leave there because of these cuts, she would be frightened, unable to cope and not know where she was ! Would you wish that for your mother?

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

**Ruth Ann Fisher, Connie Bray, Kelly Grojean Jerika Johnson Lisa Boyles Jessica Pellegrin
Brittney Vincent, Shanda South Ashley Bupp, Sherron Myles, Alicia Jordan, RN, Lauren
Biviano, Holly Abbott, Jennifer Hudspeth, Shawn Zimmer, Carey Lingenfelter, Jennifer Hyde,
Bridget Gammons, Rosalyn Curry, Rebecca Lewis, Lorrie Towery, Christie Orrick, Candice
McCrary, Christy Manning, Charlotte Millikin, Stacie Bare, Jennifer Roach, Kimberly Hudspeth,
Emily Collier, Antonia King, Alaina Abshure, Kathi Bramucci, RN, Kacey Tyler, Sherry Wilkinson,
Lori Dewitt, RN, BSN, Tonya Clark, Latrice Adams, Sherrie Caskey, Jonathan Fry, Chrystal
Thompson, Phyllis Acord, Judy Gottfried, Dina Swink, Kellye Doyle, Tina Hollowell, Lori
Ramsey, Kris Frankenberger, Tiffany Ford, Jessica Hill, Morgan Smith, Debra Davison, Ashley
Walker, Cindy Garrett Ashley Bupp (all writing separately)**

Comment: To Whom it May Concern:

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

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

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

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

Comment:

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

The proposed rule change does not prohibit paid family caregivers in the Independent Choices Program. I feel that this is in direct opposition to the Department's statement about fraud and abuse in the use of paid family caregivers. Caregivers who are hired directly by recipients in the Independent Choices program are not required to receive the same level training. There is not the same oversight by a registered nurse. Until recently, caregivers in the Independent Choices program were not required to undergo criminal registry checks or drug screens. There is considerably less oversight in the Independent Choices Program which potentially puts people at risk.

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

Comment:

Third, the new Arkansas Medicaid Task and Hour Standard appears to be prescriptive and possibly restrictive in nature of the minutes assigned to each task. Beneficiaries served in Attendant Care and Personal Care programs vary in the care needs from day to day. A Plan of Care may indicate bathing 3 times per week, but a beneficiary may be unable to bathe during one of those days. In the proposed

amendment, ADLs covered under Attendant Care Services and Personal Care Services include eating but EXCLUDE meal preparation. Providers are expected to feed recipients but are not allowed to prepare the food. Even recipients of home-delivered meals may require assistance in heating, unwrapping, and preparing the food for consumption. Providers should be able to prepare food, in addition to feeding recipients, as billable services.

The proposed rule will impact Arkansans all across the state. Providers may be unable to serve Medicaid recipients. Employees of agencies may lose their jobs. Many of the items contained in the rule change do not save the state money but, instead, will cost us in the long term. Care in one's own home is often the most cost-efficient and effective way to provide services.

I would ask the Department delay the majority of the proposed rule. Outside of the implementation of the new assessment process on January 1, 2019, there is no reason to rush more than 600 pages. The Department did not show due diligence in providing providers, beneficiaries, stakeholders, and the public adequate time to read through and understand the proposed changes. There will be serious impact to people across the state, and we should have time to make sure that we are doing the right thing.

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

Melissa Harville

Comment: Below you will find my comments and questions about the changes that you are wanting to make to the AR Choices program Effective January 1 using the Task and Standards System. These changes are nothing more than a bullying attempt by DHS and a big pain in the rear as well as a slap in the face of the elderly, disabled, and their caregivers who provide the care they need. The purpose of the AR Choices program is to help these people stay in their homes and get the care they need and be an active part of society instead of being confined to a Nursing Home or other type of facility. With these changes they have to worry about getting an infection, bedsores, laying in filth and even their own body waste for extended periods of time after their caregivers leave because most do not have family or friends they trust to come in and take up the slack. It seems to me that the real purpose of these changes are for the people to be put in a nursing home so that more of the state's money can be spent on their care. I have been a caregiver for 9 years and have never seen something as crazy as this is. My client/boyfriend is paralyzed from the waist down and his condition has not changed other than a pressure sore reopening. When the Algorithm went into effect his hours dropped significantly when nothing had changed. When we received the new plan of care his hours dropped from 172 down to 137 a month. This was all because of the Algorithm and the fact the nurse put in the wrong information about how the pressure sore was being treated. This was appealed and information from the wound clinic was submitted. At the hearing the attorney for DHS stated that the reason he wasn't getting the maximum number of hours was because he is not on life support or have any tube in his body. The hearing officer ordered a new assessment and stated the hours should be increased to 161. I don't get to just work 6 hours and go home or to another job because I live here and am on call 24/7 to take care of his needs that could include turning him in bed every 2 hours, changing his bed if he has an accident, dumping a urinal, or changing the bandage on his pressure sore, and fixing him something to eat if he gets hungry at 2:00 am. There is no one to come in and take over and there are some nights I'm up every 2 hours. I have had regular jobs with benefits, and they were not as stressful as it is being a

caregiver and the pay was a lot better. With this new Time and Task Standard you are proposing if I live here I get penalized not only that I can't work through an agency instead I am being forced to go back threw PALCO to make ends meet because the way the hours will payed for will differ dramatically, talk about discrimination and a bullying tactic. You can not just group people into 3 categories and set a time limit that it takes to complete tasks because it takes some people more time me than others. These new changes that are being proposed is just as bad as the Algorithm if not worse. These changes want to limit the time it takes someone to take a bath, get dressed, eat, and even how often they can take a shower which is totally unacceptable. These changes also want not one but 2 nurses to do the evaluations which is just wasting more of DHS money as well as putting the patients health at risk and takes more time away from the client being able to live their lives. It also states that if the caregiver and the client live together that the caregiver can not be employed through an agency and also caregivers wouldn't be switching to an agency if they were getting all the hours listed on the plan of care.

After reading and researching it seems to me what is really going on with DHS is that they don't want to take care of the elderly and disabled. Instead they want to cut their hours and let them get sick so they can continue to put money in their pockets at the expense of other people's health. With these new changes the maximum amount of hours anyone can get is 6.5 hours a day and they now get penalized if the caregiver, significant other, or even relatives lives with them and do things for them.

Also if someone gets over 40 hours a week and does not go thru an agency they will not get paid overtime and their hours will get reduced down because of it. Also PALCO will not pay overtime if the caregiver lives in the home. Seems to me that would be a form of discrimination against the caregiver because they live with the client. Seems to me this is nothing more than discrimination, not only for the people on the AR Choices program their caregivers to, as well as being a form of elder abuse and neglect on DHS. I was also told that if a system/program is working don't mess with it and leave it alone but if it's broken then fix it. Well the system wasn't broke but thanks to the Algorithm and the new changes that are being proposed it is now. So it's time to fix it and this time leave it alone. You need to put yourselves in our shoes as both clients and caregivers and see how you would like being in this situation and how you would deal with being told by a computer system how many hours of care you get. What if it was your family member? Computers and Nurses can not decide what's right for someone much less what they need or how long it will take for each task to be completed because every person's situation is different. Putting time limits on how long it takes a for things to get done causes unwanted stress on both the client and caregiver and causes them to rush and puts the client at risk of injury. Some of the questions that are nothing more than stupid and unnecessary. Asking someone who is paralyzed if they have walked in the last 3 days is a slap in the face and this is just one example. If anything make the questions fit the diagnosis because everyone is different. Don't put people in a one size fits all box and also think about increasing the pay caregivers receive and bring back nurse discretion because it does work.

QUESTIONS:

Do you think this Time and Task Standard will provide people with the care they truly need?

Will DHS be responsible if a client gets sick, has a pressure sore, or heaven forbid passes away due to these changes?

With this new system how will it determine how many times someone can have a shower or get dressed? For example what if they have a bowel movement and need another bath or their clothes changed. Does it account for that or does the client just have to sit in their own waste until their next scheduled bath?

Why are people that have family or significant others being penalized if they help them do a task after the caregiver is gone?

Why are you penalizing caregiver whom live with the client and has no other help? This is not a 9 to 5 job for them it's 24/7.

Why set budget cap when every persons care is different? Is this because you are trying to save money to pay back that \$27 Million plus that is owed to CSM that has disappeared?

Why are you penalizing caregivers who are threw agency and not PALCO?

Why are you not only discriminating against the people on the program but their caregivers as well?

Why is the rate at which hours can be bought different if you are with an agency? For example to buy an hour threw agency it's \$18 but threw PALCO it's \$10.40. Not only does this reduce the amount of hours you can purchase but yet again it puts the clients health at risk.

Will personal care hours be available in addition to attend entertaining care and will the caregiver get paid for that as well or will count against the attendees care hours? What about Respite hours?

Why are you wanting to penalize and take hours away from people who use the emergency response button, home delivered meals, etc? Those are some people's life lines.

Why do you think it is necessary to bring in yet another person/agency to do the evaluations? Are the DHS nurses not good enough anymore?

Why are you saying that the CSM states that nurse discretion can't be used when it can?

Why did PALCO get so much control?

If caregivers who changed to agency got back with PALCO will they still be penalized for living with their client? Will PALCO still take care hours away like they were before or will they cut a cut of the hours?

Medicaid pays PALCO \$18.00 an hour but as a caregiver I only make \$9.30 an hour. Where does the rest go?

If using nurse discretion is so bad then why was it used for 17 years?

Do you just want the people on AR Choices to just give up and be put in a Nursing Home due to not receiving adequate care at home due to the reduction of hours because of the Algorithm and the new Time and Task Standards?

He now gets 50 hours a month of respite, that we didn't know we could get previously. Why can't I get paid for those hours?

Why is PALCO taking away hours from his plan of care when the plan of care states he is to receive 161 hours a month? The DHS nurse stated to us that the number of hours on the plan of care is what he should be getting.

If his condition hasn't changed then why was his hours cut?

Why was using nurse discretion stopped?

Why are you also making cuts to the Assisted Living program?

If you are wanting to save money then why keep giving out enormous raises to employees who can't even make it to legislative meetings when requested to attend? Where as all the Medicaid surplus money went?

Response: Comment considered and accepted in part. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules. DHS is

proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary. The Task and Hour Standards are intended only to provide an aggregate limit on weekly or monthly hours, and not to dictate the time allocated for the actual performance of each individual task. The rule language is being clarified to make this explicit.

Larry Smith

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families.
- 6) In our situation, the ability of my wife to stay at home and converse with family members has been the key to keeping her oriented with her situation. She can converse any time of day with any one of three or four persons knowledgeable with her situation so that she can re-orient herself with no cost or loss of time for seeking outside help.

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

Martha Schneirla

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

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

- 7) believe they are trying to kill the old and disabled and keeping thier health care and rich as possible without one concern to Medicaid or Medicaid. We cant live on this and then take away our medical help may God help us

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

Victoria Fausnaught

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

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

For all of the above reasons, and many of these seniors worked for years and gave to their community planning to live out their golden years simply and stably. Please consider vetting the younger generation and illegals that abuse our system.

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

Maria Jones

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

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

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

Scott Blundell

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families. This could affect my mother who is 95 years old and currently lives independently but would have to depend on assistance if her health should change.

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

Gene Weinbeck

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families. My mother was able to die at home. It is a real blessing to be able to do so. Please do not take this end-of-life gift away from us and our loved ones.

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

Donnetta L. Swift

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families. As Americans, citizens, I feel that we should do all that we can to help those in need, help one another. That is what our county stands for and was built and hoped on. To hinder and be dismissive to the elderly and those who need security the most is ethically and morally wrong. I am saddened to think that we need urgent attention and action to stop what shouldn't be an issue at all. PLEASE remember that we all deserve the right to a fair chance and common compassion from our fellow man. So again, Please reconsider and make the correct assessment. Provide proper care, sufficient aide and provide them with honorable choices. It's important for their present and OUR future.

Response: Comment considered. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that

would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. DHS first previewed these changes in the spring and summer through a publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input. Because the comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement.

Dr. Richard Black

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

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

Response: Comment considered and accepted in part. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program. DHS first previewed these changes in the spring and summer through a publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input. Because the comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement. As for the issue of assisted living, the current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Steven Lee

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

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

Finally as a CNA I have had client who try to get by on 700.00 per month and go weeks without money after rent, food, and God forbid helping adult children when they can!

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

Joe Barron

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

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- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families

These cuts pose real harm to senior citizens, and their families, and we urge they not be enacted.

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

comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement.

Shirley Tinsley

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

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- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families
- 6) I'm sure there are people who are on Medicaid that should not be but then there are those who need to be and may not understand what they need to do to keep their benefits. Surely there is a better way to help them with this problem.

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

Kenneth Williams

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

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- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families
- 6) I am 72 years old and disabled. I can not get by without the rather small amount of assistance I receive from Medicaid. My disability is from a genetic disease. So I am to be cast to the side because of my heritage? Does that sound like any teaching from any religion or humanistic philosophy?

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

term sustainability of the program. DHS first previewed these changes in the spring and summer through a publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input. Because the comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement.

Shirley Ford

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

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

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

Chris Smith

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- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families
- 6) I've seen family, friends or neighbors that do so much better if they are able to stay in their homes

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

term sustainability of the program. DHS first previewed these changes in the spring and summer through a publicly-available webinar and five public meetings around the state. Following the publication of the notice of rulemaking, DHS conducted an additional five public hearings around the state to gather input and met with both provider and consumer stakeholder groups to explain the changes and gather input. Because the comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement.

Tami Ferretti

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- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families

I am totally relying on the benefits I am receiving, which are not much. \$500 a month, and 127.00 in food benefits, I would be living in the woods if it weren't for a friend allowing me to watch his home while he is out of state working. If it were not for him, I don't know how i will survive, I beg you not to cut any benefits that people use them for survival. please don't cut anything.

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

Susan Taylor

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families
- 6) Since when is it appropriate for the state to determine how our elders live? After paying into the system their whole lives, shouldn't they be given the opportunity to live out the rest of their lives on their terms, not yours?

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

Edwina J. Hobbs

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) They hurt families My son has Huntington's Disease and will require more care as time goes on. I am 71 years old and taking care of him and will soon need assistance for him to remain in our home. We will need help to cover home care costs. It would be tragic for him to have to leave his home before it is absolutely necessary. He is only 53 years old.

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

Elaine Lawson

Comment: We have reviewed the Personal Care changes proposed to start January 1, 2019. We have concerns about the following change: "When Personal Care services are delivered through a home health agency or private care agencies, the person providing the direct care who works for the agency may not reside in the same premises as the beneficiary...". If, as a private non-profit agency, we are deemed to be a "private care agency", several of our current plans will be effected and services for those individuals involved could be interrupted. It is already a difficult task to hire staff who are willing to go through the extensive PC training and provide those services. If the pool of qualified staff we have to draw from is limited even further

because of staff residency, then our ability to provide quality services for individuals in need of personal care services is even further hindered.

This proposed change will also limit the individuals' choice of who he or she will allow to provide intimate personal services. I'm sure many will agree that everyone feels more comfortable when intimate PC services are provided by someone they know well and who they trust. Often times, individuals served rely on family members or other staff with whom they reside to be that person. Not allowing individuals who have been cared for year by friends and family to continue to receive those services completed by the same friends and family could be a huge disruption to their lives and to the lives of the staff they employ.

We would like to request that this proposed change either be thrown out completely or an extension of the start date be made so that revised service plans could be drawn up and submitted for the individuals involved and ample notice could be given to the friends and families involved.

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

Cathi Blackmon

Comment: As the Director of Nursing for a large private care agency in Arkansas I am deeply concerned with some of the proposals the Department of Human Services are seeking to pass; and make effective as of January 1, 2019. Having worked in the field of in-home care for the elderly and disabled for close to a decade I have witnessed many changes to various programs that are designed to assist these individuals with maintaining the highest quality of life possible while allowing them to remain living independently, and with dignity, in their own home. While some of the changes that have occurred, particularly the continued inefficiency of the Prior Authorization process, I have felt have not benefited those in need of these services none have been as disturbing as what I am seeing being proposed and brought forward to the Arkansas Legislature now. The proposed change to both the ARChoices and state plan Personal Care program which would prohibit clients from having someone related to them by blood or marriage, or who resides with them, to be their paid caregiver through a licensed agency is one of the most egregious changes I have read. Those clients will be forced to use the Independent Choices Program, which is quite a misnomer, in the fact that the client is not being given a choice at all. These clients, who by the very nature of being on these programs, are medically frail and disabled, will be required to take on the responsibility of being the actual employer of their caregiver and all that this entails. If they are unable to take on this responsibility they will have to find someone else willing to take on this role for them. They will also be required to have a second person willing to be employed by them as a back-up caregiver if their primary caregiver is unable to work. Many of these clients only have their primary caregiver to assist them and do not have the luxury of finding other persons willing to take on these roles. Right now these clients are able to choose to have the burden of the Employer/Employee relationship handled by their Agency of choice. They also do not have to worry about a back-up caregiver because their Agency has a pool of trained caregivers that can fill-in for their primary caregiver if necessary. I do not see the implementation of this change having any positive effect of the health and well-being of the recipients of the services; but instead I fear will result adversely with negative outcomes for these individuals. The only answer I have been given to my questions as to what the reasoning is behind this proposal is to "prevent fraudulent activity." That

answer does not hold water for me as Independent Choices is one of the least monitored and regulated programs offered by DHS. By taking a state-licensed agency out of the picture for any client who chooses to have a family member as their caregiver it takes away the supervision and oversight by both a Registered Nurse and an Agency that are both obligated and mandated to report suspected Medicaid Fraud to the Office of the Medicaid Inspector General. Again, DHS wants to place this burden in the hands of the medically frail and disabled to report their own family member if this situation occurs. As I have witnessed with our own investigations it is not an easy thing for the client to do, even with the support and assistance of one of our RN's. If this proposal is approved, and licensed agencies are taken out of the picture, the most likely scenario is that the client will not report their family member and thus will have a decline in their health caused by not receiving the level of care they need to remain safe and independent in their home. Again, this is another burden the State is wanting to place on the shoulders of our elderly and disabled without giving them another option in order to retain their caregiver of choice. Also extremely concerning to me as a nursing professional is the two set of standards for training depending on whether a client uses the Independent Choices program, or Agency directed care. Caregivers hired through the Independent Choices program are not required to have any training whatsoever. Please read that again: they are not required to have any training. They are caring for individuals with disease processes, illnesses, and disabilities that, in order to maintain the best outcome, benefit greatly from the oversight of an RN and the specialized plan of care and instruction developed between the client and the nurse. Caregivers that work through an Agency are required to have a minimum of 40 hours of training as a Personal Care Aide (PCA) and must obtain 12 hours of continuing education per year. They are supervised by a Registered Nurse who is just a phone call away to both the client and caregiver for any questions, concerns or needs. The caregivers for an Agency are required each day to report their client's condition and any "poor" report sends the RN an alert so he/she can intervene on behalf of the client. This supervision and intervention by licensed RN's allows the best possible care for these individuals. Don't those Arkansans that choose for their caregiver to be their family member deserve the same level of care as those whose caregiver is not related to them? Don't they deserve a choice in how their services are provided? I implore you to think about these elderly and disabled citizens of our great State who simply wish to continue to have an Agency supervise their care relieving them of unnecessary stress while allowing them to continue to live independently with a sense of comfort, safety and independence. Please be their voice.

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

Tom Masseau with Disability Rights of Arkansas

Comment: Thank you for allowing our agencies this opportunity to provide comments regarding the Department of Human Services (OHS) proposed rulemaking regarding the above- referenced manuals and services.

Arkansas State Independent Living Council

The Arkansas State Independent Living Council is a non-profit organization promoting independent living for people with disabilities. The Arkansas State Independent Living Council has a Board of Directors comprised of Governor appointed Arkansans, the majority with disabilities.

The mission of the Arkansas State Independent Living Council is to promote independence, including freedom of choice and full inclusion into the mainstream of society, for all Arkansans with disabilities.

Partners for Inclusive Communities

Partners for Inclusive Communities (Partners) is Arkansas' University Center on Disabilities. Administratively located within the University of Arkansas College of Education and Health Professions. Partners is a member of the nationwide Association of University Centers on Disabilities - AUCD.

Partners' Mission is inclusion of people with disabilities in community life.

Disability Rights Arkansas, Inc.

Disability Rights Arkansas (ORA) is a private nonprofit organization designated by the Governor to implement the federally authorized Protection and Advocacy systems. Our mission is to vigorously advocate for and enforce the legal rights of people with disabilities in Arkansas. We assist people with disabilities through education, empowerment and protection of their legal rights. We serve all Arkansans with disabilities of all ages. We provide services through information and referral, direct advocacy and legal representation. ORA also provides training and outreach throughout the State.

Every year, the ORA Board of Directors solicits input into the development of the agency priorities. This solicitation is accomplished through public surveys and analyzing the reviewing prior year's request for assistance. In Fiscal Year 2019, the priorities established are as follows:

- Abuse, Neglect and Exploitation
- Community Integration
- Education
- Employment
- Access
- Self-Advocacy/Training

The priority that is most relevant to this issue is Community Integration. This priority focuses on the idea that individuals should receive quality support services, rights protection and be empowered to make choices in their lives.

Background

In 1999, the Supreme Court ruled in *Olmstead v L.C.* that public entities are required to provide community-based services to individuals with disabilities when, a) such services are appropriate; (b) the affected persons do not oppose community-based treatment and, (c) community based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other who are receiving disability services. Essentially state and local governments need to provide more integrated community alternatives to individuals in or at risk of segregation in institutions or other segregated settings. (US Department of Justice, Civil Rights Division, "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v LC.*") Further, the *Olmstead* decision required each state to develop a plan that would place individuals with disabilities in less restrictive settings.

Following the Olmstead decision, former Governor Mike Huckabee formed the Governor's Integrated Services Taskforce. This taskforce was charged with assisting the state Department of Human Services in writing an Olmstead Plan. In 2003, the Taskforce completed its charge and developed The Olmstead Plan in Arkansas. The plan contained over one hundred recommendations for the state Department of Human

Services and members of the Legislature to consider. The report highlighted the intent of the state's movement towards providing services in less restrictive settings. Waiver services reduce the need for emergency care, increase quality of life for people with disabilities and their families and allow families to remain together in their communities.

Comments to Proposed Rulemaking

This proposed rulemaking is effectively a cut in waiver services, moving the State in the opposite direction from its intended plan to reduce the reliance on institutional settings in the State. The State and Legislature needs to invest in providing community based services that meet individuals' needs, as it is evident these are the services individuals are demanding.

Task and Hour Standards

OHS proposes to use the Texas Task and Hour model to determine levels of need. We believe this to be an unrealistic assessment of the needs of individuals with disabilities. First, Texas does not use the Task and Hour model with a population similar to those who receive services under ARChoices. Texas uses the RUGs system to determine levels of care for their Nursing Facility Home and Community Based Services (HCBS) population and bases their maximum allowable amount on 202% of the State's obligation for nursing facilities. Texas uses the Task and Hour model for both its Community First Choice population, and formerly used the model with its population of children who receive private duty nursing services.

With regard to the use of the model with children, the State Human Services agency was sued and ultimately reached a settlement, wherein the State Human Services agency would be required to consider all medically necessary skilled nursing services required over a 24-hour day (over the span of time the needs arise, as the needs occur over the course of a 24 hour day). This is a far more realistic approach than the application of a model that requires an individual to predict the number of times per day that he or she will require assistance to use the restroom. Further, the Task and Hour model is not based in the reality of a community setting; instead, it appears more appropriate for determining the needs of individuals in institutional settings, when attendants may be available at any given time of the day, and are typically physically present within feet of the resident in order to meet their needs. In community settings, many individuals live in remote areas of our rural State. Requiring an attendant to travel a great distance to assist an individual with using the restroom for twenty minutes is absurd, and completely ignores the reality in which individuals with disabilities live.

Response: Comment considered. DHS is proposing to use the Arkansas Medicaid Task and Hour Standards (THS) to help determine medically necessary attendant care, personal care aide, and personal assistance under, respectively, the ARChoices, Personal Care, and IndependentChoices programs. The THS is modeled after the Texas Form 2060, a tool that the state of Texas has used for over 20 years as a basis for determining the medical necessity of hours of services provided by direct care aides in home and community-based settings, both for state plan personal care and HCBS waiver services. Under federal law, only individuals who meet the nursing home level of care may qualify for HCBS waiver services. Texas is currently using the Form 2060 to

determine medically necessary hours of care for participants in the Texas Community Based Alternatives (CBA) HCBS waiver, a waiver that serves individuals aged 65 years and older and physically disabled individuals ages 21-64 and is very similar to Arkansas' ARChoices HCBS waiver. Many of the Participants in the CBA HCBS waiver have been enrolled in the state's STAR+PLUS managed care program. Texas has mandated that STAR+PLUS managed care organizations (MCO) use the Form 2060 to determine the hours of "HCBS STAR+PLUS Waiver Services" needed by their enrollees. See section 8.3.3, Uniform Managed Care Terms & Conditions, in the current contract between the Texas Health & Human Services Commission and the STAR+PLUS MCOs, which can be accessed at <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf>.

Comment:

Cap on Services

Part of the proposed rules includes a cap on services, termed "Individual Services Budget," (ISB) operates as a cut to the number of hours of attendant care services available to individuals under this program. There is a maximum of 139 attendant care services hours available, should a recipient devote all of his or her ISB to that service.

Accordingly, the maximum amount of attendant care services available to an individual who requires daily assistance is approximately 4 hours per day. This maximum is without regard to the needs of the individual when they exceed the maximum allowable under his or her ISB, except in very narrowly tailored circumstances. A waiver recipient, "may request an exception in the form of a temporary increase in the person's ISB amount [for instances of] exceptional, unexpected circumstances affecting a participant's health and welfare and not as means to circumvent the application of the ISB policy or permit coverage of services not otherwise medically necessary for the individual[...]." Further, the allowable deviation from the maximum ISB may not last longer than one year. This policy is unduly restrictive, and we have concerns that the use of any exception to the ISB under this policy will be approaching zero.

In addition, when used in combination with the Task and Hour model, the result is absurd. The cap permits approximately 139 attendant care hours per month, which equates to 1,919 attendant care minutes per week (translated to minutes per week because that is what the Task and Hour model uses). Each task in the Task and Hour graph provided in the Proposed Rulemaking has a range of minutes a task may take. Assuming a person requires total assistance with all ADLs, and assuming the lower end of the minute range, a person who wants to be bathed every day, wants to change into their clothes in the morning and pajamas at night, wants to eat three meals per day, wants personal hygiene at least once per day, wants to be transferred to a bed or chair only twice per day will only have enough time left under the cap proposed by OHS to receive assistance using the toilet one time per week. If any one of the listed tasks takes any longer than the minimum in the minute range for those who require total assistance, an individual is left to decide between eating or bathing or toileting.

Also, assume an individual requires total assistance, but this time the minute range is on the high end. They would be allotted time to bathe, eat, groom, and transfer the same number of times as the individual in the previous paragraph, but would only have enough time left over toilet once per week, and no time to change clothes, ever.

Even with the addition of the maximum number of personal care hours, an individual who requires total assistance and the higher end of the minute range would only have time to bathe, dress, eat, groom,

transfer, and toilet (only four days per week though), leaving no time for leaving the home, for cleaning house, for laundry, for meal preparation, or for shopping. The amount of time allotted to individuals who require the maximum amount of assistance for their activities of daily living is insufficient.

1 35 minutes x 7 days per week= 245 minutes

2 25 minutes x 7 days per week= 350 minutes

3 25 minutes x 7 days per week = 525 minutes

4 60 minutes x 7 days per week = 420 minutes

5 25 minutes x 2 times per day x 7 days per week = 350 minutes

6 $245 + 350 + 525 + 420 + 350 = 1890$ minutes used out of 1919 allotted per week, leaving 29 minutes remaining for the remainder of the week. Total assistance toileting requires 25 minutes on the low end, according to the Task and Hour Standards.

For those under the RUGs system who were attributed to a RUG that, if continued, would cost more than the maximum ISB under the new rule, OHS will implement the "Transitional Allowance for Current High Cost Enrollees." This rule appears to be an attempt to pacify those individuals who would have their services dramatically cut as a result of the cap on attendant care. They would only be deprived of 5% of their services until OHS reapplies to CMS a new waiver. This does nothing to address individuals who have higher needs who might be new to this waiver system.

Additionally, many individuals disagreed with their assigned number of hours under the RUGs. If those individuals are reassessed under this new system, and deemed to require assistance that exceeds the maximum amount of services, will OHS permit them to participate in the Transitional Allowance program? Does OHS intend to treat individuals differently based solely on the time in which they established their eligibility for waiver services or level of care?

OHS bases its cap on attendant care services as equal to, or slightly more than the State would pay for that individual to go to a nursing home. In coming to this valuation, is OHS only considering the cost of nursing home care, and not those increased costs that are shown to be incidental to nursing home care, such as increased hospitalization? Moreover, the State's reliance solely on the cost of its obligation for nursing facility services does not factor the improved outcomes that are shown when individuals are able to live in the community. Olmstead is not the law of the land merely because serving individuals in the community tends to be cheaper than institutional care. In relying solely on the State's share of nursing home cost, OHS ignores the physical and psychosocial outcomes that are made better by supporting individuals who wish to remain in their communities.

While the State relies on Texas's model to determine hours of care an individual needs, it does not model its valuation of an individual's ISB after Texas. For the population similar to the ARChoices population in Texas, the maximum annual cost of services is equivalent to 202% of the State's average obligation for nursing facility services. While it still might not be enough to meet the realistic needs of its beneficiaries, it at least evidences the State's value of individual outcomes over the bare cost of services. We strongly suggest that the State reevaluate the maximum allowable ISB to provide a realistic level of care that will permit individuals to stay in their homes, instead of providing this service only if it is cost-neutral or cost-saving. Otherwise, this effort to cut costs will force people into institutional settings, contrary to its purpose.

Response: Comment considered. The proposed rules allow multiple opportunities for flexibility and professional judgment in adjusting services to meet individual needs. The intent of the changes overall is to transition ARChoices to a person-centered system, in which the needs of each individual beneficiary are addressed. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these

programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. The limits contained in the Task and Hour Standards are intended only as aggregate limits on the weekly or monthly total of hours, and not as limits on the actual performance time of each instance of a task.

Comment:

Due Process

The individuals who voiced concern to us regarding the RUGs methodology unanimously expressed concern over the lack of any consideration of their individual medical issues, expressly in the hearing setting. Individuals who present medical evidence of their need for more hours under the old program were met with hearing officers who felt they were unable to deviate from the rigid RUGs formula in determining hour allocation. The new program, similar to RUGs, reduces individuals to the tasks they need to perform, without regard to medical advice from individuals' primary care physicians or specialists, who would provide valid insight into the individuals' conditions. While there is limited discretion in the number of minutes it takes to perform each task, it is only the artificial appearance of discretion in light of the cap placed on services under this program.

We strongly suggest that the State permit hearing officers to evaluate medical testimony by those who provide care from recipients, and expressly permit hearing officers to deviate from the formulas and maximums allowable by DHS in order to ensure that individuals are receiving care that will meet their needs in the community.

Response: Comment considered. Nothing in current rules or the proposed rules would prevent hearing officers from evaluating medical testimony by any witness a recipient may choose to call in an administrative hearing.

Comment:

Independent Choices

This program allows individuals to self-direct their attendant care, personal care, and other services they would otherwise receive under ARChoices. That said, it is unclear whether the caps applied to ARChoices would apply to this program. Under the section "Attendant Care Services," it appears that the participants' needs will be evaluated purely according to the Task and Hour Standards, without regard to the ultimate number of hours for which they will provide care. The only guidance provided in the manual States that benefits are limited by the amount of the participant's allowance, which will be based on the individual's service plan. Based on the State's other rules for proposed promulgation, there is no indication of what the maximum service plan will be. Are participants who self-direct permitted to have a plan that exceeds the equivalent ARChoices ISB for the same services?

We have additional concerns regarding due process if caps similar to the ARChoices ISB are applied to this program. If hearing officers are not permitted the discretion to meaningfully consider evidence that an individual needs more care than the State has allotted them, and remedy that situation, then the purpose of assessing individuals' needs is essentially meaningless once the cap is reached.

Response: Comment considered. The proposed changes for IndependentChoices are being modified to clarify that the IC Cash Expenditure Plan is subject to the Individual Services Budget for an ARChoices

recipient. Nothing in current rules or the proposed rules would prevent hearing officers from evaluating medical testimony by any witness a recipient may choose to call in an administrative hearing.

Comment:

Living Choices

We have heard from many providers regarding the dramatic cut in rates paid to Assisted Living Providers. We fear that this cut will result in the reduction of services offered to those in assistive living, and possibly the extinction of this option for individuals who do not wish to reside in institutional settings such as nursing homes. While we encourage individuals to live in the community, we believe that assisted living at least offers a less restrictive alternative to nursing facilities or other institutional settings. As individuals will not necessarily receive the services they need to remain in the community under ARChoices, this cut will likely result in an increase reliance on institutions, segregating persons with disabilities from the community.

Timing for Public Comment

This series of proposed rules is collectively referred to by OHS as Long Term Supports and Services Transformation. It is reforming several programs that serve the population of adults with physical disabilities, and encompasses several hundred pages of rules and regulations and technical applications to CMS. Nevertheless, OHS began having public hearings within a matter of days after notifying the public of this massive change to its systems. The Arkansas Administrative Procedure Act requires that OHS allow at least thirty days for public comment. Ark. Code Ann. § 25-15-204. Given the volume of information individuals are required to review, analyze, and consider, we believe that OHS and the public would both be better served by enlarging the period for public comment.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Cindy Stafford

Comment: I oppose three major components of the proposed rate: a lack of provision for minimum wage increase; prohibition of family caregivers in agency model and unfair advantage provided to Independent Choices Program; and overly-prescriptive documentation standards (Medicaid Task and Hour Standard). First, Milliman sampled only eight providers to develop their rate. The current Arkansas minimum wage was used as the base, and voters recently approved a significant rate increase. Providers have been told by the Department that there are no plans to revisit this rate even in light of the minimum wage increase. This increase in the administrative burden far exceeds a very modest rate increase, and many providers will be unable to shoulder this additional expense.

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

Comment:

Second, the proposed rule's prohibition on paid family caregivers (to the 4th degree) in an agency model only puts frail and vulnerable Arkansans at risk and impacts jobs in rural communities. For many rural Arkansans, paid family caregivers provide a lifetime to care and mitigate the need for costlier, more acute services that may or may not be available close to home. Agencies screen all employees, including family caregivers, as part of their operation. Criminal registry checks and drugs screens are completed, and all employees receive a minimum of 40 hours of training. Also, a RN provides ongoing monitoring of caregivers and beneficiaries. The proposed rule change does not prohibit paid family caregivers in the Independent Choices Program. I feel that this is in direct opposition to the Department's statement about fraud and abuse in the use of paid family caregivers. Caregivers who are hired directly by recipients in the Independent Choices program are not required to receive the same level training. There is not the same oversight by a registered nurse. Until recently, caregivers in the Independent Choices program were not required to undergo criminal registry checks or drug screens. There is considerably less oversight in the Independent Choices Program which potentially puts people at risk.

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

Comment:

Third, the new Arkansas Medicaid Task and Hour Standard appears to be prescriptive and possibly restrictive in nature of the minutes assigned to each task. Beneficiaries served in Attendant Care and Personal Care programs vary in the care needs from day to day. A Plan of Care may indicate bathing 3 times per week, but a beneficiary may be unable to bathe during one of those days. In the proposed amendment, ADLs covered under Attendant Care Services and Personal Care Services include eating but EXCLUDE meal preparation. Providers are expected to feed recipients but are not allowed to prepare the food. Even recipients of home-delivered meals may require assistance in heating, unwrapping, and preparing the food for consumption. Providers should be able to prepare food, in addition to feeding recipients, as billable services. The proposed rule will impact Arkansans all across the state. Providers may be unable to serve Medicaid recipients. Employees of agencies may lose their jobs. Many of the items contained in the rule change do not save the state money but, instead, will cost us in the long term. Care in one's own home is often the most cost-efficient and effective way to provide services. I would ask the Department delay the majority of the proposed rule. Outside of the implementation of the new assessment process on January 1, 2019, there is no reason to rush more than 600 pages. The Department did not show due diligence in providing providers, beneficiaries, stakeholders, and the public adequate time to read through and understand the proposed changes. There will be serious impact to people across the state, and we should have time to make sure that we are doing the right thing.

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

Tiffany M. Apple

Comment: I work with In Focus Care, Inc. in Russellville, Arkansas out of Pope County and I would like to share our concerns for our agency and our clients that will be affected by changes that are proposed to go in affect as of January 1, 2019. The first issue that is going to affect many of our clients, not only within our agency but state wide, is a relative working with a beneficiary. We have clients that live in rural areas out in the woods in the middle of nowhere that we are unable to staff with anybody besides because of the location and how far it is. In one case, our beneficiaries son (who does not live in the home) is having to retire from his job just to provide care that the client to his father because no one else is able to. In a couple of cases, there are clients that will not allow anybody other than a family member assist them in bathing and our clients should not feel uncomfortable and unsafe in their own homes. In a few other cases, a family member works with these beneficiaries due to the fact that the client has behavioral issues and can be aggressive, inappropriate and/or very intimidating and can be a safety hazard to other people other that don't know them or how to handle them when these behaviors occur. Not only can it be a safety issue for those people but for the clients as well. If Medicaid decides that a relative cannot work with the beneficiary then a lot of people will move to Independent Choices, and when that happens there will be a lot of beneficiaries that will not be getting seen (fraudulent claims being submitted) or receiving services properly. At least those beneficiaries who receive services by relatives through an agency are being monitored on a regular basis, as where Independent Choices services are not monitored and are not receiving all the services that they need. The second issue is Medicaid is only offering a 3 cent raise for Attendant Care and Respite services only but minimum wage is increasing to \$9.25 per hour as of January 1, 2019 yet our agency is required by THE STATE to pay for all of the following: Initial and periodic background checks, initial and random drug screen testing, initial and periodic adult and child maltreatment background checks, training materials including mandatory in-service training and materials, workers compensation insurance, malpractice insurance, a 1 Million Dollar Liability Insurance Policy, Department of Health Licenses and DAAS Certifications and expect us to be able to pay the employees at the new minimum wage rate and all the other finances it takes to run a successful business. The raise offered is very unreasonable and we are asking for some justification.

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

Donna Alliston

Comment: Please do not stop these life giving services to our seniors! They are more important than you can imagine. If they do not have these services it will take away their independent living. Seniors do not like to depend on family for help. They prefer to have the assistance of home care. Taking away these services will be determinable to their wellbeing.

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

Sarah Carlson

Comment: I am writing on behalf of my son Ketrick. Ketrick receives personal care services due to his severe disabilities that make it impossible for him to perform these task on his own. His aunt is his aide and has been for the past 4 years. We are very grateful for this service. My concern is with the changes I was made aware of pertaining to family members working with clients and the 64 hour per month cap. Over the 23 years of Ketricks life the one thing we have learned is he does don't accept change. We stick to a very strict routine and if that routine is disturbed it sets him into a tailspin. We lose all progress that we strive for. Ketrick is nonverbal and can be very difficult at times. This is a parents worst fear, having to place your nonverbal child with a stranger. Some days are very difficult with ketrick and it takes the true love and understanding that only a family member could have for him. This type of change leaves open for abuse. We went through many aides that could not deal with Ketrick. We now have made major progress with the consistency and structure that having the same aide for four years can offer. We are very grateful for personal care services. It has made life much more manageable for us both. The hours that he receives allow me to be able to work and provide a better life for him. I sincerely hope that you will consider my concerns and the detrimental effect that these changes will have on the individuals served. Thank you for your time.

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

Lisa Masters

Comment: I am writing to oppose the ARChoices Notice of Ruling regarding the cut in reimbursement rates for the Living Choices Waiver program. The reimbursement cuts being proposed by DHS are completely unacceptable. These cuts will force many facilities and agencies to either close their doors or drastically reduce staff and other programs. These cuts will impact Arkansas seniors' lives in ways that are unacceptable. The quality of care will decline resulting in the decline of seniors' quality of life. Our seniors have worked extremely hard their entire lives and deserve to be taken care of in an environment that enhances their quality of life, an environment THEY CHOOSE, not an environment they are forced into! Forcing them to move to a skilled nursing facility will result in a decline in their health. These proposals go against everything we believe in for our elderly and send a message that is definitely not aligned with DHS' supposed Mission statement. This is hypocrisy at its finest. DO NOT LET OUR ELDERLY DOWN!!!!

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Steve Albrecht for Kindred at Home

Comment: This letter is respectfully submitted on behalf of Kindred at Home and its Community Care Services providing comments regarding the Arkansas Department of Human Services LTSS Proposed Medicaid Policy Revisions. Kindred at Home is one of the nation's largest providers of home health, hospice and community care services. In August 2016, Kindred at Home significantly increased its presence in Arkansas when it entered into a good-faith business transaction with the Arkansas Department of Health to acquire the Department's in-home health operations. During negotiations and signing of the agreement, material changes to the program were not disclosed by the state. As part of the agreement, the state made requests of Kindred at Home to retain all current employees for the first twelve months and agreed to serve all current patients upon consent. Kindred at Home honored their commitment to the state. Kindred asks the state to not make material changes to the LTSS program that would fundamentally alter the business it recently purchased from the state.

Kindred at Home Community Care Services provides personal care, attendant care, respite and targeted case management to 2,150 clients in all of the state's seventy-five (75) counties. Kindred at Home Community Care Services employs 107 full time employees, 1,427 personal care aides (159 of which are family members at risk of losing this position due to the proposed rule), and has an annual payroll of \$17,100,000.

In addition, while Kindred at Home provides aide services in level 1 Assisted Living these services are not impacted by the proposed changes to reduce the Assisted Living per diem rate and therefore Kindred at Home is not submitting comments on this portion of the proposed rule.

We do appreciate the opportunity to submit comments regarding this proposed rule that directly impact our business in Arkansas. We first want to commend the department for making some needed changes to areas of the rule related to transportation services, financial management and the extension of the time frame for prior authorization to 12 months in the community care areas. These positive changes will help to level the playing field among providers and we applaud the department for making those changes.

Specifically, the changes affecting a client's Financial Management will reduce potential abuse by no longer permitting a client's assistant to help in a client's financial decision. This will make the program similar to how other financial services are currently administered in Arkansas. Likewise, changes proposed to no longer allow transportation services to be offered will clarify what providers may and may not offer clients and promote consistent communication to clients about these services.

Additionally, the proposed rule change that allows for Prior Authorizations to be extended from six months to every twelve months is positive. This will result in better time utilization of registered nurses who perform assessments and allow greater flexibility around providing services in a timely manner.

There are, however, components that give us grave concern. We are significantly concerned about proposed reductions regarding reduced funding levels, adding new administrative reporting requirements to providers, implementing new evaluation criteria, changes to the Individual Budget Services, and the new limitations on who can provide services. Based on our current interpretation of the proposed rule we believe if the current proposal is implemented as is, our clients could experience a reduction of services available, and our work force could experience reductions of up to twenty-percent. Given the nature of this work force, combined with the passage on election day of the new minimum wage requirements that will begin January 1, 2019, this will have significant impact on the financial stability of the program, which will in turn directly impact our workforce.

In addition, we have serious concern over the impact this rule may have in the marketplace. When we acquired the state's in-home health operations in August of 2016, we did so based on certain financial expectations. The proposed rule would drastically change the assumptions this transaction with the state was based on, just twenty-four (24) months ago.

While the above-mentioned changes highlight our overall positives and negatives surrounding the proposed rule, we do seek additional input and clarity regarding the consequences of the rule's impact if implemented as proposed.

Comments and Suggestions for DHS Clarification
(Questions for DHS response are *italicized*)

AR Choices, Living Choices, Independent Choices, Personal Care and Program for All-Inclusive Care for the Elderly will now be assessed by three separate entities with the selection of an outside contractor to replace the assessment that was previously performed by the DHS nurse. The DHS Nurse, the outside contractor and the provider agency nurse will all three be making visits and assessing the individuals.

Is it the intent of the Agency to have three separate assessments/visits and is this medically and financially prudent to determine the appropriateness of the services? Also, what will be the process when and if there are discrepancies on determining need?

Prospective Individual Services Budget (ISB) (212.200)

The proposed changes to the Prospective Individual Service Budget (ISB) include establishing the maximum dollar amount of waiver services authorized for each specific participant, limited by a prospectively determined ISB. The levels are as follows a) Intensive (\$30,000 annually); b) Intermediate (\$20,000 annually); and c) Preventative (\$5,000 annually).

A majority of our clients currently receive 20-plus hours of assistance in addition to meals and an emergency device. We estimate that these combined services come to approximately \$13,000. This far exceeds the proposed Preventative ISB level.

Has the state done an impact analysis to determine the number of current beneficiaries who could lose access to these services due to the proposed changes? Reduced access to these services could jeopardize the level of independence a beneficiary is able to maintain and result in placing them in a higher cost setting in the future. We encourage the Department to consider increasing the Preventative level of funding.

Based upon our interpretation of the rule, the ISB will limit an eligible beneficiary from receiving multiple preventative services, thus jeopardizing the level of independence a beneficiary is able to maintain.

A newly released FACT SHEET by DHS states the following:

“If the beneficiary is eligible for more services than can be paid for under the Intensive \$30,000 ISB, it is stated that the DHS nurse will work with the Beneficiary to make adjustments. If the beneficiary and the DHS nurse arrive at a service mix within the ISB, but the DHS nurse feels that the services are inadequate to safely meet the needs of the individual, the DHS nurse will provide the beneficiary with alternative options. The beneficiary will have the choice of remaining with ARChoices or choosing an alternative option.”

What are those “alternative options” mentioned above?

The lowest \$5,000 ISB level could also impact a beneficiary from receiving multiple preventative services such as PERS, Home Delivered Meals and aide services. The beneficiary would need to choose which

service to receive. The lack of these services may limit the level of independence a beneficiary is able to maintain.

What is the department's intent regarding the impact on PERS, Home Delivered Meals, and aide services?

Restrictions on Who May Provide ARChoices Service

Sections 212.600 and 222.100 now state the following individuals providing attendant care, environmental accessibility adaptations/adaptive equipment, prevocational services, or respite care may not:

1. Reside (permanently, seasonally, or occasionally) in the same premises as the participant;
2. Have a business partnership or financial, fiduciary relationship of any kind with the participant or the participant's legal representative; or
3. Be related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

Our interpretation of the proposed rule has determined the combination of all of these excluded individuals far exceeds the CMS exclusion of a spouse or parent of a minor.

Is it the intent of DHS for Arkansas to exceed the CMS exclusions related to excluded individuals?

If so, it is difficult to understand the mechanism of how a provider agency is expected to determine an excluded individual down to the fourth degree of relation by blood, adoption or marriage or a business relationship with the participant or the participant's legal representative.

Further, an agency would be at the mercy of the participant/participant's legal representative to provide true and accurate information.

If by chance, an agency found out information not to be accurate, would the agency be held liable for recoupment?

In addition, what will happen to current employees that may fall into one of these categories of exclusion?

All of the proposed exclusions will have a direct impact on the current workforce and limit the available eligible workforce especially in very rural areas. Kindred at Home presently employs 159 family members as personal care attendants. The breakdown of where these individuals reside in relation to our branch offices is as follows:

Kindred at Home Beneficiaries' with Family Member Personal Care Attendants
By Branch (each branch services a 50 mile radius)

Brinkley	11	Little Rock	5
Camden	9	Melbourne	18
Fayetteville	0	Monticello	50
Forrest City	6	Paragould	19
Harrison	12	Russellville	3
Hope	17	Texarkana	7

Hot Springs	2	Waldron	0
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The proposed rule put these positions in jeopardy and given some of the rural locations will severely limit the pool of eligible people to provide personal care attendant services.

It is also curious as to why these exclusions do not also apply to the Independent Choices Waiver, especially when that waiver requires significantly less oversight to protect beneficiaries. It would be likely to expect that many beneficiaries would choose to change to the Independent Choices waiver in order to maintain their current employee who would now be considered excluded under the proposed rule. This would have an impact on current agency providers that are not contracted to provide services to the Independent Choices waiver beneficiaries.

Personal Care Specific Rule Comments:

ARChoices Specific Rule Comments

Appendix G-1. Response to Critical Events or Incidents

b. State Critical Event or Incident Reporting Requirements

Currently agencies are mandated reporters of suspected abuse, neglect and exploitation of endangered, impaired or elderly adults. The statute requires immediate reporting to APS when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

Under Reporting Requirements for providers, it now states in addition to the statutory requirements, the DPSQA requires (a)-(h) to also be reported to their department no later than 11:00am on the next business day following discovery by the provider.

While we support protecting the client, a more realistic reporting timeframe should be considered. Currently in Texas, an agency is required to report an allegation of abuse, neglect or exploitation to the state within 24 hours of receipt of the allegation. During recent proposed rule changes, home health care agencies were proposed to be held accountable to facility reporting timeframes, however, the 24 hour reporting timeframe was upheld for home health agencies. Agencies do not have the ability to gather information as quickly as facilities due to the fact the individuals are not as accessible.

The DPSQA Form -731 is also a facility-based form.

Will this form be revised for provider agencies?

The proposed rule also states that in the addition to the facsimile report, the provider must conduct a thorough investigation of the alleged or suspected incident and complete an investigation report and submit it to DPSQA on Form DPSQA-742 within five working days. Form DPSQA-742 is Long Term Care Facility form as well.

Will it also be revised for provider agencies?

Again, homecare agencies do not have immediate access to information as their beneficiaries are not on site and are often located in very rural areas.

An alternative option used in Texas allows 10 days for the written investigative report to be sent to the state from the date of the initial report. A timeframe of 10 days allows an agency time to do a thorough investigation as often a visit must be made to the home to gather more information and statements/interviews from multiple individuals.

Background checks

201.000 E. The following individuals employed or contracted with a home health provider must comply with criminal background checks and central registry checks as required by law currently codified at Arkansas Code Annotated 20-33-213 and 20-38-101 et seq.:

1. Owners;
 2. Principals;
 3. Operators;
 4. Employees; and
 5. Applicants (prior to the extension of a job offer).
- 20-38-101 only defines Operators and Employees

AR Choices Draft rules at 213.230

The proposed rule states:

B. All owners, principals, employees and contact staff of an attendant care services provider must have national and state criminal background checks and central registry checks. Criminal background and central registry checks must comply with Arkansas Code Annotated 20-33-213 and 20-38-101. Criminal background checks shall be repeated at least once every five years.

While the language above refers to “owner” and “principals” no definition is provided.

Is it the intent of the agency for corporate entities with investors and senior executives to be required to submit to background checks or is the intent to require background checks only for those individuals who have direct contact with clients?

Also, a National criminal background check is not included in the Provider Manual but yet is listed under the AR Choices Draft. Due to the discrepancy between what is proposed in the Provider Manual versus what is in the AR Choices Draft Rule.

What will be the expectation regarding the National criminal background checks?

If they are required upon every hire and at least every five years thereafter on all identified applicable individuals, it will increase Administrative costs of provider agencies.

Also, is it the intent of the proposed rule that licensed individuals are subject to the criminal background and central registry searches as well?

Additional Regulatory Suggestions for the State to Bring Arkansas In-Line with Neighboring States

Comparison of Arkansas to Neighboring States

Kindred at Home has a broad range of experience providing long-term supports and services in states across the country. Our experience has found that while each state’s services are similar the rates and costs of providing the services varies. While it may be that rates in Arkansas are slightly higher than those in neighboring states such as Texas and Missouri, it is important to note that the regulatory and administrative requirements on providers in Arkansas are also different. The table below compares the three states and highlights the administrative/regulatory differences.

Requirement	Arkansas	Texas	Missouri
<i>Location of Offices</i>	<ul style="list-style-type: none"> • Must be within 50 mile radius of beneficiaries 	<ul style="list-style-type: none"> • No defined limits. 	<ul style="list-style-type: none"> • Not licensed and no limits.
<i>Supervision of Services</i>	<ul style="list-style-type: none"> • RN visit every 62 days. 	<ul style="list-style-type: none"> • At least annually by qualified Field Supervisor (may 	<ul style="list-style-type: none"> • RN visit every 6 months for General Health

		be unlicensed if meets qualifications).	Evaluation; monthly nurse visits (RN or LPN) for Advanced Personal Care clients.
<i>Training of Personal Care Attendants (Aides)</i>	<ul style="list-style-type: none"> • Must meet specific training or previous verified employment in certain LTC settings. • Ongoing 12 hours of in-service annually. 	<ul style="list-style-type: none"> • Competency determined by field supervisor. 	<ul style="list-style-type: none"> • 12 hours of annual in-service requirements.
<i>Background Checks of Personal Care Attendants (Aides)</i>	<ul style="list-style-type: none"> • Proposed federal and state Criminal background and Central registry checks prior to hire and every five years thereafter • Drug Screening prior to hire and randomly thereafter 	<ul style="list-style-type: none"> • State criminal history check prior to hire and Employee Misconduct/Nurse Aide Registry upon hire and annually. 	<ul style="list-style-type: none"> • Family Care Safety Registry prior to hire (included Employee Disqualification List) • EDL checked quarterly.
<i>Disqualification from Hire as Personal Care Attendant (Aide)</i>	<ul style="list-style-type: none"> • Currently: a spouse, foster parent or anyone acting as a minor's parent, legal guardian of the person or an Attorney-in fact. • Proposed: Reside in the same premises as the participant; 	<ul style="list-style-type: none"> • Spouse or parent/step parent/legally authorized representative of a minor 	<ul style="list-style-type: none"> • No family member-parent, sibling, child by blood, adoption or marriage, spouse, grandparent or grandchild. • May not share residence.

	<p>have a business partnership of financial, fiduciary relationship of any kind with the participant or the participant's legal representative; or be related to the participant by blood or by marriage or adoption to the Fourth degree.</p>		
<i>State Regulatory Surveys</i>	<ul style="list-style-type: none"> • Every 2 years. 	<ul style="list-style-type: none"> • Every 3 years. 	<ul style="list-style-type: none"> • Not licensed.
<i>Internal Quality Assurance Reviews</i>	<ul style="list-style-type: none"> • At least quarterly. 	<ul style="list-style-type: none"> • Twice per year. 	<ul style="list-style-type: none"> • Not Licensed (Internal Quality performed 2-3's per year).
<i>Abuse, Neglect and Exploitation Reporting Requirements</i>	<ul style="list-style-type: none"> • Current report to APS. • Proposed- Report to APS and DPSQA no later than 11:00am the next business day following discovery by the provider. Investigation and submission of the written report due to DPSQA within five working days. 	<ul style="list-style-type: none"> • Report to APS and Report to Texas Health and Human Services Commission within 24 hours of awareness of the allegation. • Written report due to HHSC within 10 days of the notification. 	<ul style="list-style-type: none"> • APS Hotline reports are completed as identified. No other state reporting mandated.

We believe Arkansas can improve its regulatory environment by adopting some of the alternative policies utilized in Texas and Missouri without compromising oversight and protection of clients from abuse. We offer the following recommendations:

1. Make the ANE reporting to DPSQA requirement 24 hours from receipt of the allegation.

2. Decrease the frequency of supervision of services to every 6 months-1 year. (Electronic Visit Verification will be monitored.)
3. Decrease the level of the Supervisor requirement. Given that there are already going to be two RN's assessing the beneficiary it is not necessary to also have a RN supervise Personal Care.

In conclusion, Kindred at Home supports components of the proposed rule that level the playing field among providers of community care in areas such as transportation services and financial management. The proposed extension of the timeframe for prior-authorization is also a good idea. There are, nevertheless, significant areas of concern regarding reduced funding levels, adding new administrative reporting requirements to providers, new evaluation criteria, changes to the Individual Budget Services and new limits on who can provide services. We believe these changes will limit an eligible beneficiary from receiving multiple preventative services, jeopardize the level of independence a beneficiary is able to maintain, and result in significant work force reductions.

Kindred at Home appreciates the opportunity to provide comment on the LTSS Proposed Rule Changes and we encourage the Department of Human Services to revise this proposal based on the recommendations we have offered. Kindred at Home is happy to provide any further feedback necessary to assist in providing clarity and improvement in quality and compliance of the services provided. If you have any questions about these comments, please contact me at (512) 338-7795 or Richard.bruner@kindred.com.

Response: Comment considered and accepted in part. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules. Nothing in the proposed rules requires three separate assessments for beneficiaries. The proposed ISB amounts are based on spending patterns of current beneficiaries, and the limits will apply only to waiver services (including attendant care, home-delivered meals, PERS, respite care, and adult day/day health care) except for environmental accessibility adaptations. The language referenced regarding incident reporting is unchanged from current waiver terms except for changing the names of the DHS divisions involved. The criminal background and central registry check requirements are already contained in state law and are not new, the rule language is being modified to reflect what is already required. The remaining comments regarding licensure are outside the intended scope of these rule changes, but DHS will carefully review them in considering future rule changes.

Ed Holman

Comment: I would like to address my concerns about the proposed rule change dealing with changes to the assisted living program.

1. My first concern deals with combining all four tiers of service into one payment. This discourages providers from wanting residents with higher needs and does not reimburse them for labor costs that a more fragile resident will require. Medicare understands this and reimburses nursing homes based on labor and other resources that are being used. This is an unnecessary move and will limit, or prevent residents from getting proper care. Many existing tier 4 residents may be pushed into nursing homes if their rates are cut by the proposed 26% in this rule change.
2. The Milliman study that was referenced in the study has a number of inaccuracies that result in a lower reimbursement rate. Combine this with the recently passed minimum wage increase and many of the assumptions are too low. For example the study used C NA salaries at \$10.40 per hour, just last

week Arkansas Children's Hospital raised their starting rate to \$14.00 from \$10.10, a 39% increase. Our rates have to reflect the real world costs.

3. We need a mechanism for automatic rate increases as our costs go up. CMS has a market basket index that would work perfectly. Arkansas already uses this for nursing home methodology.

4. The proposed rules will not allow personal care services to be billed in an Assisted Living II setting. This makes no sense, why would DHS object to services being billed at \$35/day or lower, when the billing would be \$62 or higher in an Assisted Living setting? This is an important feature to allow AL2 facilities to at least bill a small amount until an AL waiver slot opens up. Denying this can and often does force someone into a nursing home bed if they cannot get any other services.

5. We need clearer language on the proposed moratorium language limiting AL waiver facilities.

6. After a four year process to study long term healthcare in Arkansas, DHS was given many suggestions on how to rebalance health delivery in Arkansas. This came in the form of the Stephen Group report, other earlier reports, testimony by dozens of providers, and the opinions and discussions of many Arkansas legislators. The resulting decision for DHS seems to be if you have a health issue then you need to go to a nursing home. Home health, residential care, and assisted living are all being limited or cut back and it is clear that the only option that DHS leaves is a nursing home bed! This is a dignity and choice issue. No one but the most fragile person should be in a nursing home and even then only if they, or their families agree to the move. Please make an effort to keep our options open.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Ed Holman (2nd Comment)

Comment: I need to add to my earlier list that we wish for more waiver slots for assisted living. This restriction is causing a hardship for people needing the services and is forcing some of them to go into nursing homes as a last resort to receive care.

Response: Comment accepted. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Sherron Cogburn

Comment: I am writing on behalf of my son, Jordan Pearcy and his personal care aide which happens to be his grandmother. First of all, let me start by saying Jordan doesn't handle change well. In fact, he thrives on structure. Because of this, it would be detrimental to his wellbeing to pull his PCA simply because she is his grandmother. Another issue I have with this is the fact that personal care aides in general are not paid enough for the work they do to actually care about their job and the clients they serve. I know this from experience as I have been an aide since 2003 for the same company and barely make \$10/hr. I can say that I am one of few that doesn't do the job for the money. I see firsthand the new people hired by agencies to work in homes and they have little to no training, some not able to do simple tasks such as make a bed, mop a floor or prepare a meal. I hear the complaints from the clients who are too scared to report the aides for fear they will get someone worse. My next issue for us is that my son is very trusting of everyone he meets. This fact causes me concern for anyone but family to work for him for fear of them taking advantage of him. They wouldn't have to steal from him because he would happily give anything to anyone that seemed in need. Please consider my concerns in your decision making process and thank you for your time.

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

Taylor Roberts

Comment: I am writing to you about the amendment to change the current Medicaid Waiver program that would drastically reduce Medicaid rates for those in assisted living. I strongly opposed it and am shocked that this would even be an option. I feel there needs to be more research completed and other options explored to make cuts. I have experience of what the amendment would do to the elderly community that depends on the Medicaid Waiver program. I am a Registered Nurse and have worked in an assisted living facility that is solely built for the elderly population that utilizes Medicaid, and I also work in a family health clinic that cares for a large elderly population that uses Medicaid. I live in a community where ninety percent of the people are on Medicaid, and we are a retirement community as well. To get to the point, this proposed amendment is morally wrong! When did cutting budgets and saving money justify harming people? If this amendment goes through the elderly who depend on it will be forced to either go to a nursing home, which they might not be able to afford, go back to live with their children, which who knows if they will even be adequately cared for in that situation, or become homeless. I would like you to think about if it was your grandmother, mother, or family member that this was happening to, and you had no way of paying for their stay without Medicaid. It would be devastating. I could go into much longer and in-depth analysis on why I think this amendment is wrong, but then it would turn into a book. So I will leave you with this, shame on you and all the others who proposed this amendment and/or are trying to push it through. All of the people that will be impacted in a negatively and all the lives that will possibly be lost. Life is not about money but is about helping out and caring for your fellow human beings. Especially the ones who paved the way for you to be where you are at today. Thank you for your time reading this.

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

summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Michelle Tilley LPN

Comment: My name is Michelle Tilley Lpn. I have been employed in the health care system for 23 years. I love working at Peachtree Assisted Living in Mena AR. I love the residents. They are vital, purposeful individuals. They do not want to live in Nursing Homes. They tell me "You go to the nursing home to die. No one gets out alive." "You go to Assisted Living to live!" Nursing Homes are wonderful facilities but they are geared toward people who need extensive care. The Nursing Home environment is geared more toward the hospital care setting as opposed to the "home" environment. This is not a failing of Nursing Homes it is a result of the total care facility that cares for people who need extensive, often expensive, care. Giving Assisted Living Facilities the short end of the stick is an injustice. We need Assisted Living Facilities to continue to provide dignity, freedom and care that allow the resident to continue to be a vital individual. They deserve to have a choice. They deserve to have a voice. I feel the proposed cuts give the impression that our citizens have freedom of choice in health care as long as they can pay for it themselves. And if they cannot pay? The state of Arkansas will take away their right to choose and tell them where to stay." And what about the individual already in Assisted Living that will no longer be able to afford care due to cuts? Is Arkansas going to provide some sort of financial assistance to rehome them? Does Arkansas care if they have a home?

I do not believe the cuts will save money either. Have you factored in all the health care and food stamps the displaced workers and their families will need? What about unemployment benefits to displaced workers? Was that a consideration?

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Patricia Crow

Comment: Hello my name is Patricia Crow, I work@ Peachtree Assisted Living in Mena Ar. The center here is awesome, as the residents are so happy, along with having their freedom and independence, they feel like they have a reason to live and still accomplish things on their own. I have worked in many Nursing Homes in my career, and I realize that is some peoples choice, but not everyones, basically but importantly it's a place to eat, get meds and die. As an American Citizen I believe it is everyones choice to live anywhere we want to. These people here doesn't draw food stamps, and require extensive treatment for skin ulcers, They do not have a Physician coming and visiting and charging a huge amount of money for in house care. A lot of our residents pays privately out of their own pockets, and refuses to go to a Nursing Home, as they should have a choice. We have Veterans here whom served their country and put their lives

on the line for us. I support Assisted Living Centers all the way, The Good Ole U.S.A is a country of freedom, We are not a communist Country Or Are We? It's beginning to look like it! Is the gas chamber next, just because Politicians and state funding wont help? How can We keep sending things to the moon but yet deny money to take care of the elderly and needy. I speak proudly for our Citizens, their choices, and I hope and Pray we can keep our facilities. I truly believe that assisted living is more economic than Nursing Homes, please reweigh the costs t truly believe this, these people is our extended family and We do love them.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Shirley Garrison

Comment: I would like to share my concerns about the changes that are supposed to take place in January, 2019, about family members not being able to take care of family. These disabled individuals do not like change at all. Some of them cannot take baths by themselves and will not let anybody but family bathe them. Would you let somebody bathe you that you were not familiar with if you were not able to bathe yourself? They are hard to control at times and will be aggressive with those that are not familiar with them. Most of the family members that take care of these individuals do not work so that the individual can be cared for properly and the family does need reimbursement. The caretakers get very little compensation for this. In some areas in Arkansas the disabled lives so far back only family members will care for them because employees will not drive in some of these areas. Thank you for taking these comments into consideration.

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

Matt McClure

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

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

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

Comment:

Second, the proposed rule's prohibition on paid family caregivers (to the 4th degree) in an agency model only puts frail and vulnerable Arkansans at risk and impacts jobs in rural communities. For many rural Arkansans, paid family caregivers provide a lifetime to care and mitigate the need for costlier, more acute services that may or may not be available close to home. Agencies screen all employees, including family caregivers, as part of their operation. Criminal registry checks and drugs screens are completed, and all employees receive a minimum of 40 hours of training. Also, a RN provides ongoing monitoring of caregivers and beneficiaries. The proposed rule change does not prohibit paid family caregivers in the Independent Choices Program. I feel that this is in direct opposition to the Department's statement about fraud and abuse in the use of paid family caregivers. Caregivers who are hired directly by recipients in the Independent Choices program are not required to receive the same level training. There is not the same oversight by a registered nurse. Until recently, caregivers in the Independent Choices program were not required to undergo criminal registry checks or drug screens. There is considerably less oversight in the Independent Choices Program which potentially puts people at risk.

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

Comment:

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

The proposed rule will impact Arkansans all across the state. Providers may be unable to serve Medicaid recipients. Employees of agencies may lose their jobs. Many of the items contained in the rule change do not save the state money but, instead, will cost us in the long term. Care in one's own home is often the most cost-efficient and effective way to provide services.

I would ask the Department delay the majority of the proposed rule. Outside of the implementation of the new assessment process on January 1, 2019, there is no reason to rush more than 600 pages. The Department did not show due diligence in providing providers, beneficiaries, stakeholders, and the public adequate time to read through and understand the proposed changes. There will be serious impact to people across the state, and we should have time to make sure that we are doing the right thing.

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

Regina Burkett

Comment: As an employee of a home-based personal care agency I have deep concern over the upcoming provisions for Medicaid beneficiaries that receive in – home personal care such as the disabled and elderly. Our Medicaid population is one of the most underserved groups in our communities. The Medicaid changes for January 1, 2019 will be a tremendous hardship on Arkansans who are disabled or elderly. We as a state should help this group of people to stay in their homes without the fear of being placed in a nursing home or institution.

One such revision that is up for vote by the Arkansas General Assembly proposes prohibiting a caregiver that lives with or is related by blood or marriage to the client, to continue having personal care services provided through a private agency. Instead they are being forced to have the services provided by a self-directed care program. If this occurs, it will cause great hardship for the client. The client will then be assigned the task of becoming the soul employer of that caregiver and all the responsibilities that go with the duty. Most clients receiving services are unable to take on this kind of responsibility. With only one self-directed care program in the state this is not a choice. People will not have an option to seek out other providers of this sort. This will leave the unhealthy client feeling anxious and skeptical all at once!

After studying the guidelines of the self-directed care program, it was brought to my attention that they have very relaxed guidelines and no training on assisting a disabled or fragile elderly person. It's well known that Independent Choices is a program that has fallen under much scrutiny. Many of the caregivers Medicaid fraud cases exposed by the Attorney General's office have been involved with this program. This could be because the program is one of the least monitored and regulated services provided by DHS. But, there are an abundant number of guidelines for personal care agency providers. The caregivers at an agency must be a Certified Nurse Assistant (CNA) or have 40 hours of training and receive a personal care aide certification (PCA). Agencies also provide the caregivers with 12 hours annually of continuing education courses and quarterly in-services to address new and upcoming changes in personal care. The provider's RN puts together a specialized care plan for each individual client. If a family member has any questions about the care plan or their loved one the RN is just a phone call away.

It is also my understanding that the revisions to Medicaid AR choice's program are listed as "proposed" changes and is to be voted on by our legislators. If this is so then why is Arkansas Department of Human Service's nurses already asking and telling clients, they can go ahead and switch to Independent Choices now. Please consider the client, caregiver, and families before voting for the upcoming revision. I personally believe the revisions will be making a negative impact on our underserved, and fragile population. As a tax payer and voter, I am asking that you as a legislator, duly elected by the citizens of our state, to make decisions that is in the best interest of the voters, to consider how the revision to the AR Choices program being presented by DHS will in anyway benefit the state's disabled and elderly population.

Response: Comment considered and accepted in part. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members.

But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

Regina Burkett (2nd Comment)

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

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

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

Comment:

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

The proposed rule change does not prohibit paid family caregivers in the Independent Choices Program. I feel that this is in direct opposition to the Department's statement about fraud and abuse in the use of paid family caregivers. Caregivers who are hired directly by recipients in the Independent Choices program are **not** required to receive the same level training. There is **not** the same oversight by a registered nurse. Until recently, caregivers in the Independent Choices program were not required to undergo criminal registry checks or drug screens. There is considerably less oversight in the Independent Choices Program which potentially puts people at risk.

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

Comment:

Third, the new Arkansas Medicaid Task and Hour Standard appears to be prescriptive and possibly restrictive in nature of the minutes assigned to each task. Beneficiaries served in Attendant Care and Personal Care programs vary in the care needs from day to day. A Plan of Care may indicate bathing 3 times per week, but a beneficiary may be unable to bathe during one of those days. In the proposed amendment, ADLs covered under Attendant Care Services and Personal Care Services include

eating but EXCLUDE meal preparation. Providers are expected to feed recipients but are not allowed to prepare the food. Even recipients of home-delivered meals may require assistance in heating, unwrapping, and preparing the food for consumption. Providers should be able to prepare food, in addition to feeding recipients, as billable services.

The proposed rule will impact Arkansans all across the state. Providers may be unable to serve Medicaid recipients. Employees of agencies may lose their jobs. Many of the items contained in the rule change do not save the state money but, instead, will cost us in the long term. Care in one's own home is often the most cost-efficient and effective way to provide services.

I would ask the Department delay the majority of the proposed rule. Outside of the implementation of the new assessment process on January 1, 2019, there is no reason to rush more than 600 pages. The Department did not show due diligence in providing providers, beneficiaries, stakeholders, and the public adequate time to read through and understand the proposed changes. There will be serious impact to people across the state, and we should have time to make sure that we are doing the right thing.

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

Casey Kleinhenz

Comment: I represent Community Development Corporation of Bentonville (CDC), a non-profit organization that operates the Legacy Village and Osage Terrace Gardens Assisted Living (AL) properties in Bentonville, AR. I have concerns regarding the proposed rule revisions as they relate to Assisted Living. Specifically, the program eligibility narrowed to Seniors needing less care, and the burden placed on operators as result of the proposed rule change.

I know you have had many contacts from residents and their families concerned about losing their Assisted Living home. Our administrator determined that, under the proposed rule, about 70% of our current residents are at risk of being assessed out of the building in 2019.

These Seniors and their families are happy with their lifestyle. They are thriving with the current level of care. They are "terrified" of going to a nursing home because of a policy change rather than an actual change in their care needs. I'm confident they are telling you their stories better than I can. In the balance of this letter I'll focus on where the proposed rule gives us the most operating concern. ("Concern" isn't the right word. We are terrified too.)

CDC's AL properties were developed under the Federal Low Income Housing Tax Credit program. These buildings must serve residents below 60% of the area median income level or face a form of compliance default. Our single residents must make less than \$28,000 per year. I explain the funding source to show that pivoting to more private pay residents is not an option at a Tax Credit property. The only way for us to meet compliance criteria and for residents to pay for services valued over \$3K/month is to have the Medicaid AL waiver.

The proposal is not just a rate change, it is a mandate to make dramatic changes in our service model with only two months notice. Lower reimbursement for lower care need makes sense at face value, but CDC would still need to staff for the highest

care need until all the residents are at a low tier of care. There is no offer of a rate phase-in for that scenario.

Even with a staff reduction, 22% is a significant cut. It is hard to imagine how CDC can operate with that level of reimbursement. You have said providers in peer states can perform at that rate. Perhaps they could provide insight on what specific operating efficiencies make performance at a lower rate possible. I only know CDC's operating realities. To have the cut dictated without more information on peer programs makes me feel like, state-to-state, the programs could not possibly be equivocal.

As residents assess out CDC properties will have higher vacancy levels. In the proposed rule, there is no offer of relief for that impact either. Typical residency at our AL properties is about 30 months. CDC has about 100 units. Where we might normally have 40 units turn in a year, CDC now could have 70 in addition to natural attrition. Each of those turns will have staff and real estate costs associated with it. More concerning, with waivers no longer retroactive to move-in date. CDC could be providing a significant amount of unpaid services as residents wait for an available waiver.

Loss to turnover may be a best-case scenario as it assumes there are waivers to be had. Operating losses could be much worse as there is no clarification in the proposed rule that waivers will recycle throughout the year. In the current process, waivers are released annually on February 1st, then only a handful are available for the balance of the year. As written, the rule assesses out residents on their original assessment anniversaries throughout 2019. Having no waiver availability to replace them after mid-February is potentially a massive oversight.

I would be glad to share more on our operations if you believe it would help improve the rule revisions. Like you, I believe in sustainable programs. However, with these oversights the proposed rule would not just be untenable, it would be malicious. Please do not approve this rule change. Have it revised and submit a more feasible draft after elections and the holiday season. I have faith you can propose a rule that helps Seniors and service providers, as opposed to a rule that harms both.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is

being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Cindy Taylor (Mercy Crest Assisted Living)

Comment: Mercy Crest Assisted Living is a 102 bed Assisted Living II facility in Barling Arkansas. We are a sponsored ministry of the Sisters of Mercy but are not otherwise affiliated with the Mercy Health System and we receive no funding from them. Our mission has always been to help those who are unable to help themselves as reflected in our mission statement:

*“Mercy Crest Assisted Living, a ministry of the Sisters of Mercy, provides services that advance the quality of life for elderly and disabled residents in the most appropriate, least restrictive, Christian environment, with particular concern for those **who are economically poor.**”*

Our current census is the lowest it has ever been. Many people applying are Living Choices waiver applicants waiting on approval. Most have been advised to spend down their assets and are now ready to make application, with little hope of being approved. Of our current 88 residents, 54 of them are on the Living Choices Waiver. We did not build our business model on the idea that we would take Medicaid as a significant portion of our income, however that number has expanded strictly as a result of increased need. In 2005, when our residents began coming in at an older age, we became a Medicaid provider because many of our resident were simply out living their retirement funds.

Mercy Crest has continued our mission of serving the poor through our operating budget. In the past two years, we have funded \$44, 000 in charity to residents who just don't have enough to make their monthly expenses. We have gotten grants and funded an additional \$12,000 to cover Rx costs and personal needs items for residents whose personal income is less than the state room and board amount. We've written off amounts in excess of \$24,000 for residents who are transitioning to Medicaid or are out of the facility for inpatient treatment. We have taken five residents from Adult Protective Services because DHS called and said there was no place for them to go because whoever took them would not get paid until they were approved for Medicaid and that can take a month or two under the best circumstances.

We don't participate in the Living Choices program because it makes us rich. We do it so that we can take care of those residents who need a safe and secure environment to live and maintain a better quality of life.

I beg you to consider that just because a person needs help and is economically poor, does not mean that they need to be in a nursing home. We would ask that you “grandfather” the residents that are already living in our facilities at the current or slightly reduced rate so that facilities are not forced to close or discharge residents from their home. There are some needed changes in the program, and we acknowledge that, but forcing people that are not able to stay at home to go straight into a nursing home is not the answer.

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

assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Sheronica Cooney

Comment: My name is Sheronica Cooney, I am a Target Case manager with Shining Stars of America, LLC. I received an email on yesterday from Mark White, Deputy Director on Division of Aging and Adult and Behavioral Health Services discussing about the proposed extensive changes to the LTSS program including ARChoices and Personal care. He attached a fact sheet that would answer questions if we needed to know. I notice that it talked about every services from attendant Care, respite, HDM, personal emergency services, as well as home modifications to the clients home but never mentioned Target Case management. Is it some reason that it was not mention. I am concerned because that is all I do is target case management and if I need to start looking for something else, please warn me ahead of time. I am disappointed not to see what the future holds for TCM because we do make a difference in the world. Please let me know what you find and I do apologize for venting. Thank you in advance and I look forward to hearing from you very soon.

Response: Comment considered. DHS is not proposing any changes to Targeted Case Management at this time.

Sandra J. Marney

Comment: My name is Sandra Marney. I have been a nurse for 43 years. I have worked in a assisted living facility for the last 7 years. I am opposed to the proposed rate cut. Because dhs has not provided adequate time for a true measure of the outcomes Caused by such drastic change of 21.7% cut. The drastic changes have many residents fearing becoming homeless, causing detrimental changes in their emotional and physical well-being. It is all about Jesus

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Sherron Myles

Comment: Good afternoon! As an employee of a home based personal care agency, I have deep concern over the upcoming provisions for Medicaid Beneficiaries that receive in home personal care services such as the elderly and disabled citizens. Our Medicaid population is one of the most underserved group in our communities. The Medicaid changes for January 1st, 2019 will be a tremendous hardship on Arkansans who are disabled or elderly. We as a state should help this group of people to stay in their homes without the fear of being put in a nursing home or institution. One such revision that is up for vote by the Arkansas General Assembly proposes prohibiting a caregiver that lives with or is related by blood or marriage to the client, to continue having personal care services provided through a private agency. Instead they are being forced to have the services provided by a self-directed program. If this occurs, it will cause great hardship for the client. The client will then be assigned the task of becoming the soul employer of that caregiver and all the responsibilities that goes with the duty. Most clients receiving services are unable to take on this kind of responsibility. With only one self-directed care program in the state this is not a choice. People will not have an option to seek out other providers of this sort. This will leave the unhealthy client feeling anxious and skeptical all at once. After studying the guidelines of self-directed care program, it is brought to my attention that they have very relaxed guidelines and no training on assisting a disabled or fragile elderly person. They don't provide background checks either. Anybody can get hired. It is well known that Independent Choices is a program that has fallen under much scrutiny. Many of the caregivers Medicaid fraud cases exposed by the Attorney General's office have been involved with this program. This could be because the program is one of the least monitored and regulated services provided by DHS. But there are an abundant number of guidelines for personal care agency providers. The caregivers at an agency must be a Certified Nurse Assistant(CNA) or have 40 hours of training and receive a personal care aide certification(PCA). Agencies also provide the caregivers with 12 hours annually of continuing education courses and quarterly in-services to address new and upcoming changes in personal care. The providers RN put together a specialized care plan for each individual client. If a family member has any questions about the care plan or their loved one, the RN is just a phone call away. It is my understanding that the revisions to Medicaid AR Choice's program are listed as "proposed" changes and is to be voted on by our legislators. If this is so then why is Arkansas Department of Human Services nurses already asking and telling clients they can go ahead and switch to Independent Choices now. Please consider the client, caregiver, and families before voting on the upcoming revision. I personally believe the revisions will be making a negative impact on our underserved and fragile population. As a taxpayer and voter, I am asking that you as a legislator duly elected by the citizens of our state, to make decisions that is in the best interest of the voters to consider how the revision to the AR Choices program being presented by DHS will in anyway benefit the state's disabled and elderly population.

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

Sonya Emett

Comment: Please accept the following as consideration/feedback/questions regarding the proposed ARChoices changes:

- 5-10 minute range for standby safety assistance for intensity of 1 – it takes most people more than 5-10 minutes to bathe, even individuals who do not require any assistance or standby care,

please consider increasing, Also, what is the frequency allowed? (daily, every other day, as needed, etc.) Additionally, what if someone is dirty unexpectedly on a particular day? Can bathing be added in on that day?

- What success or lack of has MN had with utilizing their assessment?
- Is the goal of ARChoices to honor people's wishes to remain home? If so, then the monetary caps do not correlate with this goal. What is your response to this?
- It is possible an individual qualifies for more hours of assistance than monetary caps allow. Why does the assessment time allowance not coordinate with the monetary caps?
- What research was completed to determine the tier monetary limits?
- Were standard care rates considered when determining monetary limits?
- How do you substantiate an appropriate Preventative Level being \$5,000 annually? What data was used to substantiate this monetary level as successful in a preventative sense?
- If others assisting patients are unable/are not providing the amount of care initially promised, is the RN allowed to increase ARChoices assistance to compensate for that loss of care support?
- Increased public hearings would be helpful, as most affected by the ARChoices program experience difficulty traveling far.
- How many times an hour will be allowed for toileting assistance? What if someone has a health issue that results in increased toileting needs? What if someone has a virus on a particular day? How is this accounted for in the assessment?
- How many times an hour can someone be assisted in transferring from bed/chair/standing, etc.?
- How frequently can clothing be washed during a week?
- Those with higher assistance needs are more likely to fall while out at necessary appointments (doctor, etc.) if they are alone. Why can't this be a consideration in the assessment as an area which may be awarded time?
- Can an area be added for assistance in reading mail to those with vision loss, since mail is usually a main communication source for imparting information?
- How much respite care is allowed?

In regards to personal care:

- Those waiting for disability via social security often need more assistance than 64 hours monthly. Can an exception be made in these situations? If not, why?
- Why is meal preparation excluded?
- Please clarify when a relative is able to provide assistance and be compensated monetarily.

Response: Comment considered. The Task and Hour Standards are intended only to provide an aggregate limit on weekly or monthly hours, and not to dictate the time allocated for the actual performance of each individual task. Meal preparation is not excluded from personal care or attendant care and will remain a covered task. The rule language is being clarified to make this explicit. The proposed rules are being revised to clarify how respite care is determined and allocated. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require.

Betty Raiford

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.

- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) These cuts hurt my family. My son is disabled and without the Medicaid Waiver my son would be unable to remain in our home and in the community among friends and family where he has spent his whole life. Put yourself in our situation - what if you had no choice but to send your son to an institution or take away the supports that enable him to lead a happy, productive life?

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

Ms. BJ Camp

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

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

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

Kim Chrisco

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

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

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

Shirley Nelms

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) These cuts hurt families.
- 6) Our country's leaders should remember and honor our senior citizens with having available to this age group the opportunity to live with independence and humility in their final years. Most Americans will live to be SENIOR CITIZENS you may be in their shoes one day.

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

comment fails to specify what “inadequate data” or “incorrect assumptions” were supposedly used in the actuarial study, DHS is unable to offer any specific response to that statement.

Claudia Michaels

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.
- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) These cuts hurt families. We, as seniors, have worked our whole adult lives. We contributed parts of our wages into Social Security, Medicare and Medicaid so these programs would be available to us if we needed them. We seniors do not appreciate younger folks trying to take away benefits we prepared for and paid. If you want to cut expenses, cut out those younger people that can work and put them to work and paying their fair share of taxes. Cut out the payments to non-citizens, for they never worked in the States and never paid in a dime. I know they are getting money some way or they would not be able to survive. We seniors are vulnerable because we are too old to get paying jobs and most of us have health problems that hamper our ability to work. So many of us only have one income, Social Security, with Medicare to take care of our medical bills and Medicaid to help. Please cut expenses by taking those off these programs that do not deserve them. Thank you.

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

Jeanne Rollberg

Comment: As a senior citizen in Arkansas myself with an elderly mother, am writing to oppose the Arkansas Department of Human Services rules and regulations issued in October. I oppose the regulations in their current form for the following reasons:

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

Response: Comment considered. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting

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

Deborah Boettcher

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

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

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

Ronald Johnson

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

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

Response: Comment considered. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the

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

Nancy Spangler

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

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

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

Fred McGraw

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

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

Response: Comment considered. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting

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

Larry Phifer

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

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

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

Nicholas Kennedy

Comment: Don't harm vulnerable senior citizens for political gain.

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

John Force

Comment: The Arkansas Pest Management Association (APMA) represents over 100 professional structural pest management or “pest control” companies in Arkansas. APMA appreciates the

opportunity to comment on the rule proposed on October 5, 2018, pursuant to *Rule # 016.06.18-016*, regarding ARChoices in Homecare which provides adult day health, respite, adult day services, adult family home, attendant care, environmental accessibility adaptations/adaptive equipment, home-delivered meals, PERS for aged adults 65 - no max age and physically disabled ages 21-64. The ARChoices in Homecare Waiver is an alternative to institutionalization in a nursing facility.

Additionally, in our comments we will also briefly weigh-in on another rule proposed on October 12, 2018, pursuant to *Rule # 016.06.18-019*, regarding pest control services covered as community transition services (CTS) under the Provider-Led Arkansas Shared Savings Entity (PASSE) Medicaid program to address the needs of individuals who have intensive behavioral health and intellectual and developmental disabilities service needs.

APMA member companies manage pests including rats, mice, ants, cockroaches, bed bugs, mosquitoes, spiders, stinging insects, termites and other pests in countless commercial, residential and institutional settings. APMA members are committed to providing quality pest management services that protect public health, food and property.

For decades, pest control services have been recognized as a private sector solution to pest problems that jeopardize public health. Pest control services can empower elderly and disabled Medicaid recipients transitioning from a healthcare institution, as evinced by their inclusion under emergency goods and services and CTS.

HCBS first became available in 1983 when Congress and President Ronald Reagan added section 1915(c) to the Social Security Act, giving States the option to receive a waiver of Medicaid rules

governing institutional care.¹ In 2002, President George W. Bush recommended covering pest control services in home-based care for Medicaid recipients, as a part of his *New Freedom Initiative* that promoted full access to community life for disabled individuals.² A few years later, HCBS became a formal state Medicaid option and was codified into law with the signing of the Deficit Reduction Act of 2005 (DRA). Successively, in 2014, along with publishing a final rule, the Centers for Medicare and Medicaid Services (CMS) listed pest control services in their guidance for CTS that should be covered under HCBS. It is no mistake that many states have found in HCBS Waivers a cost-effective means to implement a comprehensive plan to provide pest control and other services in the most integrated setting appropriate to the needs of individuals with disabilities.³ Pest control has consistently been recognized as vital to 21st Century living standards, as public health officials attribute the quality of life and increase in life expectancy that we have today to three things: better pharmaceuticals, vaccines, and sanitation and pest control.⁴

When transitioning from a facility that provides healthcare, pest control, and other services, elderly and disabled individuals face many challenges. It is imperative that their transition from an institution to a private residence meets high standards of medical care and public health protection. Because pests pose a number of health threats through the spread of bacteria, viruses, and contamination of surfaces, food, medical supplies and equipment, the Department of Human Services/Division of Medical Services (DHS) decided to include "pest control" as a covered service in the proposed rule under Emergency Goods and Services pursuant to the following provision in the proposed rule:

220.100 Cash Allowance 1-1-16

7. With the prior written approval by the Division of Provider Services and Quality Assurance (DPSQA) director (or his/her designee):

(b) Emergency Goods and Services: On a time-limited basis, the following goods and services in the event of a documented emergency representing a risk to the beneficiary's health and welfare: food and clothing; housing for beneficiary (and their service animal, if any); household utilities (i.e., electricity, water, heating fuel, and telephone); and pest control.

Recommendation #1 – Require that Only Certified, Licensed, and Registered Pesticide Applicators and Pest Control Companies Provide Pest Control Services: While APMA commends Arkansas DHS for the inclusion of “pest control” under services recognized as emergency goods and services, APMA believes that the rule can be improved by requiring that pest control services are provided by certified and licensed structural pesticide applicators and pest control companies registered with the State of Arkansas pursuant to *Ark. Code R. § 17-37-201*. Making this change will bring the proposed rule in line with existing Arkansas law:

¹ "What Is an HCBS Waiver? How Do I Get One? What Services Are," *Special Learning Inc*, <https://bit.ly/2CPn5AE>

² https://www.nasddd.org/uploads/documents/SMD_Letter_02-008_Transition.pdf

³ https://www.nasddd.org/uploads/documents/SMD_Letter_02-008_Transition.pdf

⁴ <https://APMApestworld.org/default/assets/File/APMA%20Fact%20Sheet-2018.pdf>

“(a) No person shall, for compensation, engage in pest control service work in any manner as defined in this chapter without first having qualified, including the passing of the board's written examination, and having in force a valid license issued by the board for that purpose.”⁵

Additionally, medical facilities in Arkansas are required to contract with licensed pesticide applicators and pest control companies pursuant to *final rule # 016.06.17-016* adopted on 9/20/2017. APMA believes that it is sound policy and vital to match the same level of public health protection required throughout existing Arkansas laws and regulations:

“802.2 Environment

F. The facility shall be maintained free of infestations of insects and rodents.

1. The organization shall maintain a contract for pest control that is administered by appropriately licensed professionals.”⁶

While the bulk of our comments pertain to pest control covered under emergency goods and services under proposed *Rule # 016.06.18-016*, we would like to apply our recommendation of requiring that only certified, licensed, and registered pesticide applicators and pest control companies providing pest eradication services under CTS pursuant to proposed *rule # 016.06.18- 019*:

“Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the member or his or her guardian is directly responsible for his or her own living expenses.

Community Transition service activities include those necessary to enable a member to establish a basic household, not including room and board, and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses.”⁷

⁵ https://www.agriculture.arkansas.gov/Websites/aad/files/Content/5944144/Circular_6_-_Arkansas_Pest_Control_Law,_Rules_and_Regulations.pdf

⁶ <http://170.94.37.152/REGS/016.06.17-016F-17412.pdf>

⁷ <http://170.94.37.152/REGS/016.06.18-019P-18196.pdf>

As written, it appears to APMA that pest control services could be provided by relatives. If unlicensed relatives are permitted or intended to be permitted to provide pest control services APMA disagrees with this. If relatives are in fact allowed to be reimbursed by Medicaid to perform pest control services it is incongruent with the existing Arkansas laws and regulations mentioned earlier. Please view the screen shot appended below describing CTS under the proposed rule:

Service Definition (Scope):

Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the member or his or her guardian is directly responsible for his or her own living expenses.

Community Transition service activities include those necessary to enable a member to establish a basic household, not including room and board, and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses.

Community Transition Services should not include payment for room and board; monthly rental or mortgage expense; regular food expenses; regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Must be documented in the member's PCSP.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

As written in the proposed rules, it is not clear as to who is permitted to provide pest eradication services for individuals under ARChoices and PASSE, therefore it leaves an opening for unlicensed, unqualified, and unscrupulous operators to endanger and defraud Medicaid recipients and taxpayers. By requiring that registered businesses and certified and licensed pesticide applicators execute pest control services, DHS will bring their language in accordance with existing Arkansas law. By addressing this provision in the proposed rule, DHS will not only bring their language in line with existing law, but they will also ensure that individuals receive the highest public health protection from dangerous and deadly pests possible.

Background on Pest Management Professionals (PMPs)

Highly Professional, Regulated, and Trained Industry: The U.S. Environmental Protection Agency (EPA) and the Arkansas Agriculture Department/Plant Board are the two primary government agencies that currently regulate the structural pest control industry in our State. In order to serve their customers, certified structural pesticide applicators have to undergo extensive training and certification protocols to meet rigorous federal and state standards and pass an exam with a score of at least a 70% or better. Additionally, structural pesticide applicators must complete continuing education courses to ensure that they are competent and sensitive stewards of our environment.

PMPs are Trained-in and Practice Integrated Pest Management (IPM): IPM is a pest management system that uses all suitable techniques in a total management system, to prevent pests from reaching unacceptable levels, or to reduce existing pest populations to acceptable levels.⁸ The purpose of IPM is to manage pests with the least possible impact on people, property, and the environment.⁹

IPM Methods include:

- Mechanical control
- Habitat modification
- Biological control
- Sanitation control
- Physical control
- Chemical control

Recommendation #2 – Do Not Impose Limits for Cost and Number of Pest Control Service Visits:

Imposing limits on the cost and number of pest control service visits may risk or deter the effective transition from an institution to the home—running counter to the original purpose of ARChoices in Homecare. APMA is afraid that by placing a rigid framework around the cost and number of pest control service visits that it could discourage the use of ARChoices in Homecare and result in more patients remaining in more costly institutionalized care. By not imposing a rigid framework for pest control it could incentivize more individuals to move back into their homes and save taxpayer dollars, while at the same time empower Medicaid patients. Given the choice, most patients would want to remain in the pest-free institution instead of the bed bug, cockroach, or rodent infested home. Pest control services can act as a catalyst for transitioning individuals from institutionalized care because of the healthy, sanitary, and ultimately comfortable environment that pest control provides.

Infestations of bed bugs, brown recluse spiders, cockroaches, and rodents for example may require several service visits to safely and effectively eradicate the pest infestation. Regarding bed bugs for example, according to the National Pesticide Information Center at Oregon State University:

⁸ "MDARD Licensing, Certification & Registration Pesticides Integrated Pest Management," MDARD - Integrated Pest Management, https://www.michigan.gov/mdard/0,4610,7-125-1569_16988_75286---,00.html.

⁹ MDARD Licensing, Certification & Registration Pesticides Integrated Pest Management,"

"Bed bugs can be very difficult to control... so a second treatment is often necessary to kill the juveniles after eggs hatch. Female bed bugs lay eggs anywhere they wander, either separately or in a group. Eggs can take 6-10 days to hatch. For this reason, repeated and persistent monitoring is key when trying to control bed bugs."¹⁰

A service visit cap contradicts insect biology in many circumstances and runs counter to IPM methods.

Capping the cost of pest control services is a burden on pest control businesses and Medicaid patients alike. Any cost cap could place vital pest control services out of reach for Medicaid patients. Cost and service visit caps run contradictory to integrated pest management, insect biology, and possibly the overall goal of the ARChoices in Homecare, therefore, APMA recommends not imposing caps.

Recommendation #3 – Implement an Expedited Protocol or System for Considering and Approving

Pest Control Services for Patients: When dangerous and deadly pests infest places where humans eat, sleep, live, and work—it is imperative to act quickly and protect public health. Therefore, it is vital that there is a timely and efficient protocol or system in place to allow for pest control inspections, treatments, invoices, and payments to take place. As written in the proposed rule, pest control services will only be approved after written approval: “7. With the prior written approval by the Division of Provider Services and Quality Assurance (DPSQA) director (or his/her designee)...” While we understand the need for accountability and approval, we also want to reinforce that bed bugs, cockroaches, rodents, brown recluse spiders, and other pests can have detrimental consequences on the mental and physical health of caregivers, family members and patients. So, it makes sense to APMA for Arkansas DHS to self-impose a one or two business day time limit for considering, approving, and providing a cash allowance for pest control services. APMA views this protocol as striking the near-perfect balance of accountability and protecting the patient’s health and well-being. We also recommend collaborating and communicating with caregivers for invoicing and payment whenever possible, but also encourage communication and transparency with patients, caregivers, DHS, and pest control companies. APMA is more than willing to collaborate and serve as a resource for Arkansas DHS.

Dangerous and Deadly Pests – Why Patients Using ARChoices in Homecare and Community Transition Services Need Pest Control:

Cockroaches: Cockroaches spread at least 33 kinds of bacteria, six kinds of parasitic worms and at least seven other kinds of human pathogens. According to the Penn State Department of Entomology, German cockroaches commonly cause:

“Different forms of gastroenteritis (food poisoning, dysentery, diarrhea, and other illnesses) appear to be the principal diseases transmitted by German cockroaches. The organisms causing these diseases are carried on the legs and bodies of cockroaches and are deposited on food and utensils as the cockroaches forage. Cockroach excrement and cast

¹⁰ “Bed Bugs,” National Pesticide Information Center, <http://npic.orst.edu/pest/bedbug/control.html>.

skins also contain a number of allergens to which many people exhibit allergic responses, such as skin rashes, watery eyes and sneezing, congestion of nasal passages, and asthma.”¹¹

The public health threats caused by cockroaches are numerous, alarming, and for low-income communities and Medicaid recipients using ARChoices in Homecare living in close quarters, the problems can be inherently worse. According to the University of Florida Department of Entomology, “Surveys of low-income apartments have found more than 10,000 cockroaches per apartment.”¹² Another example of the grim and grisly public health conditions produced by cockroaches are illustrated by the Journal of Community Health finding that:

“...In a survey of public housing units in Gary, Indiana, researchers found evidence of pest infestations in 81% of units surveyed and isolated cockroach allergens, and important trigger for asthma and allergies, in 98% of kitchen dust samples.”¹³

As shown in a 2014 study by the *Journal of Allergy and Clinical Immunology*, “In many low-income communities, coughing and wheezing are accepted as part of normal growing up and medical care may not be sought because it isn’t considered necessary, or it is too difficult to access.”¹⁴

Rodents: Rodents transmit diseases like murine typhus and salmonellosis indirectly through their

droppings, saliva, urine and hosting fleas. Rodents exacerbate allergies and asthma attacks due to allergenic proteins in their urine and feces. According to the U.S. Centers for Disease Control and Prevention (CDC), rodents transmit over 35 diseases such as hantavirus, rat bite fever, trichinosis, plague, infectious jaundice, Weil's disease and leptospirosis.¹⁵ Leptospirosis results in an estimated 1.03 million annual cases and 58,900 deaths around the world.¹⁶ While the majority of deaths caused by leptospirosis occur in the developing world, the United States is not immune.

Rodents can enter buildings through almost any opening or crack larger than a dime. Once inside, rodents can cause structural damage as they are able to chew through wallboards, cardboard, wood and plaster and through electrical wiring, increasing the potential risk of fire. Additionally, rodents defecate constantly and can easily contaminate any and all food and food preparation surfaces. It's important to inspect for rodent droppings, especially in undisturbed areas like kitchen pantries, storage areas, and along walls.

¹¹ "German Cockroaches (Department of Entomology)." Department of Entomology (Penn State University). January 2013. <http://ento.psu.edu/extension/factsheets/german-cockroaches>.

¹² Castner, P.G. Koehler and J.L. "The German Cockroach." EDIS New Publications RSS. March 03, 2015. <http://edis.ifas.ufl.edu/in028>.

¹³ Wang, C., M.M. AbouEl-Nour and G.W. Bennett. 2008. Survey of pest infestation, asthma, and allergy in low-income housing. *Journal of Community Health*. 33: 31-39.

¹⁴ Effects of early-life exposure to allergens and bacteria on recurrent wheeze and atopy in urban children, Lynch, Susan V. et al. *Journal of Allergy and Clinical Immunology*, Volume 134, Issue 3, 593 - 601.e12

¹⁵ "Rodents," Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/rodents/diseases/direct.html.

¹⁶ F Costa, JE Hagan, J Calcagno, M Kane, P Torgerson, MS Martinez-Silveira, C Stein, B Abela-Ridder, Ko AI (2015). "Global Morbidity and Mortality of Leptospirosis: A Systematic Review" <http://journals.plos.org/plosntds/article/file?id=10.1371/journal.pntd.0003898&type=printable>

Ants: While ants can contaminate food and food surfaces, the species of ant that is most worrisome in health care settings is the pharaoh ant. These ants can spread more than a dozen disease pathogens including *Salmonella* and *Streptococcus pyogenes* and are problematic because of their attraction to intravenous units, medical preparations and open wounds.¹⁷

Flies: Flies are much more than a buzzing annoyance, in fact, the threats they pose are serious. According to the Penn State Department of Entomology, flies carry a plethora of harrowing diseases because they feed on fecal matter, discharges from wounds and sores, and excrete and vomit on food among other causes:

"House flies are strongly suspected of transmitting at least 65 diseases to humans, including typhoid fever, dysentery, cholera, poliomyelitis, yaws, anthrax, tularemia, leprosy and tuberculosis. Flies regurgitate and excrete wherever they come to rest and thereby mechanically transmit disease organisms."¹⁸

Additionally, a 2013 Arkansas Institute of Health (NIH) published study titled, "Role of Flies as Vectors of Foodborne Pathogens in Rural Areas" has shown that various species of flies not only carry harmful bacteria such as, *Campylobacter*, *E. coli*, *Salmonella*, and *Shigella*, but also multiple viruses and contribute to the resistance of antibiotics across the world. This study found that regarding anti-biotic resistance,

“...the carriage of antibiotic resistant bacteria by flies in the environment increases the potential for human exposure to drug-resistant bacteria.”¹⁹

Bedbugs: A 2013 survey conducted by the National Pest Management Association and the University of Kentucky found that 33 percent of pest control professionals have treated for bedbugs in hospitals, while 46 percent did so in nursing homes.²⁰ Although bedbugs are not considered vectors of disease, their bites can leave itchy, red welts and their presence can cause anxiety and sleeplessness.²¹ In some cases, patients also can experience a secondary infection caused by scratching at the bites and causing skin trauma, allowing for a port of entry for infection.²²

Conclusion

Pest prevention and management cannot be viewed as being unrelated to the safe and effective transition from a medical or nursing institution to the home for Medicaid patients. Rather, it must be viewed as critical to achieving these goals. Requiring a certified, licensed, and registered pesticide applicator and pest control company for pest control services covered under ARChoices in Homecare and community transition services is an investment in the health of patients and as well as an investment in the judicious use of taxpayer dollars because unlicensed, unqualified, and unscrupulous operators are not performing pest control services. The benefits of using a

¹⁷ Jim Fredericks, “How to Control Pests in Health Care Facilities.”

¹⁸ “House Flies (Department of Entomology).” Department of Entomology (Penn State University). January 2013. Accessed July 17, 2017. <http://ento.psu.edu/extension/factsheets/house-flies>.

¹⁹ C. Barreiro, H. Albano, J. Silva, & P. Teixeira, Role of Flies as Vectors of Foodborne Pathogens in Rural Areas. ISRN Microbiology, 2013, 718780. <http://doi.org/10.1155/2013/718780>

²⁰ Jim Fredericks, “How to Control Pests in Health Care

Facilities.” ²¹ Jim Fredericks, “How to Control Pests in

Health Care Facilities.” ²² Jim Fredericks, “How to Control Pests in Health Care Facilities.”

professional pest management company often far outweigh any associated costs and, in the long run, may save valuable Medicaid funds due to the proactive preventive measures put in place. APMA appreciates the opportunity to comment on the proposed rules and we hope that the Arkansas Department of Human Services is committed to protecting public health and property by requiring that pest control services are provided by certified, licensed, and registered pesticide applicators and pest control companies in Arkansas without caps on the cost and number of pest control service visits, and that services are considered, approved, provided and paid for by Arkansas DHS within an efficient and timely framework. Thank you for your time.

Response: Comment considered. The bulk of this comment is outside the scope of and does not relate to the changes proposed by DHS. DHS will expect providers to abide by existing state law regarding the licensure of pest control employees.

Lynne Duncan

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

- 1) Lack of transparency. The state has been working on these changes for months. The nursing home industry was privy to the information on the changes, but consumers were not.

- 2) They cut \$14 million in services to our most vulnerable citizens.
- 3) They will cost taxpayers more money by forcing people into institutions.
- 4) The Department is basing some of their proposed changes on actuarial studies which appear to be based on inadequate data and incorrect assumptions.
- 5) These cuts hurt families. My mom is 81 years old and still working and living on her own. She wants to continue working and living independently as long as she can. She's in wonderful health because she's not been made to quit working and rely on others to take care of her. Our parent's and grandparents deserve better.....

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

Rachel E. Bunch

Comment: The Arkansas Health Care Association (AHCA) is pleased to write in support of the Department of Human Services (DHS) continued efforts to reform Medicaid long-term services and supports (LTSS) for the aged and adults with physical disabilities. The proposed reforms under public comment, as referred above, together represent a significant advance that will benefit beneficiaries and taxpayers, now and in the future.

Consistent with the Memorandum of Understanding (MOU) between Governor Hutchinson, DHS, and AHCA, these proposed reforms will:

1. Provide a new, more flexible person-centered approach to the assessment of functional limitations and needs and care planning;
2. Provide a clear, thoughtful methodology for determining the reasonable, medically necessary amount, frequency, and type of covered assistance each person needs;
3. Increase cost-effectiveness and fiscally sustainability;
4. Align program benefits to reduce the duplication, inconsistencies, and inefficiencies caused by the multitude of services Arkansas covers;
5. Improve program and provider accountability and the ability of DHS to monitor access, quality, and service delivery;
6. Significantly improve Medicaid program integrity, including reducing overuse, misuse, duplication, waste, fraud, and abuse;

7. Help ensure that State Medicaid dollars are not used to support services that are covered through Medicare or another third party; and
8. Help ensure Arkansas remains in compliance with federal requirements and maintains access to federal matching funds.

We commend the hard work of DHS, particularly the Director's Office and the leadership and staff of the Division of Provider Services and Quality Assurance and the Division of Aging, Adult, and Behavioral Health Services. AHCA is honored to work with the DHS to help achieve the objectives outlined in the MOU. The proposed reforms are a significant step toward realizing the MOU objectives, and we look forward to continuing to work with you.

Response: Comment considered.

Valerie Beall

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

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

As a former employee, I have been placed in a unique position to understand how cutting Medicare will effect those who will lose some of their benefits.

After paying my Medicare insurance. I receive only \$721 and believe me that is not enough for a single person to live even meagrely. It means that sometimes I have to wait to buy my meds and that I have to juggle to pay my bills. My husband works part time so he brings home minimum wages. If we are struggling now, just think about what happens when one of us dies. No heating. No cooling. Just barely living. Please reconsider the cuts intended for Medicare.

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

Judy Penix

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

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

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

W. Brant Joyner

Comment: As you all well know, the ALF Living Choices Waiver has been in existence since 2002. There were 4 Tier levels of care based on need assigned by a DHS RN from the beginning. Precedent of 16 years exists from the beginning of the program. The Milliman Report recommending a rate was produced with arbitrary and/or chosen cost numbers not real numbers from the current 59 ALF-2 Facilities that take the Medicaid Living Choices Waiver. As of this writing, I did not receive the requested Milliman foia'ed information showing actual detailed figures of the 3 facilities responding nor the actual names of facilities and personnel completing this information. This is vital to the process. I expect to see that information. At this point, I can only assume that information was knowingly withheld. If there is another reason, then I need an explanation and then the complete detailed information. Being there is precedent of the program, I cannot fathom the decreased rate. The proposed single rate is at the 2011 tier 1 level. The only explanation is to hurt the AL industry and force us out of business if we take the Medicaid Living Choices Waiver. Many emails and conversations have been had with the Nursing Home Association (AHCA) which does not represent Assisted Living Facilities regardless of anyone from that organization stating that. Foia'ed emails show the copying of the nursing home association personnel on numerous discussions regarding the living choices waiver with DMS/DHS leadership. Assisted Living Facilities deserve a fair per diem rate that is related to the nursing home rate. As a small business owner speaking for other business owners, we all have business loans and tremendous obligations that must be met and this would be devastating not only to the AL industry but also to the individual Medicaid beneficiaries that the State of Arkansas is trying to take out of our facilities, take their choices away, and force them into a Nursing Home. Also, as of this writing, the Minimum Wage proposal passed and will be another devastating blow to the AL industry. This must also be considered in any rate proposal.

This proposed rate devastation cut is not happening with Nursing Homes. While they may have had some minor cuts, most all are very profitable. Arkansas Business in 2017 ranked Nursing Homes by

profitability and 118 out of 125 listed made a profit taking Medicaid dollars. In fact, the 1st nursing home listed made 3 Million dollars in net income and had an average Medicaid daily rate of \$182. The 70th nursing home listed made over \$300,000 in net income and had an average Medicaid daily rate of \$173.00. The proposed AL rate is not comparable to the nursing home rate structure and should be since we provide much of the exact same care. We want and expect fairness from the State of Arkansas.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Stephen Cole Hiryak

Comment:

Daily needs each and every day of my life include:

- Transferring in and out of my bed
- Transferring to and from the toilet
- Transferring to and from wheelchair and shower chair
- Bathing
- Meal prep
- House cleaning
- Making of bed
- Cleaning of clothes
- Skin care
- Dog care
- Opening of bottles and cans of beverages

So for the federal government to cut funding for these services is a slap in the face of the disabled and Care givers and Families of them. It shows a total disconnect between Washington and the disabled communities of what basic needs are and how to provide them with federal and state programs like Ar/choices and Medicaid self directed services. Without these kinds of services people would be forced to be put into nursing homes and the cost would be put heavily on private insurance and medicaid and I

am certain there would be a shortage of nursing homes and the care would be sub par and people would suffer every day of there lives. To me the answer is simple the government lacks the compassion and only care about their pockets and keeping their life styles of going on vacations with there families and going on their private jets and not having a care in the world all while the disables suffer day in and day out. I feel as though as I am writing this that it will fall on def ears and wont even be read. It will all be based on the number of emails send in an if that number is low then they will just do as they wish to save a dollar and see what happens later. It will be out of sight out of mind I hope one day that the folks in government have to go through what I have to go through on a daily basis and maybe even have to stay a night in a nursing home to see how bad it is and the horrible conditions and smells and horrid food they feed people their and how skinny people are in these facilities I have seen it first hand because last month my ninety seven year old grandmother had to be put in a nursing home and she never eats all of her food. On top of that she has a roommate that in incontinent and it smells so bad that it about makes me puke who could even eat in a room that smell that bad? I cant blame her for not eating and being all skin and bones. My grandmother only gets two baths a week am sure she smells herself that god she was able to live on her own for so long this was made possible from programs like Medicaid self directed services. She had meals delivered and had a care giver that came in for several hours a day because she has dementia and has lost the ability to do everyday task as her mind has reverted to that of a child in a lot of ways. So pleas DHS do not allow our federal government to force us into Nursing homes they are modern day death camps. Also this would have been written a hell of a lot better if I had received this letter in the mail sooner and not had to wright this on the last day it would have had a lot more detail but I have ran out of time.

Response: Comment considered. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require.

Mike Shepard

Comment: I am opposed to the changes in Assisted Living Medicaid rate to \$62.89 and the reduction from 4 tiers to 1 tier.

After thorough review it is apparent that DHS did not offer adequate opportunity for development of their rate methodology with input from other stakeholders other interested parties.

1. The rate change is too significant and will cause loss of jobs, closure of rural facilities and deterioration of the quality of care that has been demonstrated in Assisted living facilities throughout Arkansas.
2. DHS failed to adequately interpret the side effects of such a serious rate cut
 - a. Economic impact on rural communities
 - b. Impact on the vulnerable and frail seniors of Arkansas
 - c. Impact of banks and the investor community from facilities closing and buildings being foreclosed
 - d. Failing to property interpret the actual cost to the state budget for Assisted Living costs compared to nursing home costs.
 - e. Increase in costs to unemployment and other programs
3. A single tier does not account for the varying levels of acuity that exists with Arkansas seniors.

Please review your findings and allow for other stakeholders to share the other significant negative outcomes from this proposal. Let's not accomplish tax cuts on the Backs of Arkansas Seniors. There are alternative methods to accomplish these goals.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Jacque McDaniel

Comment:

1. General—Comment--When reviewing the mark-up copy of the proposed PC and ARC policies, there were several referenced policies that were on the Contents page that were not included in the body? Was this by design? Were policies that did not change excluded from the mark-up document?
2. General— In light of the passage of Arkansas Minimum Wage increases approved on November 6th, 2018, the proposed attendant care rate increase of \$.12 per hour will not cover the mandatory increase of \$.75 per hour in 2019 and the related fringe benefits. Will this be incorporated in the rate increase? Minimum wage increases by another \$1.00 per hour in 2020 and \$1.00 per hour in 2021 will follow. Fringe benefits, such as FICA and workers compensation, will be additional costs for the program. Our program costs are currently more than \$18.00 per hour because we comply with the various program requirements and federal and state employment laws! Consideration needs to be given to implementing a cost-of-living, instead of erratic adjustments after 3-7 years!
3. General— In light of the passage of Arkansas Minimum Wage increases approved on November 6th, 2018, the lack of a personal care rate increase seems unrealistic when there is a mandatory increase of \$.75 per hour in 2019, \$1.00 per hour in 2020 and \$1.00 per hour in 2021. These increases will result in increased fringe benefit costs. How is the state going to address the mandatory increase in aide costs? Our program costs are currently more than \$18.00 per hour because we comply with the various program requirements and federal and state employment

laws! Consideration needs to be given to implementing a cost-of-living, instead of erratic adjustments after 3-7 years!

4. PC policy 200.100 lists one of the required central registry checks will be the "Certified Nursing Assistant/Employment Clearance Registry." Comment-- How will this be set-up and administered? Several of our aides work for more than one agency. Will there be a charge for registering? Will the individual being registered be responsible for maintaining an active number? Will this be an annual registration or one-time registration? How long will it take for a newly trained aide to receive a registration number? Will that be prevented from working until they receive this number?

5. PC Policy Section 222.100 A.3 states the person providing the direct care who works for the agency may not "3. Be related to the beneficiary by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.
Comment--During a time when there is a projected caregiver shortage nationwide, an increasing number of Boomers turning 60 each day (10,000-11,000 per day) and a historical low unemployment rate, finding workers to fill these roles is getting challenging even without the limitation on relatives serving beneficiaries. When a policy is established, the next logical step will be implementation and then post audit review. How will an agency comply with this requirement? Will the agency be required to do DNA testing or search court records? Will the aide be required to attest to not being a relative to the 4th degree? If it is determined they were actually a relative to the 4th degree, will this be considered Medicaid fraud?

Response: Comment considered. Consistent with past DHS practice, the provider manual drafts posted to the website do not include sections that are not being amended. Because the minimum wage increase potentially affects many types of providers across Medicaid, DHS intends to take a system-wide approach to reviewing the increase and the need for any changes to address it. The criminal background check and central registry check requirements mirror what is already required by state law and should not require any change to existing practice. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

Tabbatha Gilbert

Comment: I am writing to address the proposed rule changes for the ARChoices and personal care services. As I understand that changes are bound to happen, some of the changes that are being proposed will have a devastating effect on many of my consumers and their quality of life. I have been an agency owner for only three years now and am learning everyday as much as possible. I have however worked for a large agency that works with developmental disabilities since I was 18 years old. The compassion and love for any individual with any disability and the families of those individual run deep and true.

The main issue I would like to address is the rule of family caregivers. We currently have 68 consumers signed up with the ARChoices and personal care program. Of the 68, 31 of these consumers are cared for by a family member. These family members have received the same training, undergone the same background and drug screening as any other employee that works for our agency. Many of these consumers have come to our agency after working for Palco through Independent choices. They were

treated unfairly, paid lower wages and even charges on their paychecks for different fees that they did not understand. The consumers that have switched from independent choices to our agency state that they are happier, feel more connected, and feel like there is a plan in place in the event that the family member is caring for them gets sick. There are number of advantages to our consumers to be able to have an agency behind their care and have a family member care for them as well.

We have done our part as an agency to employee these family members abiding by every rule that was set in place as well as continued training throughout the year to better educate them to be able to care for our consumers. We as an agency have expended the cost of these trainings, the background checks, drug screens, etc. the same as we would have for an employee. I feel that if we are abiding by the rules and treated every caregiver as equal, our family members should not be discriminated against and made to choose the state Independent Choices program. This program is supposed to be freedom of choice for our consumers and not a dictatorship that tells them who they must use to provide care if they prefer to use a family member. And we as agencies should not be discriminated against because we are not Palco and directly funded in total by the state. I have poured every ounce of energy, time, and personal money into getting my agency off the ground and making a difference in my community.

Please reconsider the unfair rule on family caregivers used in agency. I assure you that I spend more time checking on my clients and their families than Palco ever did or ever will. This is unfair and unjust to allow one company to abide by one set of rules and disallow a private care agency to do these things. I have spoken with each of my families regarding these new rules and 100% of them are absolutely against them, some already have dealt with Palco and hated it. I have grown to know these consumers very well and care deeply for each of them. Please reconsider.

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

Alaina Abshure

Comment: My name is Alaina Abshure and I am a targeted case manager and LPN for Absolute Care Management. I came into this job in February of this year after spending 9 years working in the long term care field. I have fallen in love with this job and my clients. The elderly and the disabled are already an underserved community and I find joy in being able to help them in any way I can. Our country is built and prided on freedom and choices. These changes to Medicaid, ArChoices and Assisted Living essentially take away the choices of the elderly in our state. By changing the assessment process, familial caregiver limitations, and severe budget cuts, we will force countless recipients into nursing facilities. While many will end up going to a nursing home there will undoubtedly be many that will refuse to go, causing an increase in injuries, hospital visits, and deaths. The plan is to cut costs to our state by cutting the Medicaid budget but in reality this will increase costs. The nursing home industry is already an understaffed, underpaid and overworked industry, and we are proposing adding more work for less pay. I have been working hard these past few weeks to get the news of these changes out to my clients and gathering their input. Here are some examples of their responses:

"They WILL NOT take my wife back to the nursing home. I will crawl over earth and water to keep her out. It almost killed both of us for her to be there."

"I prayed to God every day while I was in the nursing home that I'd live to get home and I cried and cried when I saw my caregiver again."

"She (my mom) will not survive in a nursing home. She'll think I left her."

Another aspect of these changes that will be detrimental to the recipients of the waiver program is the rule no longer allowing family members to care for their family members. We have been told that the reason for this is to avoid fraud but the program they are proposing these clients with family members as caregivers switch to, independent choices, is a company that does not require background checks, training or having an RN to consult with their caregivers, allowing for a higher instance of fraud. A large majority of the recipients of the ArChoices waiver suffer from Alzheimer's or dementia. These unfortunate individuals thrive more in an atmosphere with people that they know. Some become so combative when a stranger or new caregiver is introduced that their safety is put at risk. Again it is a person's choice if they want to stay in the home and if they want to have a family member help them while they're there. There are so many people that I come in contact with that have no family, no support, no help. We should be thankful that there are family members willing to help. My clients also stress about their family members being able to make a living. Some family members have to make the choice between working and taking care of their loved one, putting extra stress on them both. We need to view nursing home admission as an exception, not the rule.

I worked in the nursing home industry for 9 years and never knew anything like the ArChoices waiver existed because they are more focused on keeping their beds full and bills paid. When I got this job I was amazed that this help was available, and now it's in danger of going away. I strongly urge you to at least take more time for the community and providers to address these changes. We've been given a short time to take in the impact of a 600+ page document. I would just like to leave you with the comment from one of my clients about these changes that has stayed with me the most and urge you to take it into consideration. Thank you.

"When you reach a certain age this country no longer cares about you. They're just waiting for you to die and don't care what you want. You no longer matter."

Response: Comment considered and accepted in part. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary. DHS has an obligation to taxpayers to carefully watch how Medicaid dollars are spent, and to ensure that Medicaid uses its limited funds wisely and efficiently. DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. But DHS is making several changes in the proposed rules that will reduce the level of savings that would have been achieved under the original proposal. DHS believes these changes are appropriate in light of the public comments received, and the final proposed rules will still achieve savings that are vital for the long-term sustainability of the program.

Elaine Lawson

Comment: We have reviewed the Personal Care changes proposed to start January 1, 2019. We have concerns about the following change:

"When Personal Care services are delivered through a home health agency or private care agencies, the person providing the direct care who works for the agency may not reside in the same premises as the beneficiary...". If, as a private non-profit agency, we are deemed to be a "private care agency", several

of our current plans will be effected and services for those individuals involved could be interrupted . It is already a difficult task to hire staff who are willing to go through the extensive PC training and provide those services. If the pool of qualified staff we have to draw from is limited even further because of staff residency, then our ability to provide quality services for individuals in need of personal care services is even further hindered. This proposed change will also limit the individuals' choice of who he or she will allow to provide intimate personal services. I'm sure many will agree that everyone feels more comfortable when intimate PC services are provided by someone they know well and who they trust. Often times, individuals served rely on family members or other staff with whom they reside to be that person. Not allowing individuals who have been cared for year by friends and family to continue to receive those services completed by the same friends and family could be a huge disruption to their lives and to the lives of the staff they employ. We would like to request that this proposed change either be thrown out completely or an extension of the start date be made so that revised service plans could be drawn up and submitted for the individuals involved and ample notice could be given to the friends and families involved.

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

Melanie Gloster

Comment: On behalf of the HomeCare Association of Arkansas Board of Directors and members who provide home care services across the state, please note the following comments related to the proposed rule change pertaining to AR Choices and Medicaid Personal Care Services (Ark. Code Ann. §§ 20-10-1704, 20-77-107, 20-77-[28, 20-77-1304, 25-10-101 et seq., 25-10-129, and 25-15-201 et seq.)

The Department has contracted with an independent assessment contractor to utilize the ARIA instrument for recipients of ARChoices and Personal Care. The Association recognizes the need to have this independent assessment tool in place by January 1, 2019; therefore, we do not oppose the implementation of ARIA and an assignment of time values for all current services. We remain concerned with the Department's ability to oversee and administer this process, as many providers and recipients are still experiencing problems with the previous implementation of the independent assessment process and with the contractor Optum.

The HomeCare Association has three primary objections to the proposed rule: flawed rate methodology and lack of provision for minimum wage increase; prohibition of family caregivers in agency model and unfair advantage provided to Independent Choices Program; and overly-prescriptive documentation standards with no apparent understanding by regulators or providers as to how these must be implemented.

The Department used the actuarial services of Milliman to propose rate changes to Attendant Care and In-Home Respite Services. Of agencies providing these services state-wide, Milliman selected eight providers. In this sampling:

- 1 provider does not accept Medicaid
- 1 provider operates as a Registry Provider
- 4 providers are Area Agencies on Aging

Each of these provider types has varying business models and calculates administrative costs in a different manner. The Association feels that Milliman did not get an adequate sampling of provider types. Additionally, the Milliman rate study uses a base of the current Arkansas minimum wage. Voters approved a minimum wage increase to \$9.25 in January 2019 with incremental changes in subsequent years. This increase is not factored into the rate study and creates another hardship on providers. Per our conversation with the Department on October 22, 2018, OHS indicated no plans to revisit this rate methodology even with the increase in minimum wage.

With an aging population, and serious issues with adequate access to health care in many parts of the state, the HomeCare Association strongly opposes the Department's plan to restrict paid family caregivers in an agency model.

In the proposed amendment to the 1915 (c) waiver (AR Choices in Homecare) (page 32), Attendant Care Services are not covered "When ... delivered through a home health agency or private care agency ... by any person who (i) resides (permanently, seasonally, or occasionally) in the same premises as the participant; (ii) has a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's guardian or legal representative; or (iii) is related to the participant by blood (i.e. a consanguinity relationship) or by marriage or adoption (i.e. an affinity relationship) to the fourth degree;" In the Personal Care Manual Section 222.100, Personal Care Services are not covered "When ... delivered through a home health agency or private care agency" and " ... the person providing the direct care ... "does not " ... reside (permanently, seasonally, or occasionally) in the same premises as the beneficiary; have a business partnership or financial or fiduciary relationship of any kind with the beneficiary or the beneficiary's legal representative; or be related to the beneficiary by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree. "

This proposed rule has significant impact to Arkansans living across the state. According to Rural Profile a/Arkansas 2017, a study published by the University of Arkansas Division of Agriculture Research & Extension, 19 counties in the state have a poverty rate of 25% or more. Even as more urban parts of the state continue to recover from serious economic challenges in 2007-2009, rural areas still struggle with both employment and population growth. The Delta, Coastal Plains, and Highlands all experienced a population loss from 2010-2015. In data compiled in 2015, rural areas had an older population than urban areas (median population of 42.0 compared to 36.8 in urban areas). In the same year, rural areas showed "higher dependency ratios, meaning more people ages 60 to 17 and 65 and older per 100 working age (18-64) people." Most significant to the proposed rule change, elderly people (65 years of age or older) make up 18.8% of the rural population in Arkansas.

Furthermore, the study details the distribution of the elderly population in Arkansas (2015). Thirty percent of the population of Baxter County was 65 and older. Ten counties had a high population of those aged 75 and older: Baxter, Cleburne, Montgomery, IZard, Sharp, Van Buren, Fulton, Stone, Marion, and Searcy. In comparison, the six counties with the lowest percentage of elderly were all urban: Craighead, Benton, Lonoke, Crittenden, Faulkner, and Washington.

An aging, rural population also presents challenges in providing adequate and appropriate health care services. In 2015, rural Arkansas averaged 69 primary care physicians per 100,000 residents. By comparison, urban areas had a ratio of 166 primary care physicians per 100,000 residents. Many counties in the Delta and Coastal Plains regions ranked in the bottom 25% of health factors and health outcomes. In 2015, 23% of Arkansas' population met Medicaid eligibility. In rural areas of the state, this percentage jumped to 26.4%, and, in the Delta, the percentage was even higher at 31.2%. Per the

University of Arkansas study, 36 counties, or half the state, had a rate of one out of four people as Medicaid-eligible (Miller and Moon 2017).

With an aging population, and serious issues with adequate access to health care, the Association strongly opposes the Department's plan to restrict family caregivers in an agency model. For many rural Arkansans, paid family caregivers provide a lifetime to care and mitigate the need for costlier, more acute services that may or may not be available close to home. Members of the HomeCare Association who provide Attendant Care, Personal Care, and Respite Care Services rely on qualified, appropriately-screened (criminal checks and drug screens), and trained family caregivers to deliver services across the state. This is especially critical in these underserved, rural counties.

The proposed rule change for Attendant and Personal Care Services prohibit paid family caregivers only for agency models of care. According to the Independent Choices Provider Manual Section 220.200, "Caregivers/Employees will be recruited, interviewed, hired, and managed by the participant as the employer or a designated Representative. Family members, other than those with legal responsibility to the beneficiary, may serve as personal assistants."

In a meeting with the Department on October 22, 2018, the Association and Providers were told that this provision in the proposed rule change was in response to DHS's concerns about accountability among paid family caregivers. OHS has made the statement that there is potential fraud and abuse in the use of paid family caregivers. The Association would point out that agencies who hire family members as caregivers treat these employees no differently than they do other employees. Each agency caregiver undergoes extensive screening, including criminal registry checks and drug screens. Additionally, agency caregivers receive a mandatory minimum of 40 hours of training and are supervised by a registered nurse on a continual basis. In comparison, caregivers who hired directly by recipients in the Independent Choices program, are not required to receive the same level training. There is not the same oversight by a registered nurse. Until recently, caregivers in the Independent Choices program were not required to undergo criminal registry checks or drug screens.

In the name of greater program integrity, the Department is encouraging vulnerable and frail Arkansans, who rely on family caregivers, to abandon the safety and security of agency oversight, and become their own employers in a self-directed model. The Association questions how the Department plans to ensure quality of care and the absence of fraud and abuse in a setting with far less oversight than the agency model. The proposed rule is unfair to providers, caregivers, and recipients across the state, saves no Medicaid dollars, and puts the safety and health of Arkansas in jeopardy. The HomeCare Association of Arkansas surveyed 15 other state associations to ascertain how Attendant Care and Personal Care programs are regulated in their respective states. Not one other state had exclusions on paid family caregivers as restrictive as Arkansas.

As part of the proposed rule change, the Department has published a new Arkansas Medicaid Task and Hour Standard which will be used to calculate hours of service for ARChoices Attendant Care, Respite Care, and Personal Care Services. While the Association and its members do not oppose the assignment of hours per the new independent assessment, there is great concern about the prescriptive and possible restrictive nature of the minutes assigned to each task. Beneficiaries served in Attendant Care and Personal Care programs vary in the care needs from day to day. A Plan of Care may indicate bathing 3 times per week, but a beneficiary may be unable to bathe during one of those days. In a meeting with the Department on October 22, 2018, there was confusion as to how the Standards were to be implemented. DHS could not confirm or deny any details surrounding the documentation requirements.

In the proposed amendment to the 1915 (c) waiver (AR Choices in 1-lomecare) (page 9), the Department states that "The registered nurses who develop the person-centered service plans have a reasonable degree of professional discretion to adjust the amount; duration, and frequency of Attendant Care Services and Respite Services to meet individual needs and circumstances." In a meeting with the Department on October 22, 2018, the Association and providers were told that DHS still needs to work on what will be allowable within these changes and to consult with the Office of Medicaid Inspector General on oversight. The Association is concerned that the Department has not adequately planned for the implementation of these service limits.

In the proposed amendment to the 1915 (c) waiver (AR Choices in Homecare) (page 29) and Personal Care Manual Section 216.212, ADLs covered under Attendant Care Services and Personal Care Services include eating but EXCLUDE meal preparation. Providers are expected to feed recipients but are not allowed to prepare the food. Even recipients of home-delivered meals may require assistance in heating, unwrapping, and preparing the food for consumption. In a meeting with the Department on October 22, 2018, the Association and providers were told that DI-IS still needed to review this item to make sure that providers were not using meal time for socialization. The Association strongly objects to this characterization and stresses the need for providers to be able to assist completely in meal preparation and feeding as a billable service.

Outside of serious issues with the quality of home care (Attendant, Respite, and Personal Care) under the proposed rule changes, there is a serious economic impact to the state. The Department has indicated that the proposed rule change will save the state significant Medicaid dollars. The Association argues that the long-term cost to general revenue will far exceed any short-term savings. Research across the country shows that home care is often the most efficient and most economic way to serve the frail and elderly.

Home care providers often mitigate the need for more acute care and delay the need for more intensive post-acute care. When possible, it benefits the state for its residents to be served in their own homes, in their own communities. Additionally, home care providers employ thousands of people across the state, often in the rural communities where good jobs are few and far between. Home care agencies are economic drivers in many communities, paying taxes, offering benefits, and assisting people with training and job development. The Association duplicated the Milliman sample size, and surveyed 8 unique providers. If the proposed rule takes effect, many providers will no longer be able to serve Medicaid recipients. This will result in a potential job loss of approximately 1,300 jobs. Extrapolate that out across the state, and communities will feel the impact. Thousands of Medicaid recipients will no longer have access to Attendant and Personal Care Services.

The HomeCare Association, its members, and the Arkansans we serve every day, request that the Department delay the majority of the proposed rule. Outside of the implementation of the new assessment process on January 1, 2019, there is no reason to rush more than 600 pages. The Department did not show due diligence in providing providers, beneficiaries, stakeholders, and the public adequate time to read through and understand the proposed changes. There will be serious impact to people across the state, and we should have time to make sure that we are doing the right thing in the right manner. It's the Arkansas way.

Response: Comment considered and accepted in part. Because the minimum wage increase potentially affects many types of providers across Medicaid, DHS intends to take a system-wide approach to reviewing the increase and the need for any changes to address it. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the

potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules. The Task and Hour Standards are intended only to provide an aggregate limit on weekly or monthly hours, and not to dictate the time allocated for the actual performance of each individual task. The rule language is being clarified to make this explicit. Meal preparation is not excluded, it remains covered for both personal care and attendant care. DHS intends to work with providers to streamline documentation requirements.

Kevin De Liban, Attorney with Legal Aid of Arkansas

Comment: Legal Aid of Arkansas writes to offer comment on the set of proposed rules issued on 10/7/18 pertaining to the ARChoices and Independent Choices programs (and, at the end, the Assisted Living waiver). The ARChoices and Independent Choices rules—including the proposed waivers, provider manuals, and other documents—propose to allocate attendant care using a new assessment system called ARIA, a new tool called the Task and Hour Standards, and new Individual Service Budgets.

The proposed rules, taken together, show that DHS intends to use a three-step process to determine care allocations. First, a contracted third-party nurse will ask beneficiaries to respond to as many as 400 questions on the ARIA assessment. Second, based on those responses, an algorithm will give an individual a "Needs Intensity Score" for each of 13 Activities of Daily Living (bathing, dressing, feeding, grooming, toileting, transferring, walking, cleaning, laundry, meal preparation, and shopping). As part of this second step, a DHS nurse will use the Needs Intensity Scores to complete the "Task and Hour Standards," a form that uses the Need Intensity Scores to allocate a certain amount of time for each ADL. Third, a different algorithm will place an individual into one of three Individual Service Budget levels, which limit the annual cost of ARChoices services to \$5,000, \$20,000, and \$30,000, respectively. Even if the Task and Hour Standards form determines that an individual needs a certain amount of care, the individual will not be able to receive that amount if it would cost more than the person's Individual Service Budget allows.

Legal Aid offers these comments based on expertise gained over the last three years in representing around 150 clients with various issues relating to ARChoices and Independent Choices. The vast majority of our clients came to us after suffering significant reductions in care due to DHS's use of the algorithm-based RUGs methodology to allocate attendant care. Others came to us for issues relating to eligibility. Through these experiences, Legal Aid understands that the two central concerns for clients regarding any proposal are (1) that the methodology allocate enough care to meet beneficiaries' actual care needs and (2) that the methodology be transparent and understandable so that beneficiaries know how DHS arrived at a particular number of care hours and, if needed, contest the agency's determination.

The proposed rule poses significant potential for problems relating to both central concerns.

(1) DHS has not published or provided the algorithms or tiering logic that the agency will use to determine the Needs Intensity Scores or Individual Service Budget and, therefore, has not made sufficient projections about the possible impact of the proposed rule.

The hypothetical possibilities of the proposed methodology are impossible to adequately evaluate without the algorithms or tiering logic that will actually determine a beneficiary's Needs Intensity Score for each ADL and a beneficiary's Individual Service Budget. DHS did not publish the algorithms as part of

the proposed rule and has stated in response to multiple Freedom of Information Act requests that it does not have the algorithms.¹

Without this information, it is impossible to say, for example, whether a person with complete quadriplegia will be given the most severe Need Intensity Scores and placed in the highest Individual Service Budget level. And, if that person is not given the highest severity scores and placed into the highest budget levels, will the assigned scores and budget levels allow care appropriate to her needs?

The experience with the RUGs methodology highlights the importance of understanding the algorithms before adoption and use. Under the RUGs methodology, an individual could theoretically receive 352 hours per month (or, about 81 per week). However, the algorithm was so restrictive that only one or two individuals in the entire three-year use of RUGs ever qualified for this level. In the rare situations when someone required a ventilator, respirator, tracheostomy, IV medications, or IV feeding, a beneficiary could potentially receive 201 hours per month (or, about 46 per week). However, for anyone without these special treatments, the effective maximum was 161 hours per month (or, about 37 per week), even for individuals who were functionally unable to perform any ADLs due to conditions like quadriplegia or cerebral palsy. Neither 201 monthly hours nor 161 monthly hours provided enough care. As a result, many people lay in their own waste, developed pressure sores, skipped meals, and endured other indignities. These outcomes were entirely foreseeable based on the algorithm. The algorithm was designed to work this way.

Since DHS does not possess the algorithms, the agency could not have performed adequate projections about the impact of the proposed rule on beneficiaries' access to care. The public is left without information about how much care will likely be available, who will be helped or hurt by the proposed rule, or other information about how the rule will play out once in use. Without this, the public cannot fully comment on the proposal.

(2) DHS's proposed Individual Service Budgets appear to arbitrarily limit services deemed medically necessary and incentivize institutional care.

DHS's Task and Hour Standards will be used to determine how much attendant care is medically necessary for a particular beneficiary. However, even if the Standards determine that a person needs, for example, 8 hours of attendant care per day, the Individual Service Budget may not allow a person to actually receive that much care.

The budget levels are set at \$5,000, \$20,000, and \$30,000. DHS's methodology for setting the \$30,000 cap is not based on the actual overall cost of nursing home care. Other estimates show the overall cost of nursing home care in Arkansas to be significantly more. Most recently, DHS puts the average annual cost of nursing home care at \$65,916 (\$5,493 per month) for purposes of penalties when beneficiaries transfer assets without receiving market value. See MS Policy Appendix R.2 This roughly accords with the 2015 estimate of the Stephens Group that put the annual cost at \$64,295 (\$5,357 per month). In this light, \$30,000 appears to be a gross underestimate.

DHS arrived at the \$30,000 by including only the costs to the state's general revenue fund and the associated federal match rate. However, this figure accounts for only 45% of the average total cost of nursing home care for an individual. The excluded 55% comprises the patient liability, the Quality Assurance fee, and the federal match on the Quality Assurance fee. In essence, DHS has constructed its budget limits to externalize the costs of nursing facility care. The additional cost will be borne by the

beneficiary through the infringement of their preference for community-based living, the federal government, and providers.

The artificially low budget cap of \$30,000 per year places individuals at increased risk of institutionalization. Although there can be a one-time, one-year upward adjustment for “exceptional, unexpected circumstances,” there is no exceptions process for an individual with an ongoing need for more than \$30,000 in waiver services. Such an individual will be required to enter a nursing facility. Therefore, the low budget cap could implicate—and, indeed, violate—the Americans with Disabilities Act’s mandate for community integration recognized in the U.S. Supreme Court’s Olmstead decision.

DHS’s proposed rule does not evince consideration of feasible alternatives. First, there is no analysis regarding higher Individual Service Budget amounts, particularly for the beneficiaries with the most acute needs. Certainly, there is no legal barrier to increasing the budget levels to be equal to the full cost of nursing facility care. Second, there is no analysis regarding why the agency could not implement an exceptions process for individuals with an ongoing need for more than \$30,000 in waiver services.

(3) DHS’s proposal will not provide sufficient care to beneficiaries who choose to receive care through agencies instead of hiring individual caregivers and discriminates against them.

Other than the algorithms about budget placement, the key information for how much care a beneficiary can receive under the Individual Service Budget is the cost for services. Here, DHS introduces price discrimination against program beneficiaries who choose to have their care provided through care agencies as opposed to hiring their own caregiver. The price discrimination infringes on the beneficiary’s ability to choose what is best for her. DHS will charge \$18 against a beneficiary’s budget for one hour of attendant care through an agency. Meanwhile, DHS will charge \$10.40 for one hour of attendant care for someone the beneficiary chooses to hire (this is called “self-directed care”). Based on these rates:

- An individual with the \$30,000 Individual Service Budget (\$2,500 per month) will be able to buy a maximum of 139 attendant care hours per month through an agency and 240 per month through self-directed care.
- An individual with the \$20,000 Individual Service Budget (\$1,667 per month) will be able to buy a maximum of 93 hours of attendant care hours per month through an agency and 160 per month through self-directed care.
- An individual with the \$5,000 Individual Service Budget (\$417 per month) will be able to buy a maximum of 23 hours of attendant care hours per month through an agency and 40 per month through self-directed care.

These hard budget caps apply even if DHS determines under the Task and Hour Standards that the person needs more care.

139 attendant care hours are simply not enough for many high-acuity beneficiaries. Even assuming that an additional 64 monthly personal care hours are available, the maximum care someone using an agency could receive would be 203 per month (or, about 47 per week). This translates to roughly 6.5 hours per day to do everything that someone with total functional dependence needs—getting in and out of bed, bathing, grooming, dressing and undressing (at least twice per day), preparing food (two to three times per day), cleaning, eating, using the bathroom, doing laundry, going shopping, and helping with other household chores or activities. Many of Legal Aid’s clients with total or near-total functional

dependence require at least 8 hours per day of care, which suffices only when the care is split over several episodes during the day.

Our clients' experiences illustrate the many reasons a beneficiary might prefer agency care. Most notably, it can be difficult to hire a caregiver who can be available for the beneficiary's specific care needs. For example, a beneficiary may need multiple visits in a day—a couple hours in the morning, again in the early afternoon, and again just before bed. A single caregiver is unlikely to be available to come at three separate times over a span of 12 to 16 hours, especially when they only get paid for a portion of that. Agencies can often meet the need for multiple visits in a day.

The calculations assume that an individual will not spend any portion of her budget on other services that will count against the budget, such as meal delivery or the personal emergency response system,

Again, without the algorithms, it is impossible to evaluate the likelihood that a beneficiary will be placed in the \$30,000 ISB. This hypothetical addresses the best-case scenario, which will likely not be reality for many ARChoices beneficiaries.

If the agency determines under the Task and Hour Standards that a person needs fewer hours, that person will not have the option to buy more than the Standards allow even if there is enough money in her budget to do so.

There are myriad other reasons an individual might prefer agency care. First, many beneficiaries simply do not have family or friends to hire for self-directed care. Hiring strangers poses the inconvenience of placing ads in the paper and interviewing people and the risks of letting strangers in one's home. Second, caregivers hired by an agency receive mandatory training in caregiving that a caregiver hired through self-directed care is not required to receive. Care may be better and safer through an agency. Third, if a caregiver calls in sick or has to miss work, the beneficiary has to figure out how to replace them for that shift, often with little advance warning (there are also limitations that mean a temporary replacement cannot be instantly hired). Going without care for a shift can be devastating. Fourth, if the beneficiary is not satisfied with a caregiver, the beneficiary has to fire them and arrange to hire someone else. Fifth, the beneficiary always has to sign and submit timesheets and manage other administrative aspects of the caregiving relationship. Agencies shield the beneficiary from the various risks and hassles.

While Legal Aid supports our clients having the option to choose self-directed care, it is not appropriate for everyone. An individual must be able to choose the care situation best for her circumstances. Yet, DHS is driving beneficiaries to choose self-directed care by the prospect of depriving them of hours through the pricing differential. Instead, DHS could simply increase budget limits for individuals choosing agency care or lower the actual cost charged to the budget for agency care (not the amount paid to the agency provider) to equalize the amount of services available between beneficiaries who choose agency care and those who choose to self-direct. The possibility that DHS would equalize the available services by increasing the cost of self-directed care would not be advisable. As analyzed above, 203 hours of care—the best case scenario—will not be sufficient to meet the care needs of many high-acuity beneficiaries.

(4) DHS's proposed rule eliminates assistance with community participation.

Historically, attendant care has been available to help beneficiaries with communication, traveling, errands, and community activities. This could include going to doctor or therapy appointments, going grocery shopping, going shopping at thrift stores while out on other errands, going to a free concert at the town square, taking a “walk” in the neighborhood in an electric wheelchair, or meeting a friend for a once-a-month lunch. Such activities get the person out of the house, affirm her dignity, and ward off the isolation that disability can impose. Indeed, individuals with physical disabilities are at least three times more likely to experience depression compared to the general population.⁶ Beneficiaries need assistance to have meaningful access to community activities.

However, DHS’s proposed rule entirely eliminates attendant care for communication, traveling, and errands. Furthermore, the proposed rule expressly excludes from attendant care “Companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship).” Based on these definitions, it is not clear that a beneficiary can use attendant care to travel to a grocery store or medical appointment. And, it seems impossible for there to be any assistance with community activities.

Legal Aid understands that the thrust of attendant care services is for physical assistance to help an individual maintain community-based living outside of a nursing home. However, DHS’s proposed rule appears short-sighted in that it fails to recognize the vital importance of community participation as part of community-based living. Such participation is vital to an individual’s health, well-being, and, ultimately, ability to remain out of a nursing home. Moreover, community participation has been recognized as part of the ADA’s integration mandate as encompassed by Olmstead and related court decisions.

Program beneficiaries live precariously, actually counting minutes and hours of care to determine how they will maintain an independent life. The experience of Legal Aid’s clients shows that they judiciously use attendant care for occasional outside-of-the-home trips as befit their circumstances; they do not waste precious time. DHS has offered no evidence that attendant care is being used excessively or wastefully for out-of-home activities. Thus, there is no justification for restricting attendant care to limit these possibilities.

(5) DHS’s proposed rule limits care choices and care hours for individuals who receive care through family members or friends.

(a) Care Choices. Currently, some beneficiaries who receive care from a family member or friend have the caregiver work through an agency. The agency assigns the family member or friend to only the one beneficiary. This arrangement alleviates the administrative burdens described above. However, DHS now proposes to ban a beneficiary’s family members (by blood or marriage) or anyone who resides in the beneficiary’s home from providing care through an agency. A beneficiary who wants that particular caregiver will have to choose self-directed care and the associated administrative burdens. Again, this indicates an agency preference for self-directed care that does not seem appropriate. If nothing else, it infringes on a person’s ability to freely choose the situation right for her.

(b) Care Hours. For many of Legal Aid’s clients, the allotted amount of hours does not cover actual care needs. Where a beneficiary has family available, the family members often make themselves available at all hours of the day in case the beneficiary needs to use the bathroom during the night, starts coughing and needs a sip of water, needs to be turned or moved from their regular position,

needs to have their clothes changed, or needs help with other various tasks that do not follow a set schedule. The Task and Hour Standards does not have a way to capture the time devoted to being available for or actually providing this additional, unpaid care as part of the overall determination of need for care hours.

While ignoring this unpaid care where it could increase a care allocation, DHS will seize on unpaid care to reduce the amount of paidcare authorized. Under the Task and Hour Standards, DHS will reduce the time allotted for attendant care by any time spent on tasks voluntarily performed by other sources. In a similar fashion, DHS will not allow attendant care for any tasks shared by the beneficiary with other adults who live in the home. If the caregiver uses part of the home also used by the beneficiary, time spent cleaning that part will be reduced from the beneficiary's allotment. Both factors seem burdensome to document and administer and run a high risk of reducing beneficiary's hours inappropriately.

More broadly, the twin factors show that DHS's approach is biased towards reduction.

(6) Limited flexibility provided for care determinations overlooks the area of greatest need. After DHS employed the RUGs methodology for years without any flexibility, the limited flexibility introduced by DHS is a welcome change. However, the benefits of such flexibility should not be overstated. In fact, DHS has overlooked the area of greatest need.

There are two main areas where DHS has introduced flexibility. First, as referenced above, if an Individual Service Budget is insufficient to meet an individual's care needs due to "exceptional, unexpected circumstances," a DHS panel can authorize a one-time, one-year increase. DHS states that such "exceptional, unexpected circumstances" may include the death of a spouse or caregiver or discharge from inpatient treatment. Second, if a DHS nurse thinks that the amount of time authorized for particular ADL on the Task and Hour Standards is not enough due to "extenuating circumstances," the nurse can ask a supervisor for permission to adjust it upwards modestly (a few minutes per task). Such upward adjustment must fit within whatever the Individual Service Budget allows.

This flexibility is not sufficient. The one-time exception to the ISB will not address those clients who have an ongoing need for more than \$30,000 in waiver services. Given that this budget level limits individuals who choose agency care to a total of 203 hours per month (47 per week; 6.5 per day), flexibility to exceed the \$30,000 limit is the greatest need to ensure that individuals receive enough care. The fact that an individual has acute care requirements will not meet the limited "exceptional, unexpected circumstances" adjustment, and, even if it did, those acute care requirements would persist beyond the one-year adjustment period.

Furthermore, as noted above, without the algorithms for the Needs Intensity Score on the Task and Hour Standards, it not possible to estimate how the allocations will play out for clients with particular care needs. Reliance on nurse-driven adjustments for a few minutes here or there (if possible within a person's budget level) is no substitute for a system that allocates care appropriate to someone's actual needs.

Conclusion on ARChoices and Independent Choices

Legal Aid's clients need a methodology for care allocation that (1) provides enough care and (2) is understandable. DHS does not have and has not provided algorithms needed to evaluate whether the proposed methodology will actually allocate sufficient care. Analyzed according to the information provided, even the best-case scenario for care hours raises significant concerns that care will be insufficient, especially for individuals who receive their care through an agency. Furthermore, as shown through these comments, the methodology is complex, including multiple steps with numerous variables. Based on DHS's history of due process problems, it is not clear that the agency will be able to adequately explain to beneficiaries how their care was determined such that they will be able to fairly contest the decision. DHS has other options available to it, particularly consideration of higher budget limits. Ensuring that the new methodology provides sufficient care will reduce foreseeable disputes.

Response: Comment considered and accepted in part. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary. Neither eligibility nor hour allocation will be finally and ultimately determined by an algorithm. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules. DHS is also revising the rules to make explicit that attendant care and personal care may be provided to assist a recipient with ADLs or IADLs while at a community event.

Comment:
Proposed Changes to Assisted Living Waiver

In addition to the comments on the proposed rules ARChoices/Independent Choices, Legal Aid offers this brief comment on proposed changes to the Assisted Living Facility waiver. Legal Aid has represented clients trying to qualify for the ALF waiver.

The ALF waiver is an important part of Arkansas's programs to avoid institutionalization. An assisted living facility provides a community-based option for people who can no longer remain at home but for whom a nursing facility would be undesirable. The proposed 22% reduction in rates paid to assisted living facilities for care would seem to threaten the sustainability of such facilities. As it is, some of Legal Aid's clients who qualified for assisted living placement had to wait months for a slot. Anything that delays or reduces availability of assisted living facilities runs counter to the interests of low-income Arkansans searching for alternatives to institutionalization and could implicate the ADA's integration mandate as encompassed by Olmstead and related court decisions.

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

summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Angela Smith

Comment: It has come to my attention that my mother in law, Martha Elam may lose the Home Instead Program benefits, through the AR Choice Case waiver Program. At this point in her life she isn't bed ridden but has an extremely hard time getting around. She has severe congestive heart failure, diabetes, asthma, and stage 3 kidney failure with having one kidney already removed. Plus she has numerous other health problems. With this program it allows her to remain in the comfort of her home without the higher cost of the nursing home. She is unable to do all the cooking and cleaning herself anymore. Having someone come in the care for her basic cooking and cleaning needs really helps the quality of her life. Plus it gives her something to look forward to having someone come in since she can no longer drive and is homebound. Without the use of these services she will become another resident at a nursing home. Thank you for the time and your consideration in this matter.

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

Dru Sorey (2nd Comment)

Comment: Your assessment standards sound impersonal and uncaring. You can't standardize the assessment since every individual's situation is different. These clients are living human beings not a number, micromanaging human beings especially those taking care of our seniors is never good. We're not robots but human beings. DHS staff are not medical doctors, so they are not trained to determine what is medically needed for that patient. If you still think nursing homes and assisted living are cheaper, again I ask, "who is being bought off by these big conglomerates." Your taking the CARE out of health care. The Meals on Wheels people don't have time to check on a person's well being with all the meals they need to deliver daily. There doing good to get them all delivered.

Response: Comment considered. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary.

Danny Bates

Comment: I am the father of a developmentally disabled 39 year old adult. My son is taken care of by family member who teach him life skills and help with his personal care. Ricky does not handle change and would be devastated and embarrassed if another adult he is not use to assisted him with these skill. These task have got to be done by someone, so doesn't it stand to reason he would be better served by family than a stranger. I have dedicated my life ensuring Ricky is given the dignity of proper care by family that cares for him and he trust.

I am asking you to oppose the ruling for no family to be a paid care giver for a person with disabilities. Please respond to this letter so I understand what is taking place in my son's life.

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

JoAnn Jensen

Comment: I do not want a stranger in my home. That would be like going to a nurseing home. I will not do that. Are you trying to punish familys?

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

Sabrina Dickerson

Comment: I am the Aunt and also the caregiver and preform personal care for my nephew Ricky Bates. Ricky is a 39 year old with the mental capacity of a 5 year old. Ricky has always had ether myself or his dad to do his personal care he would not tolerate a stranger or someone else doing these task for him. I do these things for a salary. I love Ricky but I depend on the salary I make with him to keep on working for him. If I were not paid for this I would be working doing these things for someone else while a stranger would be doing them for Ricky. This would disrupted Ricky's life and cause a hardship on him. I ask that you reconsidered this ruling.

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

Vicky Love

Comment: My name is Vicky Love and I work for TLC Homecare. I take care of my mother in law. If this new rule goes into effect my mother in law will not get the help she so badly needs unless we go through a large company that is impersonal and I have heard many very negative things about. She is the type that does not like anyone in her home that she doesn't know. I feel like their are a lot of clients that feel this way. A lot of people are set in their ways. I have gone through all the training, background checks and drug tests just like any other worker that works for an agency. I quit my job of 10 years to take care of her. This rule if passed would take a toll on me financially and her medically unless we are forced to choose to go with a company we know nothing about and a company that has NOTHING for us the way TLC has. I feel like this new rule discriminates against the family for wanting to take care of their loved ones through an agency we trust and an agency that cares for us as people . Please reconsider on this rule and let family take care of their loved ones through a program they choose with the time they leave left on this earth.

Response: Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can

arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

David Hicks

Comment: My name is David Hicks and I am on AR Choice. I used to use Palco but was not happy with the agency, so I switched to TLC and I am very happy with TLC they are very professional and caring. It has been brought to my attention that you no longer want family members to help with my care. I do not agree with this my wife (Janice) and daughter (Jeanie) has been my caregiver for all these years, they give me the best care because they love me. I do not want a stranger coming into my home that I know nothing about. Please reconsider your proposal.

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

Marci Garrett

Comment: I am writing this in regards to the change that is being considered that will no longer allow for me or anyone else to have a family member take care of them through services like TLC. I think this is wrong because some of us have mothers that are doing it. And who else but a mother can do a better job at taking care of their child? I have been in and out of the hospital my whole life having surgeries because I have Spina Bifida and surprisingly I have not been around a whole lot of medical professionals that know very much if anything about my birth defect so I don't trust anyone but my mom to do what I need to be done. I cannot tell you what to do all I can do is ask you to put yourself in my place if it were you that was disabled and you needed someone to take care of you would you want a stranger who knows nothing about you taking care of you or would you want a member of your family doing it? If you ask me the answer is simple someone who has known you your whole life is better qualified than a stranger regardless of whether they work for a hospital or not. Neither me or my mom have ever asked for anyone for help when it comes to me she has been doing it all on her own until the past couple of years when we found out about TLC and it has been a godsend because it allows her to be home with me more. If you chose to no longer allow her to take care of me through TLC then I will essentially be losing my mom because she will have to work an outside job or two full time I know I have asked you to put yourself in my place but here's something even better for you to think about. Would you want someone who your child doesn't know or feel comfortable with taking care of them or would you rather do it and also get the benefit of spending more time with them to me it's a very simple choice what's it to you? And also I do not want to go back to Palco because they were not as available and supportive as TLC when it came to questions we had TLC has been more like a family to us because they are there anytime day or night when we need them. I should not be forced to go back to a company that has people that work for them that find me needing something from them inconvenient which is the experience I had the whole time we were with Palco and with TLC I've never had to ask for anything they have went above and beyond a company and if I was happy with Palco in the first place I would've never switched to TLC that should tell you everything you need to know. And the last time I checked I thought we still had the right to choose who takes care of us?

Response: Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can

arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

Wanda Love

Comment: Hi, my name is Wanda Love. My daughter in law works for TLC Homecare and comes into my home and takes care of me. This agency helped me in so many ways. I knew nothing about the option to stay home and have my family care for me until I met them. I was headed down the road towards nursing home in the near future and this program that TLC showed us has kept me at home. I trust Tabbetha and Billy, the owners of the agency and I know that they have my very best interest at heart. I do not want to go through the Independent Choices program, I want to stay with TLC Home Care and have my daughter in law as my worker. Please I have many health problems and her coming in helps me and also helps keep me out of the hospital. She tells me there is a new rule that might be passed that would stop family from coming in to help take care of their family unless we switch to Independent Choices. I trust Tabbetha and Billy, the owners of the agency and I know that they have my very best interest at heart. I do not want to go through the Independent Choices program, I want to stay with TLC Home Care and have my daughter in law as my worker. I as one do not want someone that I don't know coming into my house and trying to take care of me not do I want some company to be in charge of care that I have not met and trust. I'm a very private person and don't feel comfortable for people I do not know helping me with bathing and personal things. Please let family keep taking care of their loved ones through agencies that they are already comfortable with and developed relationships with. I would very much appreciate it.

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

Janice Hicks

Comment: My husband David Hicks is on AR CHOICE and it has been brought to our attention that you are wanting to change the program and you do not want to let family members help. I think this is a very bad decision because family has the very best interest of caring for their love ones. David has been paralyze for over 20 years and myself and our daughter Jeanie has been his caregivers this whole time. David has been in the hospital a total of 2 times over these years, once for gallbladder surgery and than he got pneumonia from the surgery. I do not want a stranger coming into our home when we are capable of taking care of David. We have found TLC agency they are very professional and caring, if I need anything all I have to do is call and they will answer and help me out. David had is annual check-up and he is in good health considering his condition. David is also in early stage of dementia and I do not want a stranger coming into our home he does not know.

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

Sheila Garrett

Comment: I believe that I should be the primary caregiver of my daughter, Marcia Garrett for multiple reasons. She has been in and out of the hospital most of her life. She has also faced multiple surgeries that required at home care afterwards that has lasted up to weeks. Not only because I am her mother, but also because I have dealt with every kind of surgery and complication with her by myself. This has prepared me for any kind of care she may need now or in the future. The new policy that will be started in January will no longer allow me to care for my child through TLC but will have to switch back to Palco or require a stranger to come into our home. Therefore, my daughter and myself are very uncomfortable with this, she has been discriminated against all her life by people who believe that her disability keeps her from doing everyday things, not only by our society but by our government too. Putting this policy in place will either lead me to be away from my disabled child or lead me to work for a company that I have already worked for that doesn't care about the consumer or the workers. They show up at my house, step out of their car, ask me to sign something and leave! TLC comes in my home, sits down and genuinely cares about my daughter. The nurse from TLC has even helped change my daughter when she had an accident during our meeting, Palco would have never did this. I know her needs and how to take care of my daughter. Being a single parent and supporting three other people is truly hard. This program that is in place now eases the stress of it while being able to care for my family. We are worried about a stranger coming into our home and having to start from scratch. Learning about the medicines she can and can not take, the certain procedures that have to be done when bathing or cleaning her, the way her body has to be proportioned when she sleeps or naps, what she can and can't have food wise and even where on her body has to be checked daily to keep from infections or new sores happening. To reinstate, I believe that this program is a good way to help bring money in while allowing families to get at-home care from someone they can trust, someone they are comfortable with and someone that knows they and their needs. Please abide by your "freedom of choice" and let us stay with the agency that truly cares and let the family continue to work and provide for their families.

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

Mark Meeks

Comment: I am writing regarding the proposed legislation that concerns having family members being a paid caregiver. I am 30+ year quadriplegic and been fortunate to have my mother assist with my daily care for the last 30 years. We have used many alternative care programs and it has never been an issue that she is one of my caregivers. She lives only a few hundred feet from my residence and provided care for me on a routine (daily) basis. She assists with my bowel program which is very sensitive and a personal part of my daily routine care. My mother has been the most reliable and attentive caregiver I could ask for. My family in general, mother, father, brother and wife are available to assist with any of my needs 24/7. Also, I would like to point out that my mother (being my paid and primary caregiver) has gone through the same processes that are required of any other caregiver; training, background checks, drug screens, etc. Caring for me has been her sole income for many years and it would affect her greatly to lose her income for no reason on her part. We have used several programs over the years and TLC Homecare has taken us on, we have had the utmost quality for alternative care. The main purpose of alternative care is to give the patient the right to choose who cares for them. Choosing a caregiver is more than choosing someone who may be "qualified". You are trusting your life with them, opening your home to them; in that sense it is much more secure having a trusted family member provide necessary care. It would be detrimental to my health and well being to trust that someone else provide

the level of care that my mother does. I hope that this issue would be taken more into personal consideration. If you think about yourself being in a situation that you would need personal care, then you too would likely prefer the care of your family member before a stranger. I am fortunate to have my family (especially my mother) available to provide my care, as they are priceless to my life.

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

Jeanine Thacker

Comment: I was recently notified that Medicaid plans to stop allowing family members to care for their relatives under this program. I am writing to you to voice my disapproval on this proposed change. I have been a caregiver for my father for many years, along with my mother. I have passed background checks and have had training other than the basic hands on training. I have through daily interaction with my Dad. I also have my Dad's best interest at heart and want to see him thrive. I am not an outsider coming into a person's home to care for them for a few hours a day, that may or may not have the individuals best interest at heart. I feel like I am being discriminated against simply because I am a family member. There are no better caregivers for an individual than someone that loves them. My Dad recently had his annual check-up and was told that he is in excellent health given his condition, this is directly related to the fact that my Dad is taken care of by us, not stranger coming into my parent's home nor do my parent's want a stranger coming into their home to do what we are capable of doing. If we wanted strangers to take care of my Dad, we would have put Dad in an assisted living facility. There is a reason he is home with people he loves and there is a reason he is thriving despite his condition. Please re-asses this proposal and do not allow this to pass.

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

Dessie Henson

Comment: I Dessie Henson is concerned about that plans about a respices. Im his mother and lv been working with him almost all of his life (and his dad to) Since we brought him in this world and until after his axcident and now a stranger would have to get to know him and lm would get upset cause hes used to us. The stranger would not b a family to him. And the stranger would make him feel uncomfortable, unpleasant. I hope you re-consider yur plans, and think of him and how he feels. (Jim) he likes for us to takes care of him. Sometimes we all go ridding out togeather n his van lm now used to b a respices can l stay one-! TLC is Good! Sgned; Dessie

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

Dessie Henson (Via Telephone)

Comment: “Tabbatha, Im so worried about having to use Palco again. We had so many problems with them and they were rude and it was hard to get anyone on the phone. I hope they don’t take your agency away from us. We trust & love you guys.”

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

Melinda Meredith

Comment: My mother needs the care and I work so many more hours than what I get paid for. It allows me to stay at home and make sure she is cared for. It would be devastating to rip me out of her care. She would not be able to have a total stranger come into her home to take care of her: We want to stay with TLC Home Care.

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

Jimmy Henson

Comment: I jimmy Henson have been a client for over 20 years. My dad has been taking care of me the whole time. I am pleased with the care I receive. My mother does respices for me. They No how to prepare my food they way I like it and how to care for me the way I lie it. As I have heard if it an’t broke don’t fix it. I think that we the client’s should be thought of and given a say in these matters. If it were you or your family member what would you think then. May you be lead by God in your dicsion.

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

Jimmy Henson (Via Telephone)

Comment: “I do not want to go back to Palco, we have been there and we are treated much better through TLC Home Care’s agency.” “Where is my Freedom of Choice?”

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

Cynthia Mitchell

Comment: I Cynthia Mitchell i'm not liking the bill that supposed to be approved against relatives working with loved ones who have health issues and disabilities. I won't want any others taking care of

my family members who are some points begin to take advantage of them especially if they are nonverbal, and incapable of make clear decisions of mind body and soul. You people in higher place have no clue as to what it takes to care them, because you would rather throw them to dogs like trash. I have a 46 year old brother who is down syndrome and has the mind of a small child. My mother is back bone she does everything for him. When he was born they said put him I a facility and forget about him. That didn't happen and I'm grateful to have such a loving caring mother who learned us and him how to communicate with each other. My family means the world to me. I do welfare checks on my brother and my mom who 76 years and strongly content with my brothers well being. I disagree strongly with removing family members as a paid caregiver through an agency of our choice. The other option_ that you give us is a JOKE. Going through Independent Choices, them people are a mess. I'm not comfortable with the thought of having others come into my mother home to take care of my brother. I do welfare checks on her and him all day long. Some caregivers don't take this job seriously as others do. Messing with something that's not broken always turn out to be the damn disaster ever. LEA VE IT BE ITS NOT BROKEN WHY TRY TO FIX IT. I FEEL THAT YOU GUYS WOULD RATHER PUT THE MONEY IN YOUR POCKETS THEN OURS. We have worked with Tabbetha for a very long time. I used to work for Tabbetha when she worked for First Step and so did my mom, taking care of consumers as well, not just family. And we she opened her own agency, we couldn't have been happier because she cares so much about people and their families. I still work for TLC now with other clients besides my brother and so does my mom. Why is that we are certified to work with people we are not related to through TLC but we cant work for people that we are related to? This is DISCRIMINATION at its very best. This can not go through. PS. I also relieve my mother when she need a break for her on personal time free of charge because you guys wont give enough respite hours for my brother TO GET WHAT HE NEEDS.

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

Raymond Henson

Comment: I Raymond Henson am concerned about your plans. I have a Quad son that I have been taking care of for over 20 years. He has been on the program since his accident. To make the changes that you are talking about will affect myself and a lot of other's. My son Jimmy is content with thing's the way they are. He say's if it works don't fix it until it breaks. Taking care of him is the only income have. There's no way that I could find another job and steel help take care of him please concenter how this well affect all party's involed.

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

Raymond Henson (Via Telephone)

Comment: "This consumer come to TLC Home from PALCO and strongly disagrees with having to go back to PALCO to continue being caregivers."

Response: Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many

public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

Debra and Jimmy New

Comment: My name is Debra New. I am an ABA Therapist and a mother of a 20 year old son with autism who requires help with his everyday life skills. This may include bathing and toileting. My son has a desire to be like other young adults his age but needs that help to accomplish these task. My son has a few family members that are also his caregivers and helps him with his personal care. He is comfortable with these family members he has been around them most of his life. He is non-verbal and depends on them to understand his needs. To protect his dignity he would not want a stranger or someone he does not know doing these things for him. Family does this not just for the pay but out of love for him. If family members were not getting a salary for doing these task for him they would be working somewhere else making a salary and a stranger or outsider would be required to do them. This not only would be upsetting for him but it takes some of his dignity away. I want you to vote against changing the family rule please respond to this letter on this issue.

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

Johnnie Pearl Tidwell

Comment: I Johnnie Pearl Tidwell, my son Shawn A Tidwell age 47, Down Syndrome have been approved for 24 hours care and number 357 on waiver list. I have been taking care of him all this time why would I want a stranger coming into my home with no experience to the care of him when there is family that know his do's and don't . Why would you go to this company, get with the time Arkansas is so far behind when it comes to mental or disable clients. You are not better the clients only making things worse. Craig Clouds and Mark White you need to visit other states znd get educated on the mental and disable status when it comes to taking care of them. It don't make sense to change everything every other month. Do you guys have someone with these problems or you just sitting making things hard for people that have this problem with their love one. I don't want different people coming in and out of my home with so much going on in the world today. Would you like for different people in and out of your home if you had a disable person?

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

Qunicy B. Hurst with Superior Senior Care Corporate

Comment: We appreciate the opportunity to provide comments to the recent proposed regulation changes. Our comments are specific to two documents: the ARChoicesManual Update and the Personal Care Manual updates.

We welcome changes that better the system and create a more sustainable future; however, we feel many of the proposed changes would negatively impact the programs and its recipients. Our comments on the proposal are as follows:

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation: 201.105 Provider Assurances 10 -1-16

Agency Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted an ARChoices Waiver Person-Centered Service Plan (PCSP).

SSC Response: The proposed Regulation 212.600 Restrictions on Who May Provide ARChoices, which restricts a certified, qualified, fully-vetted family caregiver or any qualified individual whom lives with the beneficiary, is in direct conflict with the Agency Staffing Provider Assurances.

The proposed Regulation 213 .230 Attendant Care Services Certification Requirements 1 -1 -18, which proposes to add federal background checks to attendant care services providers, whether they have lived outside of AR in the past five consecutive years or not, and currently take 12 weeks and longer to receive, plus Child Maltreatment Central Registry checks, and the Adult and Long-Term Care Facility Resident Maltreatment Central Registry check is in direct conflict with the requirement to maintain adequate staffing levels to ensure timely and consistent delivery of services.

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation: 212.00 Eligibility for the ARChoices Program 10-1-16

Functional assessment results in a score of three or more on Cognitive Performance Scale

SSC Response: Removing the 'functional assessment' requirement will have a broad effect across the state with the growing dementia -related disease processes. This proposed regulation would create an access issue for vulnerable seniors in need of services.

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation : 212.200 Prospective Individual Services Budget

If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. This exceptions process is intended as a safeguard to address exceptional, unexpected circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:

In the professional opinion of the nurse panel, unique circumstances indicate that additional time is reasonably needed by the participant (or the participant's family on his or her behalf) to (1) adjust waiver service use costs to within the applicable Individual Services Budget (ISB) amount, (2) arrange for the start of or increase in non-Medicaid services (such as informal family supports and Medicare-covered services), and/or (3) arrange for placement in an alternative residential or facility-based setting.

SSC Response: We are concerned that the process of having a panel of at least three registered nurses review requests for temporary increases in care will be too slow. A major benefit of having respite, as it is currently structured, is it allows a beneficiary to quickly receive approval for extra help if their primary caregiver is unexpectedly unable to care for the m. When this is the case, time is of the essence to secure additional help. We are concerned that the proposed review process will be inefficient considering the current challenges and slow response times to provider requests

Methodology for Determining Individual Services Budgets:

The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (3) below, is as follows:

For an individual with an assessed ISB Level of Intensive, the Individual Services Budget is \$30,000 annually.

For an individual with an assessed ISB Level of Intermediate, the Individual Services Budget is \$20,000 annually.

For an individual with an assessed ISB Level of Preventative, the Individual Services Budget is \$5,000 annually.

SSC Response: These amounts are substantially lower than current levels, especially given that they are shared between several services. There are also many unanswered questions, such as:

Exactly what services are to be purchased with these budgets?

Who assists in selecting what services to purchase and what qualifications will they have to ensure the most beneficial financial advice is given?

How do the beneficiary and providers know how much budget is used at any given time?

Are providers allowed to work within the set budgets to allow more services to the beneficiary? For example, billing a lower rate per hour so that the budget is depleted slower, thereby allowing the beneficiary to receive more hours of attendant care service. We have read that this will be a practice utilized by Independent Choices to lower caregiver rates and maximize hours for clients.

Why it is necessary to add budgets on top of already established maximum allowable amounts? Under the proposed system, Prior Authorizations ("PA" or "PAs") are unnecessarily costly and duplicative.

Beneficiaries are given a maximum available number of hours each month for attendant care. The authorization comes in the form of a 9503 and the provider is not allowed to bill more than the monthly maximum hours allowed. Implementing the PA system has been overly burdensome with untold costs

to the state both in terms of money and quality of care. The state will be paying even more money to an outside vendor to help manage this unnecessary PA process. Now, OHS is proposing to add another unnecessary layer of costly bureaucracy to the already cumbersome process. This needs to be reexamined. We would suggest that any restrictions that do not serve a purpose and cost the state more money be eliminated.

We would also request that any existing ARChoices beneficiary who scores higher than Tier 3 be grandfathered in to remain on the waiver, if they desire to do so and are able to safely remain at home with waiver assistance and alternative resources.

Document Name: Proposed ARCHOICES2- -18 Provider Manual Update

Proposed Regulation: 212.320 Authorization of The ARChoices Person-Centered Service Plan (PCSP) with Personal Care Services

The following applies to individuals receiving both personal care services and ARChoices services.

The MMDHS RN is responsible for developing an ARChoices PCSP that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DHS RN authorizing the services.

A PCSP developed on or after the effective date of this Provider Manual may not include attendant care services unless the PCSP 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.

SSC Response: There are numerous beneficiaries who currently receive attendant care services, but may not need more than 64 hours a month of personal care. Two years ago, ElderChoices and AAPD services were combined to create ARChoices. The ElderChoices services of Adult Companion and Homemaker were combined into Attendant Care, which is now offered under ARChoices. Many of the tasks included under these services would likely not be defined as personal care. We have always been told that CMS requires the beneficiary to exhaust state-plan services first, but there has always been a great number of beneficiaries who only need a certain amount of personal care (under 64 hours a month), yet still need help with tasks currently included under attendant care. We have clients who either perform their own personal care or receive most of it by an unpaid family member. The family member may provide this service in the evenings when they get off work, for example. The beneficiary may need help during the day with IADLS such as: preparing meals, help with housekeeping, laundry, shopping and errands, etc. We are concerned that if only those beneficiaries who receive the maximum amount of personal care are eligible for attendant care, there may be many who are not able to receive the help with /AOL's that is currently keeping them safe and healthy at home.

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation: 212.600 Restrictions on Who May Provide ARChoices Services 1-1-16

Individuals providing attendant care, environmental accessibility adaptations/ adaptive equipment, prevocational services, or respite care may not:

Reside (permanently, seasonally, or occasionally) in the same premises as the participant;

Have a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or

Be related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

SSC Response: Residence should not affect the ability of the caregiver to receive compensation for professional experienced care.

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation: 212.600 Restrictions on Who May Provide ARChoices Services 1-1-16

Individuals providing attendant care, environmental accessibility adaptations/adaptive equipment, prevocational services, or respite care may not:

Reside (permanently, seasonally, or occasionally) in the same premises as the participant;

Have a business partnership or financial, or fiduciary relationship of any kind with the participant or the participant's legal representative; or

Be related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

SSC Response: Receiving care through an agency and by a family member is the only option for many beneficiaries. These beneficiaries are unwilling or unable to take on the responsibilities of an employer. Their caregivers are not just family members; they are trained and certified PCA's and CNA's. These family members have spent time and money and are now proud that they are qualified to work through an agency. There should be no reason they would be disqualified from working. Right now, there is an extreme shortage of caregivers. They are often the only source of help for their loved one. If family caregivers were prohibited from working on January 1, there would be no one else available to care for their family member unless the beneficiary is willing and capable of being an employer through the Independent Choices program. The beneficiary would potentially be forced to leave their home and enter institutional care. This rule change would also be a mistake from an economic perspective. There will be hundreds, possibly thousands, of caregivers out of work and likely filing for unemployment. Right now, they are paying taxes and contributing to our economic growth. Not to mention the added cost of institutional care and the adverse effect of beneficiaries leaving their homes; property taxes, mortgages or rent, utilities, maintenance, would all go unpaid. One-on-one care for clients in their home is an important benefit to the elderly and medically frail and in turn maintains and grows a strong economy for Arkansas.

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation: 212.300 Person-Centered Service Plan (PCSP) 10-1-16

D. Task and Hour Standards (THS):

Calculation of total hours of attendant care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be

calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of attendant care hours approved for the participant for a month.

SSC Response: We are strongly opposed to this monthly methodology. The monthly max methodology does not allow a caregiver to provide the daily/weekly service on the individualized, person-centered plan. These beneficiaries must have continuity of care each week. Their chronic conditions persist no matter how many days are in the month or how those days in the month fall from month to month.

Beneficiaries must not have visits cut due to the monthly max capping out before their daily/weekly service plans. In conversations we have had with OHS staff, they have agreed that this monthly hour maximum methodology is inefficient and unhelpful.

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation: 213.210 Attendant Care Services 10-1-16

Attendant care services are not available (not covered and not reimbursable) through the ARChoices program when and to the extent any of the following may apply:

When reasonably comparable or substitute services are available to the individual through an Arkansas Medicaid State Plan benefit including without limitation personal care services, home health services, and private duty nursing services;

When attendant care services delivered through a home health agency or private care agency are provided by any person who (i) resides (permanently, seasonally, or occasionally) in the same premises as the participant; (ii) has a business, financial, or fiduciary relationship of any kind with the participant or the participant's guardian or legal representative; or (iii) is related to the participant by blood (i.e., a consanguinity relationship) or by marriage or adoption (i.e., an affinity relationship) to the fourth degree; and/or

SSC Response: We are strongly opposed to the restriction on family member caregivers (those who have obtained the necessary certifications/qualifications) and those who reside in the same premises. See comments to 212.600.

On dates of service when the participant:

Receives personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan for the same tasks;

SSC Response: It is common that a beneficiary would need personal care services on the same day. It is not always known, predictable, or schedulable when someone will need personal care assistance. Many clients are incontinent and may have an accident at any time and some require split-shifts to accommodate routines for morning and evening. There are many different scenarios, but only allowing one episode of a task during a 24-hour period is unreasonable and ill-advised.

Receives Medicare home health aide services, whether through traditional Medicare fee-for-service or a Medicare Advantage plan of any kind for the same tasks;

SSC Response: ARChoices providers would not be aware if either of these services would be an option to the client. We are concerned that providers could face recoupment over elements beyond their control. Once eligibility has been completed and services authorized by OHS, a provider would be under the assumption that the services are in fact authorized. Since Health Homes have not been established through the waiver, ARChoices providers are not in the loop of services that may be provided outside of the waiver plan of care, listing the waiver providers only.

Receives targeted or other supplemental benefits from Medicare Advantage plan of any kind, where such supplemental services are reasonably comparable to or duplicative of attendant care services, personal care services, or self-directed personal assistance;

SSC Response: We would not know if any services were provided by these providers that would be duplicative. This might be possible under Health Homes, but not as of Jan 1, 2019.

Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the DHS RN.

SSC Response: This will affect a great number of beneficiaries and is too restrictive. Many clients receive personal care in the morning before ADS and need the same care in the evening and must be able to use their attendant care services, which should be interchangeable with personal care services.

Receives long-term or short-term facility-based respite care; and/or

SSC Response: Too restrictive. Beneficiaries still may need assistance in their home with AOL's

Receives services from an inpatient hospital...unless approved in writing by a DHS RN as reasonable and necessary given the time of day of the facility admission or discharge, the need for transition assistance, or an inpatient hospital admission incident to an emergency department visit or direct inpatient admission by the attending physician.

SSC Response: We are strongly opposed to this. It should not be left up to an individual RN's discretions. If a client receives attendant care in the hours before an admission to a hospital or emergency room, the services must be billable. If a client needs services upon discharge from a hospital or emergency room, the waiver should not restrict the beneficiary from receiving those services. We serve adults with physical disabilities and frail older Arkansans. The response time from OHS RNs has been poor at best overall, and some do not respond to emails or phone calls at all.

Attendant care services exclude all of the following:

Companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);

SSC Response: We are strongly opposed. For the first time in the history of this program, all forms of companionship and socialization would be eliminated. There are numerous studies on the

importance of socialization for the overall health and well-being of the home care recipient. Many are homebound and this would be their only form of social interaction. The absence of a human element is

not only cruel but has also been shown, through numerous clinical studies to be unhealthy for the homebound beneficiary. See: Social Relationships and Health: A Flashpoint for Health Policy (J Health Soc Behav., 2010 Volume: 51 issue: 1 suppl, page(s): 554-566)

Cleaning of any spaces of a home or place of residence (including without limitation kitchen, bathroom, living room, dining room, family room, and utility or storage rooms, and the floors, furnishings, and appliances therein) shared by the participant with one or more adults who are, together or separately, physically able to perform housekeeping of these areas; and

SSC Response: The aide is expected to assist with toileting, showering, bathing, meal preparation and eating (all of which are activities which can create a considerable mess), but cannot clean up after they do so. The aide's activities may create the need for housekeeping, but the burden will fall on someone else to clean up after the aide. This will lead to unsanitary conditions and turmoil within the client's home. Kitchen food prep areas must be kept clean and sanitary as well as bathtubs/showers and toilets. We would suggest, at a minimum, that housekeeping tasks be allowed when they are required due to personal or attendant care activities.

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation: 213.230 Attendant Care Services Certification Requirements

All owners, principals, employees, and contract staff of an attendant care services provider must have comply with national and state criminal background checks and central registry checks. Criminal background and central registry checks must comply with according to Arkansas State Law Code Annotated §§ 20-33-213 and 20-38-101 et seq. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry

SSC Response: Federal background checks, and more specifically the fingerprinting requirement, is an enormous burden and can take up to 12 weeks to complete. Current regulations require individuals who haven't resided in AR for the past consecutive 5 years to submit to a federal background check. If it is accurate, it should be clarified in the rule that this requirement will not be effective until Arkansas becomes part of the National Instant Criminal Background Check System (NICS).

Further, the requirement that we check three different registries is overly burdensome. Currently, providers must manually pull files and read through each name to ensure that a prospective caregiver is not on the list. No digital search function is available for any of the three separate registries. We would suggest that the new checks are omitted, and current regulations followed until such time that the State has ensured the availability of expedient background checks and an efficient method for providers to run the three required registry checks.

Document Name: Proposed ARCHOICES-2-18 Provider Manual Update

Proposed Regulation: 213.700 Respite Care

Respite Care excludes:

Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship; and

Respite Care services are not covered to provide continuous or substitute care while the primary caregiver(s) is working or attending school.

Reimbursement is not permitted for Respite Care services provided by:

Any person related to the participant by blood (consanguinity relationship) or by marriage or adoption (affinity relationship) to the fourth degree;

A resident of the participant's home or place of residence (whether permanent, seasonal, or occasional);

SSCResponse: First, we strongly oppose the restriction on respite for services when the primary caregiver must work or attend school. These are activities that we should be encouraging for the benefit of the individual and our state's economy. We understand that respite is not meant to be long-term, scheduled care, but why should bettering oneself preclude them from getting care for their loved one? We suggest this regulation be revised back to its current state.

Second, we would like to reiterate our comments regarding non-permitted caregivers and socialization here. These participants do not have interactions like the younger and more mobile population. There are numerous studies that link the absence of these activities to declining health and increased chance of institutionalization. Additionally, we do not agree that family members should be excluded as caregivers.

When a family member is providing care, the new rule creates numerous problems related to the decisions they must make between caring for their loved one and working. Unless the beneficiary who is their family member is willing and able to be an employer (Independent Choices), they cannot provide care for their loved one and receive compensation. If they choose to forego compensation to care for them anyway, under the new rule, respite care is not available when they need to work outside the home.

Document Name: Proposed PERSCARE-1-18 Provider Manual Update

Proposed Regulation: Persona Care Provider's Assessment Proposed Individualized Service Plan

As part of each prior authorization request, each provider shall submit a complete and accurate form designated by OHS. The form must be prepared, certified, and signed by an Arkansas licensed registered nurse.

SSC Response: We must see this form in order to make comments during the comment period. We are unsure as to what is expected to ensure a form is "certified". The RN is signing the form; how will the form be certified other than signature?

The completed form designated by OHS shall include all information required on the form applicable to the individual beneficiary, including:

Beneficiary and provider information;

Detailed information concerning physician-diagnosed physical and Behavioral Health Services conditions, identified physical dependency needs, and mental/cognitive status; and

SSC Response: Will the provider RN be required to talk with the client's doctor or nurse to gain detailed information regarding the physician-diagnosed conditions?

For each physical dependency need identified, written descriptions including:

The provider's assessment of a beneficiary's need for personal care services must include a written description of each physical dependency need. The identification of each physical dependency need must include:

The extent to which the beneficiary can personally perform individual task components of routines and activities of daily living;

SSC Response: Will the provider RN be asking these questions over the telephone?

2. The extent beyond which the beneficiary cannot personally perform individual task components of routines and activities of daily living and

The type and amount of assistance the beneficiary may need with each task thus identified, including the frequency (per day, week, or month, as applicable) of each task with which the beneficiary needs assistance and for which other sources of assistance are not available; and

The extent beyond which the beneficiary cannot personally perform individual task components of routines and activities of daily living;

SSC Response: We cannot make proper comments without the benefit of "the form" that OHS mentions. At this point, providers do not know if the provider RN will be making a home visit for an assessment, interviewing a doctor, or using a questionnaire over the telephone.

Detailed information on all personal assistance available to the beneficiary through other sources, including informal caregivers (e.g., family, friends), community organizations (e.g., Meals on Wheels), Medicare (e.g., Medicare home health aide services), or the beneficiary's Medicare Advantage health plan;

A proposed service plan, with proposed hours/minutes and frequency of needed tasks consistent with the Task and Hour Standards (as described in Section 240.100); and

SSC Response: We are unclear of the process. It seems redundant to require the provider's RN to complete a "designated form" and make it consistent with another form that has already been completed by another RN. What is the purpose of requiring an RN to transpose numbers from one form

to another? Now that times will be associated with specific tasks, wouldn't the provider just need a copy of the Task and Hour results?

Document Name: Proposed PERSCARE-1-18 Provider Manual Update

Regulation: 216.211 Meal Preparation

SSC Response: We have been assured that this section is not present in the proposed rules due to no changes being made to the section. We would like to state our objection to any alteration or removal of this section for the record.

Document Name: Proposed PERSCARE-1-18 Provider Manual Update

Proposed Regulations: 217.000 Benefit Limits

This 64-hour limit on personal care services for beneficiaries aged 21 and older is a firm cap for which there will be no extensions or exceptions. Providers may, request extensions of this benefit for reasons of medical necessity. Submit written requests for benefit extensions to the Division of Medical Services, Utilization Review Section.

SSC Response: There are some people who cannot or will not enroll in ARChoices. There has always been a route for those who need the most extensive help to receive an extension over 64 hours a month.

Since June of this year, personal care extensions have been the saving grace of any new enrollees into ARChoices. When the ARChoices waiver is full, these people will not be able to receive the help they need to remain at home. In the event of litigation or other circumstances that interfere with the availability of waiver services, the non-waiver personal care extension should ALWAYS be an alternative for those qualifying for the services.

We suggest the following exception be inserted: "excepting any circumstance where waiver services are not available to an individual who would otherwise qualify for waiver services but for administrative restriction placed on the waiver by CMS or the federal or state judiciary. "

We understand the importance and necessity of making cost-saving measures to protect the sustainability of these critical programs. It is concerning to us that no providers of the services affected from the above were consulted or even made aware of these proposed changes. We are not only stakeholders in this industry, but we are experts in the delivery and management of these services. It is disheartening, to say the least, that our opinions and insight were not considered in the creation of such a large plan. Moving forward, we would appreciate the opportunity to discuss what we believe would be real cost-saving changes that would help the state, without hurting its most vulnerable.

Thank you again for your time in reviewing our comments. As a statewide Arkansas Medicaid provider for over 25 years, we understand the importance of these programs and the impact they can have on the participant's lives. We appreciate the opportunity to work with you to better serve our citizens and communities.

Response: Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this

rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

W. Josh Green with Healthmark Service Inc.

Comment: Before I address my concerns and criticisms of the amendment request, I would like to acknowledge my respect and admiration for the people working within the Department of Human Services (DHS). They have been tasked with the challenging and ostensibly, distressing directive of identifying and eliminating the waste, fraud and abuse plaguing the state's Medicaid program. Given the scope and reach of the department's mission, the number of Medicaid recipients and the circumstances surrounding their participation; understanding that there will be overlooked opportunities and unintended consequences is reason enough to reconsider potentially flawed amendment requests and proposed changes as counterproductive to the program's intended purpose. When credible arguments and evidence are presented alleging the fecklessness of a proposal or request, it is incumbent upon elected officials and department executives to review and potentially revise. I contend that the changes proposed to the Living Choices waiver and other long-term supports and services (LTSS) reforms, are shortsighted and risk jeopardizing the elder and disabled access to more conducive, value-based alternatives.

As part of Governor Asa Hutchison's goal to slow Medicaid growth by reducing expenditure increases by \$835 million from FY '17 to FY '21, DHS, in unprecedented fashion, implemented work requirements for certain Medicaid recipients. Only time will tell what complications and/or solutions this policy will produce. Continued efforts in pursuit of these reduction goals involves substantive changes to the ARChoices, Living Choices and Independent Choices waiver programs as well as the Program of All-Inclusive Care for the Elderly (PACE). These proposed changes include administrative restructuring and regulatory modifications, changes in eligibility requirements and limitations, the diversion of assessment responsibilities to an independent contractor and revised restrictions and requirements of service. My current position in Healthmark Services allows me to speak confidently about the implications these changes will have on assisted living providers and only peripherally about home health & personal care providers. Given my limited knowledge of the latter, I will focus on the former. It should be noted, aside from the Living Choices waiver, there are perceived negative implications regarding the changes to the other aforementioned programs as well.

Given the compressed timeframe under which I researched and wrote this response, I will acknowledge that some ascertains made wherein may contain some inaccuracy. I attempted, to the best of my knowledge and ability, to present facts and remain objective despite being aware of the inexplicable political motivations surrounding these reforms.

Section 1: Proposed reimbursement rate reduction impact and savings.

1.1: The information gleaned from an actuarial study conducted by Milliman Inc. is reasonably accurate, but not without its flaws. It has formed the basis for the proposed reimbursement rate reductions. The number of level II assisted living facilities (ALF) surveyed to generate the practitioner mix assumptions, overhead load estimates and annual units of services was only representative of 4.5% of assisted living providers in Arkansas. 5 of 64 facilities were surveyed and only 3 of those 5 surveys were used in the estimates. This fact is not mentioned in the letter outlining the findings of the study.

1.2: The practitioner mix assumptions or number of nursing and administrative staff is relatively low. Providers may find these figures unreasonably low depending on their care and service standards and desired staff/resident ratios. The staffing assumptions approach the practical limits of what would be minimally necessary.

1.3: The study acknowledges the removal of the 4-tier level of care criteria and the installation of a single tier system. A reduction in reimbursement rates of 21.7%¹ was calculated based on the three previously mentioned assumptions/estimates. Based on my own estimates, the assumptions/estimates are fair in relation to the direct costs of service. The current tier rates are as follows: tier 1 = \$70.89, tier 2 = \$75.48, tier 3 = \$81.89, tier 4 = \$85.35.

1.4: The average expense (including capital costs) to maintain and provide assisted living level II care services for one-bedroom apartment at a Healthmark Services managed ALF is \$2804.02 per month. If you assume a full month of care (e.g. 30 days, with zero exclusionary days) the revised rate of \$62.89¹ will reimburse ALF \$1,886,70. Including the SSI benefit of \$750.00, minus the personal needs allowance, ALF will only recoup \$2567.70 or 92% of the associated costs.

1.5: Based on the cost neutrality demonstration the proposed rate changes will result in a net decrease in aggregate Medicaid expenditures by approximately \$10.6 million over two years.² This raises the question of whether these paltry savings will be worth the potentially subversive consequences. Considering DHS received almost \$10 billion in appropriations for FY '19,³ forgoing the 0.1% savings in favor of a more amenable proposal hardly seems like a major concession.

Section 2: The market value of assisted living services.

2.1: Arkansas is currently the second most affordable assisted living provider in the nation with a median monthly cost of \$3037.00 for a one-bedroom apartment.⁴ This number alone indicates that assisted living providers in Arkansas have gone to great lengths to keep cost down for its residents. Healthmark Services has raised its room rates for the first time in four years, partly in response to the proposed changes. The negative operating margin associated with servicing Medicaid beneficiaries will force providers to implement stringent cost reduction strategies and explore new opportunities for revenue generation. Developing new revenue sources for an existing business involves research and substantial time and financial investments. Cost reduction plans can be implemented quickly and at virtually no cost, for this reason the short-term response by ALF, while necessary, will likely be to the detriment of the staff and residents. Such cuts will include: Staff reductions, sourcing goods and supplies primarily on price, limiting resident social outings and personal development programs, eliminating employee recognition and appreciation programs, reducing employee benefits, forestalling plant renovation and updates, etc. All these cuts and cutbacks will be necessary for any ALF with high a ratio of Medicaid beneficiary occupancy.

2.2: The median daily cost for assisted living in Arkansas is \$100.00.⁴ The proposed daily reimbursement rate plus the SSI benefit equals a daily reimbursement rate of \$86.56. This will result in a negative 9% operating margin on all Medicaid residents served by Healthmark Services. That margin is derived from Healthmark Services' \$93.65 per patient per day (PPD) expense. To mitigate the shortfall, some ALF will be forced to strictly limit the number of Medicaid beneficiaries they accept or refuse them altogether. Living Choice waiver beneficiaries living in rural areas, and the ALF operating in those areas, will be particularly vulnerable to significant financial pressure, including bankruptcy. Rural market ALF tend to have higher numbers of Medicaid residents.

2.3: When considering a value-based approach to health care services, as is encourage by the Centers for Medicare & Medicaid Services through its Accountable Care Organizations model; assisted living is considered, with little debate, the most cost-effective long-term care option in Arkansas.

Comparatively, a home health aide has a median daily cost of \$119.00, and skilled nursing facilities \$176.00.⁴ Granted, individual circumstances greatly impact choice and need, but as ALF move away from servicing Medicaid beneficiaries their alternatives will prove to be either, costlier to government and/or worse for the individual and their responsible party. In all sincerity, one does not have to stretch their imagination to consider that some may find themselves in dire circumstances.

2.4: Considering the above sections, I can only conclude that there is either a willful ignorance of or an unabashed apathy towards the market value of assisted living services amongst the formulators and proponents of this request as it is currently written. To make matters worse, as ALF react in the various ways mentioned above, the risk of falling out of compliance with the Settings Rule outlined in 42 CFR 441.301(c) (4)-(5).

*Source 4 cites the same survey that was originally used in the HCBS Waiver application to help determine reimbursement rates as negotiated between ALF and DHS.

Section 3: Apparent contradictions between existing and new policy initiatives

3.1: As the Social Security Act §1915 (c) (1) dictates, HCBS waivers will cover “part or all of the cost home or community-based services (other than room and board).” While federal law and the Arkansas Level II Assisted Living Facilities Rules and Regulations make this separation clear, the manual defines assisted living as “Housing, meals, laundry, social activities, transportation (assistance with and arranging for transportation), one or more personal services, direct care services, health care services, 24-hour supervision and care, and limited nursing services.” The intent of the HCBS waiver is to allow the states flexibility in developing innovative, cost effective approaches for target groups. These new approaches, focused on maintaining independence and connection with the community, serve as long term care alternatives to hospitals, nursing homes and intermediate care facilities. When the Living Choices waiver was designed, both providers and regulators recognized that room and board is the central feature in assisted living services. The costs associated with the construction, renovation and maintenance of the facilities to meet IBC Group I-2 and NFPA 101 Health Care building codes must be absorbed by reimbursement rates to make providing services to Medicaid beneficiaries economically feasible. The unavoidable truth is that room and board can not be excluded from the Living Choices waiver given its intrinsic nature to in assisted living, that is why flexibility in developing HCBS waivers is granted to the states.

3.2: As previously mentioned, current regulations use a 4-tier system to identify the varying care needs of the individual beneficiaries. The new system will also consist of 4-tiers, but under a different format: tier 0 (zero) and tier 1 will indicate that the individual’s assessed needs do not support the need for Living Choices, tier 2 indicates that the individual’s assessed needs are consistent with services available through either the Living Choices waiver program or a licensed nursing facility, tier 3 indicates that the individual needs skilled care and is not eligible for the Living Choices waiver program.⁵ Only those assessed with tier 2 needs will have assisted living services available to them and it will likely be decided that some tier 2 needs will be better served at nursing facilities. Depending on how well the new assessment instrument works, this new tier structure may restrict eligibility for assisted living.

3.3: Tiers will be assigned to beneficiaries through assessments that will be conducted by a “DHS Independent Assessment Contractor” using a new independent assessment instrument (ARIA) will replace the current ArPath assessment instrument and remove the administering responsibility of DHS registered nurses.⁶ From January ’18 to August ’18 Medicaid enrollment in Arkansas has dropped 3% or

by approximately 24,100 people.⁷ As of October 8, 2018 another 8,642 Medicaid enrollees have lost coverage as a result of the work requirement and another 12,600 are currently non-compliant.⁸ Medicaid enrollment has been gradually declining since July of '17 and that trend will likely continue. Seemingly contradictorily, DHS has added 68 new positions within the department, created a new division and outsourced in-house responsibilities to independent contractors. In fairness, two existing divisions were combined to make room for the new one. To complicate matters further the new assessment instrument has proven to be problematic in implementation and application. Brant Fries, President of InterRAI, the nonprofit coalition of health researchers that developed the assessment instrument had this to say:

“Moving rapidly from an irrational to a rational system, without properly explaining why, is painful. Arkansas officials didn’t listen to my advice. What they did was, in my mind, really stupid. People who were used to a certain level of care were thrust into a new system, and they screamed.”⁹

Despite an injunction and an apparent attempt to circumvent that injunction, DHS appears to be moving forward with the use of this controversial instrument.

Section 4: Counterintuitive and counterproductive political & bureaucratic maneuvering

4.1: While it has proven difficult to find reliable figures on state spending on prescription drugs. Arkansas DHS requested \$529.4 million in FY '19 appropriations for prescription drugs.³ Based on request going back 6 years the most recent request represents 33.5%. In November of '16 Arkansas voters approved the legalization of cannabis for medicinal use. The Arkansas Department of Health has identified the following conditions and/or associated chronic symptoms that cannabis could potentially treat: cancer, PTSD, arthritis, Alzheimer’s, intractable pain, severe muscle spasms, seizures plus 8 other conditions and/or chronic symptoms. The top 3 selling drug types in Arkansas in '17 were opioids, benzodiazepines and stimulants.¹⁰ Opioids are typically prescribed to treat pain and benzodiazepines are prescribed as a sedative or anticonvulsant. It is well researched and documented science that cannabis is effective in treating epilepsy and other conditions that produce seizures. In a recent study conducted in Israel, the country responsible for preeminent cannabis research concluded:

“Our study finds that the therapeutic use of cannabis is safe and efficacious in the elderly population. Cannabis use may decrease the use of other prescription medicines, including opioids. Gathering more evidence-based data, including data from double-blind randomized-controlled trials, in this special population is imperative.”¹¹

I chose not to omit the last sentence because it indicates unique opportunities for research advancement. The medicinal use of cannabis in Arkansas is a reality, we should seek to produce the best possible outcomes for all Arkansans who might find it beneficial. Assisted living facilities may provide a uniquely appropriate environment to conduct this type of research. If regulated wisely, medical cannabis will help to serve the state’s financial interest by potentially reducing prescription drugs use and generating new revenues through associated fees and taxes.

4.2: According to its own mission statement the Arkansas Health Care Association (AHCA) was established to, “educate, inform and represent members and member facilities before government agencies, other trade associations and related industries.” The Arkansas Assisted Living Association (AALA) is a subordinate group within the association focused on issues concerning assisted living. The amendment request appears to put the interest of these two groups at odds with one another. While the AHCA is beholden to all its members, including AALA and its members, it represents 185 of the 230

skilled nursing facilities in Arkansas. For reasons I will mention later, there is a conflict of interests between the nursing facility representation in the AHCA and their willingness to address the concerns of the AALA and advocate on its behalf. This divide is quite pronounced and is becoming acrimonious.

4.3: In September of '15 Dennis G. Smith became a senior advisor to Cindy Gillespie, Director of DHS. Amy Webb, Chief Communications Officer at DHS commented, "His role will be to guide, advise and assist us as we negotiate waivers with CMS and help us design health care reforms." 12 There were attempts made to discuss these proposals with directors and elected officials while they were still being formulated. Some of those attempts were met with the response that a 'consultation with Dennis Smith' would be more productive. Mr. Smith is certainly qualified to serve his role as advisor given his 7-year stint as the CMS' Director of the Center for Medicaid and State Operations during the Bush Administration. He has a continued professional relationship with Seema Verma, Administrator for CMS, and he testified before the Senate Finance Committee on September 25, 2017. I think it is safe to say that he still garners a degree influence at the federal level. These facts raise 3 questions: Why was such a prominent figure in Medicaid administration and policy reform not offered an executive position with DHS? Why are concerned providers directed to speak with an advisor whose responsibilities do not include addressing to public inquiry? And, to what degree does Mr. Smith influence health care reform in Arkansas? When considering the Living Choices amendment request, it is important to note where Mr. Smith's thought on the flexibility states have when crafting HCBS waivers:

States are billing Medicaid for rehabilitation services that are "intrinsic elements of non-Medicaid programs" and he (Dennis Smith) asserted that "the definition of rehabilitation services is so broad that there is a risk for federal dollars to be inappropriately claimed." 13

Some states have made legal arguments that under certain condition room and board are elements of the rehabilitation service. This quote mirrors exactly how DHS now views the HCBS waivers and the associated reimbursement rates. Reimbursement is for services only; room and board are strictly excluded even though some services have an intrinsic element that include room and board.

Section 5: Influencing reform or altering business models

5.1: Arkansas has made major strides in balancing the LTSS system over the last 10 to 15 years. This has been the result of both federal and state policy, that was presumably created to respond to market forces. The expansion of HCBS programs has played a major role in the number of Medicaid recipients in nursing facilities decreasing by 12.23% from FY '13 to FY '17.14 This tells us that when given the option, people are choosing assisted living and home care over nursing facilities for their long-term care needs. Conversely, over that same period private nursing facility expenditures have increased by 3.36%.14 PPD figures for each of those five years indicates an average annual increase of 4% and an overall increase of 16.7%. There was also a 6.8% increase in the number of available nursing facility beds from 24,570 in FY '13 to 26,247 in FY '17, with 1,617 beds added between '16 and '17 alone.14 This is pointed out to build on the fair assumption that nursing facility bed supply is outpacing demand. The direct correlation between supply and price could indicate that nursing home providers are positioning themselves for an anticipated increase in demand. As previously mentioned, when assisted living and home health providers are gradually forced to reduce the number of Medicaid recipients they serve, those recipients will be limited to nursing homes as their long-term care option. One can not help but question the coincidental nature of this fact. One explanation for increased supply could be in anticipation of the 'silver tsunami,' or perhaps donations from specific nursing home stakeholders with well-established reputations for making contributions to gain political access have had an influence on policy reform.

5.2: As of 2016, HCBS waivers consumed 57% of total Medicaid LTSS expenditures.15 To put that into perspective, adjusted for inflation, that represents 3170% increase since 1985. According to

seemingly endless number of sources, the LTSS industry will be among the fastest growing industries in the world in the coming decades. Arkansas has mirrored these trends, but it remains to be seen how well positioned the state will be to meet the changing consumer preference. The recently proposed LTSS reforms seem to be ignoring the obvious evidence that community-based services have a major role to play in meeting the rapidly changing expectations and needs of the aging boomer generations. As has already been clearly stated, HCBS waiver participation is expanding quite rapidly and consequently institutional long-term care is in decline. This trend is expected to continue so long as regulatory road blocks, such as participation caps, are not regularly revised. One must assume that HCBS providers represent stiff competition for nursing facilities and their response to the rapid market shift has been ineffectual.

5.3: Nursing Facilities have been slow to adapt to the onslaught of increased regulation, changing market dynamics and increased competition. Some have been able to sustain lower occupancy rates by adjusting care models, adding new services and tweaking operation practices. Attracting more patients for short-term care, opening pharmacies and home care agencies, accepting higher need patients, experimenting with staffing schedules and converting shared rooms to private ones.¹⁶ These tactics have had modest success and do not appear to be a viable long-term strategy. Using political influence to affect policy and mitigate the losses of the shifting long-term care landscape only present a short-term solution as well. Shifting the cost burden to competitors through reform will only stave off the market demand for HCBS temporarily. Perhaps, it would do so long enough to adjust the traditional nursing facility business model, but it will not prevent the inevitability of having to make that adjustment. I personally view this as another opportunity for this industry to move forward and start offering the settings and services people prefer. Assisted Living and Nursing facilities share many of the same problems and I think each has plenty to learn from the other. This moment presents an opportunity rich with the potential to benefit both.

Conclusion:

The growth of assisted living and other HCBS providers is obviously the result of consumer preference. If it were purely policy driven the market would not have responded as positively as it has. The need for the unique set of services nursing facilities provide is undeniable, post-acute care and rehabilitation services in particular. When considering fiscal responsibility, some of the information found in this response is meant to imply that the purview of DHS is replete with savings opportunities that do not sacrifice the quality of and access to services. Imagine a circumstance where we can set our egos and personal aspirations aside and start working together to create an improved model for long-term care delivery. I may be idealistic, but I truly believe we can develop a more well-rounded and responsive system if we can cooperate by fostering a shared sense of responsibility, innovate with focus on results and accept that our individual realities conflict with our collective reality and ignoring the latter in favor of the former will only serve us in the short-term. The current path we tread is likely to produce a system that will be a disservice to the patients, residents and staff. If we truly hold the interests of those people at heart, we will seek to combine our efforts and produce an outcome that surpasses expectations and sets a higher standard.

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

developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Jennifer Hallum, Area Agency on Aging of Western Arkansas

Comment: Request for Amendment to a 1915 (c) HCBS Waiver-Section 2. Brief Waiver Description

A large proportion of waiver participants are also Medicare enrollees. Whenever possible, dual eligible beneficiaries should access and receive Medicare-covered, medically necessary services and supports rather than relying upon substitute or alternative Medicaid State Plan or waiver-based services.

AAAWA response:

Information is vague. We ask that criteria for beneficiary having access to Medicare Advantage personal care services be explained more in detail, such as if Medicaid state programs homemaker and respite services will be available to beneficiary if utilizing MA personal care program.

AAAWA response:

Please provide clarification on how much time will a beneficiary have to enroll in a MA to start services before state program is discharged.

AAAWA response:

We have concern that a beneficiary will have to utilize the Medicare Advantage personal care service if there is a copay or deductible required.

Includes the timetable for transitioning individuals to the new waiver (i.e., will participants in the existing waiver transition to the new waiver all at the same time or will the transition be phased in?).

As described above, existing participants will be transitioned to the amended waiver on revolving basis according to the expiration date of their current person-centered service plan and timing of their next re-assessment. Existing participants requiring earlier-than-planned re-assessments because of care transitions or other life changes will be phased into the amended waiver during that re-assessment and new service plan.

AAAWA response:

We would like to see more communication between DHS and providers on existing waiver re-assessments to avoid lapses in client care.

Appendix B: Participant Access and Eligibility 8-6. Evaluation/Reevaluation of Level of Care

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (specify):

DAABHS has established and maintains procedures for tracking review dates and initiating timely re-evaluations prior to each participant's respective level of care review date and prior to the expiration of the participant's current person-centered service plan (Arkansas' term for a person-centered care plan). This process ensures timely reevaluations prior to the level of care review date and the expiration of the person-centered service plan so that no lapse in service occurs.

Specifically, DAABHS registered nurses (RNs) and RN supervisors use a "tickler" file system approach to monitor upcoming review data and service plan expirations. The process of reassessment begins two months prior to the expiration date of the current person-centered service plan or two months prior to the annual anniversary date of the last independent assessment, whichever is earlier . The case is added to the assessment schedule. Once the re-assessment is completed and the level of care revised as appropriate, the DHS RN begins development of the new person-centered service plan.

AAAWA Response :

Will the service plan's start date be the same day as the assessment or the date that the DHS RN completes the new person-centered service plan? There has been conflicting information on this date, clarification would be appreciated .

The DHS RN supervisory staff, through the record review process and through routine monitoring and auditing procedures, notifies the appropriate OHS RN, RN supervisor and the Independent Assessment Contractor if a re -assessment has not been completed within the specified DAABHS policy timeframes.

The ACES report produced by the Division of County Operations is used as a tool bythe DHS RN and RN supervisor to determine if the assessment is current or has expired. Patterns of noncompliance are documented and disciplinary action is taken if necessary.

AAAWA Response:

Is the ACES report an addition to this amendment? This report would have been an excellent tool this past year. The statement above on the patterns of noncompliance, is that about Providers or the DHS offices?

AAAWA Response:

AAAWA supports the procedures detailed above. We would also appreciate a list of names and numbers to contact, or a resolution process in the event we are unable to resolve questions on a local office level.

AAAWA Response:

Since the changes effected on January 1, 2018, there has been so much confusion. We would like to see more training available not only for providers but for DHS staff as well.

C-1/C-3: Service Specification Service Type: Other Service Service Title : Respite
HCBS Taxonomy: (no change)

Service Definition (Scope):

Specifically, Respite Care consists of temporary care provided for short term relief for the primary caregiver, subject to the following :

1. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b)supervision necessary to maintain the health and safety of the participant, as supported by the independent assessment and determined medically necessary by the DAABHS registered nurse; and

AAAWA Response :

We propose clarification on Respite services. Respite is no longer to be used for Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship;

AAAWA Response:

Please provide clarification on if Respite care services replace Personal Care due to Respite being AOL and IADL services now, if both programs are required the same date of service.

212.200 (Section II -19)

A. Individual Services Budget

3. Each participants Individual Services Budget shall be explained when the DHS RN consults with the individual on the person-centered service plan. This may be done through written information.

AAAWA response:

We prefer this be done in person. If this is not realistic, we ask that it be communicated in person whether they will be receiving the explanation in person or in a written explanation. The word "may" is too vague.

4. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.

AAAWA response :

We ask that this notification be done in conjunction with a phone call. There are issues at times with the mail service being timely, addresses be incorrect.

B. Adjustments, considerations, and Safeguards Regarding Individual Service Budgets

2. Should the DHS RN determine that the ARChoices waiver services authorized for the participant within the limit of the applicable Individual Services Budget, other Medicaid or Medicare covered services, and other available family and community supports, when taken together, are insufficient to meet the participant ' s needs, the DHS RN shall counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The DHS RN may also order a re- assessment of the participant.

AAAWA response:

The concern we have is with the reduction in payment to Assisted Living. We are hearing that there will be Assisted livings that will stop taking Medicaid or shut their doors. So, if this does occur it leaves clients with a no care option or nursing home placement which is more expensive. Client choice should be regarded as the top priority.

3. In the event that a participant's ISB requires changes or limitations to AR Choices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type, or amount of AR Choices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.)

AAAWA Response:

Can the different mix, type or amount of AR Choices covered services change from week to week or month-to-month? How often would they need to revise the plan?

4. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person ' s ISB amount applicable to a period not to exceed one year.

AAAWA Response:

Please detail further how the beneficiary will be notified that they have been qualified and can receive a temporary increase in care needs. What is the turn-around time since there is the requirement of a panel reviewing this form the moment these needs are communicated to the DHS RN?

212.600 Restrictions on Who May Provide AR Choices Services

- A. Individuals providing attendant care, environmental accessibility adaptative equipment, provocation services, or respite care may not :

- 3) Be related to the participant by blood (consanguinity relationship or by marriage or adoption (affinity relationship) to the fourth degree.

AAAWA Response:

AAAWA understands that 4th degree to be 1st cousin, niece nephew, grandchild, sibling, or child. We believe this to be too constricting. As I stated with the governor, I see no evidence there is an issue of quality of care by any employee based on solely on the genealogy of the beneficiary. It is odd that this requirement is not required on any other stakeholder. With the knowledge that there is a shortage of health care workers, it seems to hinder providers to deny someone the ability to work in rural areas of Arkansas where the whole town is practically related. We think this is unrealistic and unnecessary.

213.210 Attendant Care Services Section II -36-37 Instrumental activities of daily living include:

- A. Meal planning and preparation of meals consumed only by the participant .

AAAAWA Response:

Not sure how this will be monitored. Obviously, our Aide is not going to cook for a house full of people. However, there could be instances where the spouse is not a cook and what is one meal if he shares it with the beneficiary . Just seems a bit unreasonable that the aide will monitor who eats what

- B. Laundry for the participant or incidental to the participants care

AAAAWA Response:

Obviously , if the aide is doing tons of laundry something should be addressed . Again, making this a matter of policy is a little unreasonable.
Communication (this has been removed)

AAAWA Response:

We think again this should not be the only thing we are providing in the home. However, knowing that senior isolation is detrimental to a senior's health. The care we provide should be and will continue to be heart felt. Part of that is communication as this might be the only conversation a senior receives during the day.

C. Housekeeping (cleaning of furniture, floors, and areas directly used by the participant).

AAAWA Response:

We would ask that this be reviewed under the view of is this realistic and how much of this is really an issue that it should warrant a policy .

D. Assistance with medications (to the extent permitted by nursing scope of practice laws)

AAAWA Response :

We agree 100%. However, those who wrote these proposed revisions did not understand that med set up would be a skilled service under Medicare. This would be handled by the RN
Section II - 38

Participants may choose to receive authorized attendant care services through any of the following:

E. Consumer-directed attendant care through Independent Choices, the Arkansas self-directed personal assistance benefit under section 1915 (j) of the Social Security Act, provided the individual can self- direct the assistance and subject to the requirements of the Independent Choices provider manual and applicable provider qualifications and certification.

AAAWA Response:

AAAWA supports the Independent Choices option. However, we think there should be more oversight to this program than what has been outlined.

213.230 Section II -40

Attendant Care Services Certification Requirements

The following requirements must be met prior to certification by the Division of Provider Services and Quality Assurance (DPSQA) by providers of attendant care services. The provider must:

B. All owners, principals, employees, and contract staff of a home-delivered meal services provider must comply with national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with according to Arkansas State La111 at Code Annotated §§ 20-33-213 and 20-38-101 et seq. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility

Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

AAAWA Response:

AAAWA agrees with the proposed requirement of the Maltreatment Central Registry check . However, I would ask that resources be allocated to this department to ensure that the check specifically on Maltreatments are processed timely. We ask that the turnaround be 2 days not 2 weeks as is customary currently. This deters the timely and efficient hiring of new staff and hinders the viability of an organization. With this added amount of work to be added to this department, it would certainly increase the wait time of these returned if adequate staffing was not evaluated.

213.311 Hot Home-Delivered Meal Provider Certification Requirements

F. All owners, principals, employees, and contract staff of a hot, home- delivered meal services provider must comply have comply 1.vit h national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with according to Arkansas State Law at Code Annotated §§ 20-33-213 and 20-38-101 et seq. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long- Term Care Facility Resident Maltreatment Central Registry ; and the Certified Nursing Assistant/Employment Clearance Registry.

AAAWA Response:

AAAWA agrees with the proposed requirement of the Maltreatment Central Registry check. However, I would ask that resources be allocated to this department to ensure that the check specifically on Maltreatments are processed timely. We ask that the turnaround be 2 days not 2 weeks as is customary currently. This deters the timely and efficient hiring of new staff and hinders the viability of an organization . With this added amount of work to be added to this department, it would certainly increase the wait time of these returned if adequate staffing was not evaluated.

213.700 Respite Care 11-56

10. Reimbursement is not permitted for Respite Care services provided by:

A. Any person related to the participant by blood (consanguinity) relationship) or by marriage or adoption (affinity relationship) to the fourth degree.

AAAWA Response:

B. AAWA understands that 4th degree to be ist cousin, niece nephew, grandchild, sibling, or child. We believe this to be too constricting. As I stated with the governor, I see no evidence there is an issue of quality of care by any employee based on solely on the genealogy of the benefi ciary. It is odd that this requirement is not required on any other stakeholder. With the knowledge that there is a shortage of health care workers, it seems to hinder providers to deny someone the ability to provide respite care in rural areas of Arkansas where the whole town is practically related. We think this is unrealistic and unnecessary. We ask a less restrictive requirement.

E. Any provider organization that employs or contracts with any above individual-

AAAAWA Response:

AAAAWA does not understand this statement. Is it referring to (A-D). I would ask this be struck out as being too vague of a statement in which to comply.

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

Herb Sanderson (2nd Comment)

Comment: AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, is a nonpartisan, nonprofit, nationwide organization that helps empower people to choose how they live as they age, strengthens communities, and fights for the issues that matter most to families, such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. AARP Arkansas, representing over 300,000, is Arkansas's largest organization representing the needs, views, desires, and hopes of Arkansas's 50+ population. AARP appreciates this opportunity to provide feedback on the Arkansas Long-Term Services and Supports (LTSS) reforms that would significantly change Arkansas's delivery of LTSS services. While we recommend the Arkansas Department of Human Services (DHS) proceed with the new assessment process, we strongly urge the delay of the other proposed changes. We believe that these policies, taken together, will reduce access to community-based services and move the state backwards in time, against the tide of states across the nation that are moving away from reliance on institutions and instead supporting self-determination, choice, and community inclusion. Our comments on specific aspects of the proposed LTSS reforms follow.

Assisted Living Rates

The state is proposing to replace its current four-tier Assisted Living (AL) reimbursement methodology (with rates ranging from \$70.89 to \$85.35 per day) with a single statewide per diem rate of \$62.89. According to the letter from the state's rate-setting contractor, the new composite AL rate reflects a 21.7% rate cut.

Creating a single statewide rate may place residents with higher needs at greater risk of inadequate service levels or denial of access to AL services. In moving from the current four-tier approach to a single statewide rate, the state is actually moving away from an AL reimbursement best practice. A recent (July 2018) report from the Millbank Memorial Fund, Center for Evidence-Based Policy,¹ profiled the Arkansas AL Waiver, noting that each of the four need-based tiers reflects a bundle of services and that a beneficiary's plan of care must align with the tier to which he or she is assigned.

The report further notes:

"This program offers lessons for the application of bundled payments for HCBS. The four-tiered system may be a model for incorporating a beneficiary's level of need into HCBS bundles. The daily rate is a method of paying providers for the bundle of services that a beneficiary relies on each day for a prolonged period." (Source: Millbank Memorial Fund, 2018)

Providers may be incentivized by this new single rate to “cherry-pick” residents who can be served safely at a lower cost. Moreover, the single payment rate is also based upon the 2017 distribution of need and risk among the members, and not all providers will face the same distribution of risk.

We are concerned that the data and assumptions used to calculate the new AL rate may not adequately reflect actual provider costs. According to the rate-setting letter, provider survey data from only three AL providers was used to assess overtime costs, practitioner mix within a facility, and wage rates and benefit levels. We believe a larger provider survey sample size is warranted, given the significance of the rate cut proposed. We also urge the state to make the provider survey data collected public to increase transparency in the rate-setting process.

We also note that the proposed rate assumes no practitioner overtime costs and that LPN wages were assumed to be at the 25th percentile of the Bureau of Labor Statistics (BLS) salary data (\$34,860 after inflating to 2019), lower than the assumption used to calculate the proposed facility-based Adult Day and Adult Day Health rates (where the 50th percentile of the BLS salary data was used for practitioner wages) and for in-home personal care staff (where 75th percentile of the BLS salary data was used). Taken together, these assumptions suggest that AL providers will find it very challenging to compete for staff, especially in the current tight labor market.

Also, as the rate-setting letter notes, the assumptions used are highly sensitive to small changes. If, for example, the assumptions are changed to (1) a facility size of 45 residents (instead of 50), (2) higher salaries, including a personal care staff wage at the BLS 50th percentile (instead of the 25th percentile), and (3) a higher occupancy load, there would be no need for a rate reduction.

No information is provided regarding the likely impact of the proposed rate cut on current providers and the residents they serve to ascertain whether access and quality will be compromised. While the rate-setting letter indicates that survey responses from three providers were utilized in the rate-setting process, there is no information provided demonstrating that these providers would, in fact, remain financially viable after the 21.7% rate reduction, and if so, whether these three providers are reasonably representative of all Arkansas Medicaid AL providers. Given the size of the cut proposed, it is not unreasonable to expect the state to demonstrate – with greater transparency – that access to Medicaid AL services will be maintained and that current placements will not be disrupted.

Proposed Rates for Adult Day Services (ADS) and Adult Day Health Services (ADHS)

Like the proposed AL rates, the rate-setting assumptions for ADS and ADHS are highly sensitive to small changes. The state is proposing a -1.1% rate reduction for ADS and a 0.5% increase for ADHS. Assuming one less enrollee (10 instead of 11) would lead to an increase in the rates by 9% and 11%, respectively.

Proposed Rates for Attendant Care and In-Home Respite Services (AC-Respite)

The “billable hours” assumption used in the rate-setting calculation appears overly optimistic. The state is proposing to increase the AC-Respite rate by only 0.7%. In the rate-setting letter, the state’s rate-setting contractor assumes that all hours worked by direct service workers will be billable except for 10 days allowed for vacation, sick, holiday, and training time. This 100% productivity assumption appears to be overly optimistic. Even a small change in this assumption would result in a higher proposed rate.

Individual Service Budget Caps

The state is proposing to assign enrollees to a service tier based on need (see below). Waiver eligibles will be assigned to Tier 2 and will be subject to an individual service budget (ISB) cap that varies by need:

- Tier 0: the individual's assessed needs, if any, do not support the need for personal care services (PCS), waiver services or nursing facility services
- Tier 1: the individual qualifies for PCS, but not waiver or nursing facility services. PCS is capped at 64 hours per month.
- Tier 2: the individual qualifies for services through either a waiver or a nursing facility with three possible ISB caps:
 - Intensive: \$30,000 (matches average nursing facility cost excluding the resident share and the portion financed by the nursing facility provider tax)
 - Intermediate: \$20,000
 - Preventative: \$5,000
- Tier 3 the individual qualifies for PACE or a nursing facility, but not waiver services.

AARP believes that the waiver ISB caps may not be sufficient for high needs individuals and could force persons needing greater services into institutions. Furthermore, the caps are antithetical to the goal of federal Olmstead legislation and CMS Rebalancing initiatives. The highest limit for Tier 2, of \$30,000/per year, plus the maximum of 64 PCS hours available from the state plan, limits the number of hours per week for attendant care to 32. The state notes that waiver participants can opt to self-direct care and hire caregivers at a lower cost to increase number of hours available by paying a lower hourly rate. A lower hourly rate could also affect the quality of the services delivered and may also force individuals unable to manage self-direction into institutional settings.

While the transitional allowance for current high cost waiver enrollees is a positive aspect of the state's proposal, no information has been provided regarding the number of current waiver enrollees that will be affected by the proposed ISB caps. For current high cost enrollees, the state is proposing to maintain CY 2018 service levels in year one of the reforms but allow only 95% of CY 2019 service levels in year 2. It is critical to understand how these caps compare with the current system to gauge how many participants are affected. While allowing a transitional period is laudable, for many it will only delay, but not mitigate the inevitable loss of services. It would appear that the only alternatives for those needing greater services are institutionalization or loss of all services.

The state's formulation of the highest Tier 2 ISB cap is inappropriately influenced by the state's nursing facility provider tax, unduly limiting enrollee choice. The highest ISB cap –\$30,000 – is based on the equivalent nursing facility cost after excluding the portion supported by the nursing facility provider tax. The actual total cost of a nursing home placement is considerably higher. From the federal budget neutrality perspective, enrollees that could otherwise choose to be served on a waiver will be forced into an institutional placement.

Service Eliminations

We are opposed to the following benefit limitations that the state is proposing:

- The state is revising both Attendant Care and Personal Care to exclude tasks related to socialization and entertainment, tasks performed for individuals other than the enrollee, and tasks that are within the scope of practice of licensed professionals. We believe that the

elimination of any service classified as socialization or traveling would inappropriately limit opportunities for community inclusion or participation.

- For PCS, the state proposes to eliminate the “extension of benefits” option for extenuating circumstances when an enrollee reaches the 64-hour per month limit. This change further limits an individual’s ability to remain in the community and narrows choices for self-determination.

Limitations on Family Caregivers

The state plans to prohibit family members to the fourth degree, including relationship by marriage or adoption, from providing agency-based Attendant Care Services to an adult family member. Given the low unemployment rate in Arkansas, the lack of trained providers, and the desire of many older individuals to receive care from family members and those they trust and who have cared for them previously, we believe this prohibition is unwise and shortsighted.

In conclusion, AARP Arkansas has serious concerns over the impact of these proposed changes and urges you to delay their implementation. While a thirty-day comment period meets legal requirements, a thirty-day period to read, evaluate and comment on a rule that exceeds 600 pages in length is fundamentally unfair to the citizens of Arkansas. Every single family in our state with elderly or medically frail members deserves to be provided with the time needed for an appropriate review of the proposed rule changes. It is impossible, within a thirty-day period, for families to fully weigh the drastic changes this proposal would make in the care that is available to those who need it most.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver’s family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

Little Rock Public Hearing 10/29/18

Michelle Joyner (Little Rock Public Hearing 10/29/2018)

Comment: First of all, I want to thank you for the opportunity to comment on this. I'm Michelle Joyner, I'm an APRN, and me and my husband both own Village Park of Conway. We're an assisted living facility,

level two, and we have been in this business for over 14 years. We have been taking the Assisted Living Waiver since 2009, so we are pretty familiar with it. So, I'm going to read some comments of my concerns. And I'm talking in regards to the Living Choices Waiver and the Assisted Living. Okay? In 2011, the lowest level of care for a Tier I was \$62.98. Think about that for a minute and the increased providers as we've assumed so much cost since then. Precedents exist in this program. It has been in existence since 2002. The new proposed rate of \$62.89 per day is an arbitrary number based on many assumptions and overhead loads in other states, along with three responses from assisted living facilities which were provided to an actuary group called the Millennium Group. Okay? The word "assumption" is listed 20 times in this four-page report. That's a lot of assumptions to come up with a rate that is lower than our level one tier right now. That's a lot of cost assumptions. And the validity of this actuary using a 75 percent overload -- overhead load should be challenged since there are no details of what was included in the operational cost. What the cost -- what is included in this cost and what does it cost to do business and perform ADL services in an assisted living facility in addition to overhead rates used? This includes taxes, capital expenditures, capital maintenance costs, business loan costs, insurance costs, building and liability, profit margin, which is why any business is in business as we speak. We cannot continue to do business or stay in business if you are offering services at just cost. For example, if you go to the store, you buy a dozen eggs. You are not paying what that cost of those dozen eggs are, you are paying a third-party, you're paying somebody to deliver, you are paying other people. When you pay them -- it might cost the person raising the eggs a dollar per dozen. By the time it gets to the store, you would be purchasing it for \$2.67 per dozen. What is going on here, why am I saying this? It's just, if no one purchased the eggs at cost, it could not happen on a company producing eggs, it will go out of business. The moral to the story is that assisted living facilities cannot take a rate based on cost that is not usual and customary or ethically or morally correct as mentioned in the example given. So, why is assisted living services any different? Why should we, as providers, be forced to sell our ALS services at cost? The only explanation is that Medicaid and DHS is considering driving the assisted living waiver businesses out of business. To me, as providers, we have tremendous obligations that must be met, that would be devastating not only to the AL industry, but also as an individual and recipients that take the Medicaid that are in your facilities. Furthermore, this proposal forfeits Medicaid recipients the right to options of whether they want care at institutions, such as nursing homes, or in assisted living, and places them in the position where their independence is not supported and eliminates their choice to access of care by cutting the per diem rate so low that assisted living facilities cannot not feasibly operate on a \$62.89 per day budget. The proposed budget compromises quality and continuity of care for Arkansas Medicaid recipients who meet the eligibility requirements and standards for assisted living options. I like to think of the Waiver as a program, as a shared expense between a recipient and the state for care services that cannot be afforded in a private pay setting. These people represented in the Waiver program are your teachers, professors, your factory workers, and your farmers. I even had a CIA agent. That doesn't mean they lived in a ditch and didn't provide for their future. It just means that they cannot pay a private rate, and so they qualified for the Assisted Living Waiver to obtain services. These recipients -- my point is that these people are hard-working and paid their share of taxes and voted. These recipients reserve their right to vote and are still active in our process today. Under the current pay structure, there are four tier levels based on care of need, with a rate structure between \$70.00 and \$85.00 a day, developed by DHS' own nurse's assessments using the ARPath which we understand is going away, it's going to the independent assessment. How can DHS support a \$62.89 day rate that is less than the lowest tier of need? Assisted Livings have been proven to be a valuable resource for

Medicaid recipients who want to maintain their independence and be involved in choices for their medical care. I also want to bring your attention to Arkansas Business 2017 where they rate nursing homes by profitability, 118 out of 125 listed made a profit taking Medicaid dollars. In fact, the number one nursing home made \$3 million in net income and had an average Medicaid daily rate of \$182.00. The seventieth nursing home, the lowest, made over 300 net income and had an average Medicaid rate daily of \$173.00. Lastly, in the timing of this release of the rate proposed for the 2019 budget give participating providers no time to the devastating loss in revenue and will have grave consequences that will include closure of some facilities that take 50 to 100 percent Medicaid operations. What is DHS's response to this? They will find alternative placements to these Medicaid Waiver recipients. This disrupts the recipient's continuity of care and their environment. To further insult the facilities' budgets, a new minimum wage increase is on the ballot in November and was also effective in January -- will probably go through and be effective in January of 2019. And this was not included in the proposed budget for the Milliman Report for the 2019 Assisted Living Waiver of \$62.89 a day. That's all I have. Thank you.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Ms. Bobbie Riffle (Little Rock Public Hearing 10/29/2018)

Comment: I could understand most of what you said and I agree completely. DHS says that they want to avoid people having to go to nursing homes, yet it seems in these programs they are doing everything they can to force people into it. My daughter is severely handicapped. She wouldn't survive any length of time in a nursing home. And we have struggled, really struggled over the last two years under ARChoices. We appealed, we tried to get the nurses to understand. It was a matter of a few questions and that computer program that we were told nothing about. And it was like there was no concern,

really. Excuse me. I have a cold or allergies or something. But anyway, we finally changed to another DHS program. It seemed like the difference in daylight and dark. The people came and they said -- see, the other people were saying, "No, you don't qualify. You don't qualify for more hours." They cut us

back in areas to less than what we had 15 years ago, yet my daughter has progressive disease. Tremendous change in those 15 years, unbelievable change of being able to do less. Anyway, the new people came out and said right off, "We see. She qualifies for Tier 3, she should be able to get 24/7

care." We said, "We don't want to give up our entire parental help. You know, we are not asking for more than what we need, but we have to have help." My husband and I are both in our upper 60s, and I'm disabled, I have the same disease, and I can't lift her, I can't help very much at all. And I have

seen the toll it has taken on his health trying to do what they were making us have to try to do under this RUG program. Well, all of that is to say, this does not -- the paperwork I got does not explain how this ARIA, A-R-I-A, is going to work either. It doesn't say what the questions are, it -- I failed to bring my paper up here. But it said something to the effect like it would be used to develop your plan.

Well, how is it going to be used? Is that just part of it, is that all of it? In the old program, the RUGS -- thank you. Under the old program, it seemed like the RUG computer program, you know, that was God,

you know, whatever it said, that's what you got. You know, you couldn't reason with it. Well, I don't see any explanation how this new ARIA program is going to work. Is it just some more questions, and that's it? You know, and also it doesn't explain -- because we didn't know some things until we went through the appeal process that when they come out to do an evaluation, they are supposed to show you what they have written down, what they have down. They never did that with us. And twice we have had

evaluations where we asked for -- well, on the first time we didn't know. The second time we knew that we were supposed to get it. We asked for it. "Well, we will get it to you in a week or so." And again, the second time, the evaluations were wrong. They would say, "Sometimes she needs help with this." And I wrote a long thing of corrections to it. I said virtually every one of them, instead of sometimes, it was always. My daughter can only use one hand, her left hand, she trained herself to be left-handed, a little bit. She cannot feed herself, she can only talk in a whisper, she cannot walk, she cannot turn over in bed. She can't do anything hardly for herself. How could anybody -- and she was there, I was there, and the caregiver was there when the questions were asked. How could anybody say, "Sometimes she needed help"? Well, my opinion is that -- and question, too, is that these evaluators -- these independent evaluators are hired on contract, I believe, with the stipulation that we need you to save us money, and that money has been the bottom dollar. Because when this ARChoices came up, instead they were going to hire these independent people and all for the same money. And now, here

again, I see in this that it says, on like the next to the last page, they expect these changes to result in a net decrease in aggregate Medicaid expenditure of \$9.27 million in state fiscal year 2019, and

\$13.92 million in 2020. Is this on top of the savings? That's a question for you. Is this on top of the savings that was supposed to have been pared out on the ARChoices? I mean, do we keep all the time just paring down, cutting down? How many of your expenses and things are going down? Nobody's is.

And I'm reading in the paper all the time, the legislature, all of them, they got raises, the teachers got the time reading about the state employees got raises. I'm not saying they don't deserve raises, but I'm

saying the care for these people, the cost of it is not going down. And if the person has a progressive disease, their needs are not going down. And if the goal is to keep them out of a nursing home, then you can't cut them down to where they can't be served at home, where they want to be, most of them, or they will end up in a nursing home, you are going to pay it out anyway. And those nursing homes

are making in the millions of dollars and not taking care of people well. Because I had my mother in there temporarily. It broke my heart, I think it gave me high blood pressure, because there were so many things that went wrong. Anyway, I don't want to get off topic here. But cutting down on all of this is not the answer to keeping these people out of nursing homes, that's for sure. Another question comes to my mind. When they talk about saving money, yet they talk about hiring these outside people. I get disturbed when I read in the paper about all these different -- whether it's the public schools, whether it's the state agencies, or what, hiring outside independent contractors for thousands and thousands of dollars. Don't we have any smart people in Arkansas? Out of all these people at DHS, aren't some of them capable of doing this? I mean, they have a lot of payroll there. It's just all the time you are reading lot of this money for these outside people when we are paring down the services, the whole basic need here it exists for. And the PAs people, I have nothing against the PAs people, individuals, I like

the lady that came out, she was very sweet, very agreeable, but she is getting paid, I don't know what she is doing for me. We had a caseworker come out, she has come out --we have been on -- we were on the ARChoices program about 15 years. So, I have seen a lot of it. And the caseworkers come out,

they put a bunch of stuff in the computer, I have no idea what they do. But personally, I haven't seen anything that it has really done for us as the client in need, my daughter in need. Let me see what else I have here. A big question, I started in on this before, is the contract for the ones who are doing

the assessment geared to them lowering costs in order to -- for them to keep their contract or for the contractor to get more pay? If "yes" -- if the answer to that is "yes", I don't see how you can call them

independent. They are not independent. They are trying to keep their contract or they are trying to get more pay. And I agree with the lady there, that there are a lot of assumptions. In fact, you were talking about the daily rate there. You divide that just by eight hours a day, it would be about \$6.00 an hour for eight hours a day. Well, in going through the Internet today on the different documents --excuse me, my lips are getting dry -- I read in one where they had down an assumed \$15.00 an hour because of different costs and stuff, and I thought, that, in itself, is contradictory to the dollar figure you had.

\$15.00 is over twice that an hour, and there are a lot more than eight hours in a day, too. These people don't get well after eight hours, they are sick all 24 hours and in need of care all 24 hours. All right. If you will give me an address, I will try to type up my comments and give them to you. I think we have until November 7th; is that correct -- to do that.

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

Lenora Riedel (Little Rock Public Hearing 10/29/2018)

Comment: My name is Lenora Riedel, R-I-E-D-E-L, I'm with Countryside Assisted Living. We are in northwest Arkansas in the town of Huntsville. We are privately-owned, we are just one facility, but we service 56 Medicaid residents. And we have been doing the Waiver program, like Michelle, since 2009. And I have seen over the years how many people have benefited from assisted living. It saved them from going to a nursing home when it wasn't safe for them to live at home. And I know that we offer great service to them. And whenever people call me, and I get calls almost daily, and especially this whole year I have had to give them the "I'm sorry, but Medicaid is on wait list" speech. And it's sad, because I know that they are needing services. And I have to tell them, "Your only option is to try to be approved to go into a nursing facility in the meantime." And sometimes they are not appropriate for skilled nursing facilities. And it's just sad, it's a sad thing that we have seen. But whenever they ask me about the level of care, that we tell them, you know, I say, "We are a level two provider." "Well, what is the difference between you and a nursing home?" Well, there is not much. We offer so many services that the skilled nursing facility offers, the only thing is, they cannot be bedridden and we don't offer infusion. And so, whenever you are thinking about it -- and we have a facility in our town, as well, that's a skilled nursing facility, they are at about 50 percent rate. We stay at a hundred percent, we are always full. We have 92 residents. And I mean, 56 of them are Medicaid. So, it's over half. And whenever we offer, you know, people coming in to go to a nursing home, it's just not an option for them. So, I know that the need is there. You know, there are plenty of nursing homes that are not even operating at 50 percent. And I feel like the state is not acknowledging that, that they are not acknowledging how needed assisted livings are. There are more and more people, you know, like your daughter, that might have to go to a facility one day that's not necessarily appropriate. And I just feel like it's pushing more and more people into nursing facilities that shouldn't be there. So, are they going to lower their standards on nursing homes? No, they are not. So, are they keeping them in their homes when it is not safe? That's basically what they are doing. And I want to just make one comment that I have noticed, I appreciate you, Mr. White, for taking notes and listening, I really -- I do see that. So, I appreciate that. I have looked up, and it's roughly around \$2.00, maybe less, a day for assisted livings to run -- or it's \$2.00 more per day for assisted livings to run from state funding after you take in any federal money, everything. \$2.00 a day. But yet now they are wanting to cut us 21.7 percent. It just doesn't make sense at all. Okay. Another thing that I want to comment on is the fact that there was only six assisted livings that were sent a letter to be -- for the survey they were doing. Only three, apparently, responded. And I don't know why it wasn't sent out to every assisted living that is a Medicaid provider-- because I feel like they were hand-picked, that's my personal opinion -- and I don't agree with that. I don't feel like they have enough data to make the assumptions that they apparently have. And I have gone over the Milliman report and they are, for 50 people, so 50 Medicaid residents, they are saying that your staffing should be 19 people. And last time I checked, we don't operate on a minimum staffing requirement. We are double that. And it's not the fact that we just have plenty of money to throw out there, but we know that the quality of service that we want to provide is not at a minimum level staffing. We -- you know, our residents, they are kind of oblivious to, I guess, what the state requires people to be at. And so, whenever we say it's a one-to-15 ratio during the day, you know, that just -- it amazes them. And that's talking, you know, your indirect staff such as your kitchen aides, you know, laundry, dietary, anybody like that, not just your CNAs. I don't know anybody that could operate on 19 people for 50 people, total employees. We have 48, and that's for 92 residents. But we -- you know, we have great employees, but we also -- we have a lot of employees that, you know, do a lot more. We

have our activities lady, we have our laundry lady. And, you know, I don't think that they think about those things whenever they are doing this Housekeeping. Because, I mean, if they are wanting to cut all that indirect care, that's going to require the CNAs and PCAs to do all of that, when they are already being stressed because they are doubled up on their people that they are taking care of just to meet the requirements, because the facility cannot run on \$62.89 a person. You can't run. So, like us up in northwest Arkansas in rural Madison County, that is probably going to shut us down. If we do not cut staffing ten to 14 people, which is what the standards say that we should do, because to survive the 21.7 percent cut, we will have to close down. And that will force 92 people into a facility or into a home where they cannot take care of themselves. One thing I just want to add is that only -- I think it was five percent of people in the State of Arkansas that are on the Medicaid Waiver program for assisted livings are tier level one. Five percent. The majority are tier level three. And with about 25 percent on four and two. So, they are wanting to pay us at less than the tier one level that only five percent of Arkansans -- Medicaid Arkansans are on. So, I really just don't feel like that they have had enough data to do all of their -- to come up with quality research, and I feel like they just have not taken enough time. I know this was proposed about two years ago and it kind of got to the wayside. But, you know, even then I think it was only like an eight percent cut that they were wanting to do. We were, you know, scared then on an eight percent cut. So, one more thing. There is a lot of governmental agencies, such as Social Security, the military, and other agencies that do a cost of living adjustment raise per year. And it's usually ranging from one to two percent, depending on the year, based on, you know, how well they did, you know, what they can sustain. Sometimes it's zero percent. My husband was in the military for eight years, so I have seen those zero percent cost of living adjustment rates. If you were to take that and tell them, Social Security, that they are going to have to get a 21.7 cost of living adjustment, they would shut down, they would not have enough funds to operate. Because no company can sustain on that huge of a jump. And, you know, I think it would be better if it had been thought out a little bit more, but also maybe offered, you know, maybe in different increments, not hopefully leading up to 21.7, because that is what is so bad. But, you know, a couple of percent total, I could see. But, you know, anybody that has priced a car in the last five years, I swear the cars have gone from, a Suburban was \$45,000.00, \$50,000.00, and now you're paying \$80,000.00. So, tell me the cost of living has not almost doubled. I just would like more time, more data, more input from facilities, because three is not enough. And this Milliman Report is about the stupidest thing I have ever seen. So, thank you. I appreciate your time.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the

data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Kimberly Stoneman (Little Rock Public Hearing 10/29/2018)

Comment: Good evening. Public speaking is not my forte, so I will try to not be nervous, and slow down. Kimberly Stoneman, I'm Care Director for CareLink, speaking against the proposal to prohibit family members from serving as caregivers for their relatives in the ARChoices and Medicaid Personal Care programs. A statistic everyone in this room is well aware of, the population of 65 plus is expected to double in the next 30 years. Today half of this population already needs some kind of assistance with long term care. At the same time, we have a critical shortage of home care workers in an industry that already has high turnover. As the aging population has grown, the demand for home care workers have also grown with an estimated one million more caregivers needed by 2026. At CareLink, half of our caregivers hired in the last two years are already gone within one year, with the average lasting less than six months. In our HR exit surveys, the number one reason they leave is low wages, followed by travel requirements, and the stresses of caring for aging and ill clients. A 2014 AARP study indicated that family caregivers spend an average of 24.4 hours per week providing care, with nearly one in four family caregivers spending 41 or more hours per week providing care. The same survey indicated that 20 percent of family caregivers left their jobs entirely to care for a loved one. We estimate for our clients on the ARChoices Medicaid Personal Care program, 130 clients will be affected by this regulatory change if it comes to pass. I spent about a week doing a literature search to see if I could find any studies that indicated paid family caregivers gave inferior care or committed fraud at a higher rate than non-family paid caregivers. I could not find one study. We had a very nice meeting by the association with DHS last week where we have asked to be provided with this data. So, I could find no evidence of that. But I want to tell you from seven years at CareLink some of the benefits that I have seen from having paid family caregivers. They are more familiar with the needs of their loved ones. They are more familiar with their schedules. They are more reliable and they have the incentive to provide superior care. They are in closer proximity to their client or have a willingness to drive farther to serve their family member as their client. They provide many hours of unpaid care over what the average care plan authorizes. And we all know care plans are authorizing fewer hours these days; correct? Family caregivers, as paid caregivers, have better connections to additional resources for their clients, and in rural areas, paid family caregivers often have fewer employment opportunities that would allow them to stay near their loved ones during the hours they most need care. Our response to this proposed change. When we asked DHS why they wanted to go to this regulatory change, they gave us two words, "better monitoring" and "accountability", which we support. All of our caregivers, whether family or not, are required to pass background checks and drug tests before employment, complete 40 hours of classroom and clinical training, and pass a personal care aide exam before becoming caregivers. At CareLink, for

the last 12 years all of our caregivers used an electronic visit verification system to record their time. All of our caregivers are supervised by RNs. All caregivers meet the requirements to document their daily tasks and client condition notes. They must complete 12 hours of continuing education credits to maintain their certified personal caregiver status. And all of our caregivers are subject to the same handbook and disciplinary guidelines. In conclusion, we believe that the above response to the changes, specifically the EVV change that CMS is maintaining all new care agencies go to in the next two years will satisfy DHS' request to have better accountability and monitoring for caregivers. Thank you for your time.

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

Josephine Aaron (Little Rock Public Hearing 10/29/2018)

Comment: Good evening, everyone. My name is Josephine Aaron, and I, too, work for CareLink. I am the personal care aide for my mother-in-law. Prior to becoming her caregiver, I worked in the Human Resources Department at CareLink. And during this past summer, my mother-in-law was diagnosed with dementia. Now, before the dementia, she had always been a feisty woman. Since then, though, we discovered an increase in that. We discovered that less often somebody was home with her, a loved one was home with her, she became more depressed, she became more agitated. When a caregiver was with her and no one else was at home with her, she became paranoid. After a while, she began making threats against the caregiver, threats against herself. There would be many nights when she would go to my husband and ask him to take her home because she felt like she was not at home. And we realized that we needed to be there for her. But it wasn't enough to have another caregiver come in to care for her, she needed somebody who loved her and she knew who loved her and cared for her. There are many times when she would have an outburst and a caregiver there wouldn't know how to respond. And, of course, it's a human reaction to respond defensively or to try to explain your actions, even though the caregiver didn't do anything wrong. But that seemed to just actually worsen the situation. And it would cause the caregiver to become more distant. My mother-in-law at times would even lock herself in her room. She needed to know that her family was there for her, that her family would be there to love her and to provide that level of care for her. And so, this August, my husband and I made a decision that I would leave the Human Resources Department in order to become my mother's caregiver. And since then, we have noticed a great improvement in her health, her mental health, her physical health, because she is no longer depressed she is eating a little bit more. And the finances -- or the income that I receive from becoming her caregiver helps to go right back to her, provide the Ensure that she needs, the protein nutrition shakes that she needs, provides getting her hair cut, or taking her out somewhere every once in a while so she can get out of the house and enjoy herself. And so, I really hope that you all would reconsider prohibiting family members from caring for their loved one. It's really important in maintaining -- you know, keeping their loved ones in the home and it helps to improve their health. And so, I really hope that you reconsider that. Thank you.

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

Rizelle Aaron (Little Rock Public Hearing 10/29/2018)

Comment: Good evening. I'm Rizelle Aaron, and that was my wife who just finished talking. Just a couple of things to reiterate what she was talking about, what she is saying. Many families don't have the money and cannot afford for one to leave a full-time job and go to a part-time job caring for a relative in the home like my wife has. And so, the majority of people that have family members that are caring for them in the home don't have the resources available that we do, which puts them at a disadvantage. You heard my wife mention that -- some of the things that she does with the money that she makes now is to give it to my mother so my mother has things that she can do that helps her and assists her with her daily -- with her daily living. One thing my wife did not mention is that she is also a full-time student. And so, being a full-time student and then being at home with my mother during the daytime, and alternating with me to care for my mother, is a major undertaking. And so, I also, obviously, oppose any changes to family being able to take care of family members through these assisted programs in the home. One other thing I want to point out, I've got an aunt, my mother's sister, in the same condition. They don't have the resources that we have, and one of her children is her caretaker. And so, when we talk about eliminating family members being caretakers for their loved ones, then the alternative, or the only option that may be left is assisted living or placing them in a nursing facility. Now, earlier, a couple of people talked about nursing homes and assisted living.

Governor Asa Hutchinson gave tax breaks, millions of dollars in tax breaks to the most wealthiest of Arkansans, many of them business owners, including nursing homes and assisted care facilities. Those tax cuts were meant to generate growth, jobs, and business. Now, this evening we are hearing those same people that are begging for more money. And so, apparently those tax cuts are not working the way everyone thought that they might. And so, now I'm thinking, as a tax-paying citizen, maybe the Governor should consider rescinding those tax cuts and then maybe giving those wealthy business owners a few extra dollars a day to care for their clients. And finally, I certainly thank you for this opportunity, and I certainly hope that this particular part of this initiative will be stricken to allow family members to care for their family and their loved ones, because nobody will care for your family like family. Thank you.

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

Tara Hollinger (Little Rock Public Hearing 10/29/2018)

Comment: Okay. I'm going to touch a little bit on what they're talking about. I'm Tara Hollinger, and I have Quality Senior Care, and I service clients all over central Arkansas. I have

been in business going on almost my 19th year of doing this. I have never seen the things that are being proposed from DHS, from, you know, whoever they are being proposed from, quite like this. A lot of it, with the lack of a better word to say is what you said, stupidity. With a family member taking care of their loved ones, wouldn't we think that that's what everybody would want? Would you want, you know, a family member to come and take care of you? Obviously, you would over somebody else. As

far as the fraud, where is the data that shows that if you are a family member that you are committing fraud, or it cuts down on fraud or -- I mean, I would like to see the proof of that. Another question I have for you all, and this is a big question, why does Independents Choice, number one, and have for years, because I have been doing this for many years, why were they able to have family members work with their patients? Not only are they able to have family members working with their patients, they do not have to have the one year's experience, verifiable experience of being a caretaker, which most of the time is through a long-term care facility, or maybe even sometimes an assisted living. But most of the time, I think it's an one-year of long term care requirement, or a CNA, or a personal care assistant, what we were talking about through -- what she was talking about at CareLink, a 40-hour, why do they not have to have that, but all of us other companies do have to have that? And it was brought up in the webinar, Independents Choice that still would be able to take care of their family. No, that's not the same standards. It's not -- we each should have to do the same thing, every one of us should have to do. Talking about cutting hours for families. You know, it's strange to me -- I have several patients with dementia and Alzheimer's diagnoses. So, let's say in the past two or three years they have been on the ARChoices program, they have been getting Medicaid. Okay. They have been on that program, let's just -- I'm just throwing out a ballpark figure, they get 40 hours a week on that program. Then Optum comes in, which is a paid contractor, independent contractor through the state, and they are going to cut their hours after them having hours of 50 or 60 a week, cut it down and say they don't need that care. Oh, I didn't realize that dementia and Alzheimer's patients got better. They don't. They progress and get worse. So, I have a big, big problem with that. And I'm kind of like on that, there has got to be somewhere, government is doing some shady stuff on that. Really, I mean, that's just about all I have to say, other than how is the state trying to save money in trying to get all these cuts, and the cuts come to patient care, whether it be in assisted living, whether it be at in-home like me, but then the state is going to pay millions to independent contractors to come in and do the jobs that our DHS nurses can do. When I started my business, how many -- years and years ago, the DHS RN came in. That's what she was paid for. She did a subjective and an objective assessment. She just went in, listened to the patient, and then observed on the patient. Why do we need her to do that now, Optum's RN to do that now, and company, my company's RN to do that now? Why do we need -- why are we paying three RNs to do that? It makes no sense. And then, going to cut on the assisted livings and get a cut basically just on patient care. And when y'all proposed this, just like I believe one of the ladies said back there, you are proposing this to come in effect January 2019? That would take so many businesses down. You think that Medicaid is going to have problems now? What about all the workers that we have? They are going to have to go to, you know, find a job somewhere, they are going to have to get on Medicaid for food, they are going to have to, you know, whatever, get on some type of social services. So, I just think as -- not you, but as everybody is sitting up in the offices at DHS, you need to be doing what you are

doing now and listening to us and listening to who it's going to affect. And I'm not talking about businesses financially. I'm talking about just as much patients, and we are going to stick them in nursing homes? Huh-uh. So, that's all I have to say to that.

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

Amanda and Eric Stone(Little Rock Public Hearing 10/29/2018)

Comment: Sorry, I'm short. Can you see me? My name is Amanda Stone. My husband is a disabled vet. He can't drive, there are days that he can't function. Well, his parents have been in a bad way for a number of years. In 2007, I believe, his mom went into a coma for a while. When she came out of her coma, she was not able to take care of herself. Luckily, Dad was already not working, he did everything he could to take care of her. Eventually, his health got to the point to where he couldn't do it anymore. And instead of them asking for help, they are proud people, they would go days without

eating because they were too sick to get up to fix something, they would forget to take their medication, or forget they already took their medication. They overdosed themselves several times because they didn't know any better. They were going back and forth to several different doctors who were giving them the same medications for different things, or medications that were canceling out other medications. This was horrible. It got to the point to where my husband and I were going over to their house at least once a week to help them clean, to help them cook. Then, Dad went to the hospital again and we didn't know if he was going to make it out this time, because he had already had heart surgery. You know, both of them are diabetic, both of them are heart patients, Dad is on dialysis, he is end stage renal disease, both of them have problems walking long distances. Luckily, we just got Mom off oxygen in January. But she has been living with us for three years, they both have. Since we have had them living with us, I have taken my father-in-law off 21 medications that he did not need to be on because the doctors weren't letting him know, "You need to stop taking this." I have taken Mom down off half her medications for the same reason. We have got them new doctors that will actually listen to them.

So, my mother-in-law is not being overdosed on her insulin anymore. We had to get her checked for dementia and Alzheimer's. Come to find out, the doctor she had was overdosing on her insulin, that's what was doing it to her. My in-laws were killing themselves and they didn't know it. My husband and I talked about it. He has got two older sisters, his sisters said, "Put them both in a home." Why? At that time, they were both in their early to mid-60s, way too young to have all the problems that they have. You know, I can't tell you how many times I have been at the emergency room for 12 or 14 hours taking care of somebody else's parents. Now, don't get me wrong, I don't mean that in a bad way. I love my in-laws, I love them like they have been mine forever, and I will take care of them. Me and my husband will fight if it comes down to the point she has got to go -- they have got to go in a nursing home. But I'm only allowed hours for Mom because, stupid Dad, he has a pension. Oh, my God, he planned for the future. But it's not enough to take care of all of his medical bills, it's not enough to take care of what I

do. I'm allowed 41 hours a week to take care of one parent. Two weeks. Oh, excuse me. Two weeks. 41 hours for two weeks. I get up in the morning, I make their coffee, I make their breakfast, I take their sugars, I give them their shots. I make sure that their room is clean, their living room is clean. We bought a house just so Mom and Dad can have their own bedroom and their own living area so they have got enough room and don't feel cramped. I take care of them at lunch, I take care of them at dinner. I help dress them when they need it, I help bathe them when they need it. And I'm lucky enough that they don't feel embarrassed by asking me for help now. Now, what happens when it gets to the point to where I don't get those hours anymore? I can't work, I can't. My husband can't drive. His PTSD will not -- if you want to live, he doesn't need to be on the road. Dad can't drive, Mom can't drive. They have a tendency to go to sleep sitting there talking to you. I can show you the schedule on my phone, and there is one weekday in the month of October that I don't have one to five different things that I'm driving to. Where am I going to get a job that's going to allow me to do these things? Well, I can work at night, that's true. But what happens if there's a late night emergency room? With Dad being on dialysis and being a diabetic and a heart patient, another heart attack is just waiting. Mom has mini strokes. What happens when one of them isn't so mini? You know, luckily enough, my daughter still lives at home. So, sometimes she helps me with the driving. But that's still not enough. Thank God my husband was a medic in the Army. He helps me take care of them. He does just as much as I do, if not more. But that's on the days that he is able to. So, why are you getting rid of family taking care of family when I'm family taking care of two family and still not being appreciated enough? If you -- if anybody thinks there is any fraud or any mistreatment or anything of my in-laws, I invite everybody to come to my house. Ask them what it was like before I was there, and ask them what it's like now that my husband and I take care of them. My parents are actually getting up and walking around now, where before Mom had a port-a-potty next to her chair in the recliner -- or in the living room because she couldn't walk to the bathroom. Don't take away the only thing that has helped them, please. Thank you.

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

Charlie Millikin (Little Rock Public Hearing 10/29/2018)

Comment: I'm Charlie Millikin, I'm with Absolute Care Management, another in-home services agency, and we have several offices across the state, and I'm in the Russellville area. And I just wanted to support what this young lady just said. Because at the heart of the matter for me is the patient, because I'm an RN and my job is to use my compassion for people to help them have a better quality of life. This young lady couldn't be a better advocate for those people that she cares for. And that's why I feel like the family members who report to these people that they take care of at home. There is no better advocate for your mother or whomever you happen to be taking care of that's related to you than you.

If you take away their right to take care of that person at home and you give them Independent Choices, they can still work for them as a family member. However, you have removed a resource for them to

call and say, "Hey, Charlie, Mom has got an area on the back of her bottom that I need you to come look at, because I'm not sure what to do with it." It's a very serious condition when someone gets a bedsore or things that are not necessarily from not being turned properly but from lack of nutrition and different medical conditions that causes that to be a problem. So, what you are doing, if you take away the option for that family member to care for them through agency and you allow Independent Choices to be the person who provides for them, you have removed that resource that can offer to get them physical therapy when they have had a fall and the person who is their care provider who works for agency can call and say, "Charlie, Mom fell again. This is the third time this week. What can we do?" I can make a phone call to a skilled nursing facility -- or skilled nursing home health who can come out and evaluate that person and see if they can help their quality of life improve by coming out to that home and providing physical therapy at home to help them to be able to maintain their mobility longer, prevent those falls that are causing broken hips that are costing Medicaid money when they have to go for surgery and they have to have rehab in a nursing facility, or the rehab at home that is provided once they leave the nursing home, usually -- or from the rehab stay. I think it's a term that my grandma and lots of people's grandma probably used to say, "An ounce of prevention is worth a pound of cure." And I feel like by taking away the option to have us as a resource, agency RNs who are trained to recognize the need for intervention is going to further impair people who are able to stay at home with the help of family and cause more of a burden on Medicaid by having them to have more medical needs because they are not noticed and interventions aren't put in place in time to help prevent a bigger problem. So, I just want to ask you guys to consider the lack of resources -- you know, the resources you are taking away if that option is taken away from our home health. Thank you.

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

Ira Lewis (Little Rock Public Hearing 10/29/2018)

Comment: Good evening, ladies and gentlemen. My name is Ira Lewis, and I reside at Scott, Arkansas. I am one of the caregivers for Daryl Lessor, who is 100 percent handicapped. I used to work for PALCO and DHS until the last of February. I was -- since February, me and my husband would go get my grandson off the van in the afternoons. My daughter, she worked with DHS, which she is having to retire because of not services. We were notified in the last of February that their alternative care would be cut off as of February, the last of February. My last check came, which included the last of February, the first of March. PALCO took my last week of pay, kept it. Then, they were supposed to recertify us within 20 days. Mr. James Hayden is the name that we had a representative to come out. And she brought papers out which deliberately had the wrong things on them. We were told to send our certified to -- our certified to August the 31st in 2018. And then, they told me that we had to re-up everything. And we did, submitted all the papers. We heard nothing from them until July the 31st. My grandson has yet to be recertified. Me and my husband has been going up every day, getting my grandson off the bus, and we are -- this is our grandson. And you talk about people working, which it

took and outside of pep. Well, if it wasn't for the love and care, wouldn't nobody be able to be there to get my grandson off the bus. And we drive all the way from Scott every day without pay. This has been going on ever since March. July, they sent me another paper, and told me to -- I already knew that you had to -- if you had a criminal background check, you need to put that to Arkansas State Police. We were given the wrong papers. And I sent my certified money to get my background check to James Hayden in care of DHS. So, I am here to tell you that DHS has not been fair. And if it wasn't for the care - - when you go to a nursing home facility, I'm here to tell you that it's just a job, there is no love. You clock in, you do a job, you don't care anything about those people. Now, I have -- I know for myself that DHS and PALCO is not fair. If you think so, you can ask -- I read in the paper that is exactly -- it started when Governor Asa Hutchinson, I'm sorry to say that, he used to -- I voted for him. But since the Republicans came in, everything that the Democrats had is going to waste. I don't know what they do at night while we are sleeping but study to take away from the less fortunate, the people who cannot help themselves. If it wasn't for the family love, just like this lady said, the people we really love would be in the care of somebody just clocking in and getting paid, no love there at all. A dog love care. And me and my husband love our grandson so much. And he is 35 years old, he has never walked, he has never talked, he goes over there in North Little Rock. And God knows he needs care. And so, these are the things that instead of trying to take money, and I'm telling everybody, you need to go out and vote, because if I had my choice, no Republican would ever get my vote. And I'm fixing to sit down after that. But they are not right, and I am a truth speaker. They are crooks.

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

Sharon Justice (Little Rock Public Hearing 10/29/2018)

Comment: My name is Sharon Justice, I am the co-owner of Elite Care, it's a personal care agency in the very small town of Malvern. A lot of what I had planned to say has been touched upon, so I'm not going to go into a lot of detail. I do want to pose the question of, again, as far as family caregivers, it seems like that was brought to the table to be taken off the table without any data being presented to anyone about why a family member would be considered more dangerous for fraudulent behavior than anyone else. What I do want to add to what people have said is, and this is from experience of working in this for -- my partner and I have been in business going on seven years, and we have quite a few patients that are cared for by their family members. In our agency, they are followed by RNs that go in and make sure that they are there doing what they are supposed to do. They are trained by the RN to do what they are supposed to do. They are required, as someone else said, to have qualifications. In Independent Choices, anyone can do it, there are no requirements. The family can choose anyone that they want to take care of them, which I'm not saying that -- I mean, that's their right. But what I am saying is, when you are setting a standard for an agency not to be allowed to do that because you have found it to be more possibly fraudulent. But on the other side of that coin you have people that have no training and they are not being followed up on by anyone, that that concerns me and I'm questioning

how did you come to that determination? Who came to that determination? The other thing I want to say is, I'm a very small company. I worked for 30 years as a registered nurse in hospitals, and we decided, "Hey, you know what, let's open our own little business." And we worked really, really hard, two of us, we worked full-time at the hospital, and then on our days off --we split a job, literally. And on my days off, I worked the company, on her days off, she worked the company. And it has taken us six years to build our company. If you take our family caregivers away, not only are our clients going to lose the people that they want, that they love, and that they trust, that we are going to lose nearly half of our caregivers, we are going to lose almost half of our clients, and we are going to lose over half of the money we make in a year in less than six weeks, because the proposal is for this to happening January of 2019. So, you are going to take a company that was built by two RNs that want to take care of their community and you are going to flush it, because we will not survive when half of our business is gone in eight weeks. It's not possible. So, there is a second part to this I want to say, and then I will be quiet and sit down. There was another proposal, and that's about transporting. Clients cannot be transported, we won't pay for transportation. And I understand there is a Medicaid van. I worked in psychiatric medicine for many years. There is a psychiatric van, there is a Medicaid van, they take them to medical appointments, and that's all they do. They will take them to the doctor and they will bring them back, barring they don't live 50 miles somewhere out in the country, because they are not bringing the van for them. We have people -- and I'm not saying that we should be paid to take them to a doctor's appointment if they can get on that Medicaid van. But we have people that live very rural and the only time they get to go anywhere is when the aide takes them and lets them go shopping for their own groceries, and they help them get in there and they get to go somewhere outside their home for a little while. But the proposal is, take it away. I don't understand that. I don't understand why, because agencies -- private agencies, we pay huge insurance rates to be able to allow our caregivers to transport our patients to get their hair done if they want to, go to the grocery store, get to a doctor's appointment that that Medicaid van is not going to pick them up. Or even if it is -- let's say this. Let's say we have someone that lives, I don't know, in Hope, and their doctor -- their main doctor is in Little Rock, and they end up being given six hours for care that day, and they are going to get on that Medicaid van and they are going to be on the van or at the doctor for the full six hours, because that's how long it's going to take them to get transported there and back. There isn't going to be no stopping at Wal-Mart to maybe pick up a few things on the way, or maybe have lunch with their caregiver, you know, have a meal out. I mean, there is more to taking care of somebody than giving a bath and making sure they can get a spoon and feeding their face. There is more to it. It's companionship. And that's going away, too. No more encouragement, no more supervision, no more -- none of that. Well, I don't get that. I don't get that at all. Because that is part of being a person, you need those things. That should be as important as getting your body washed. In fact, it might be more important. So, those are the things that concern me. There are some more, but they will be coming in writing. But thank you for your time.

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

Donna Kelso (Little Rock Public Hearing 10/29/2018)

Comment: Hello. I'm Donna Kelso, I'm at Superior Senior Care. And it has been my privilege to serve Medicaid beneficiaries in this state for the last 13 years in personal care, in home and community-based services, the Waiver programs. During this time, I have had the pleasure of getting to know many of the clients. I have talked with them about their home and community-based services, their concerns, and their preferences in the services available to them. Not once in all of these years have any of them stated to me, "I want to go to a nursing home, that's my preference." Not one, not ever. We are strongly opposed to 600 pages of revisions in a short period of time. How many personal care providers are here tonight? Okay. We are still, after 11 months of the very minor changes to personal care, still having problems with the system. So, that's one reason. But there are other reasons, of course. We would object to the restrictive proposed rule changes that affect both the client and their caregivers in such a negative way. In the Medicaid rules and regs proposed for Section Two, 212, the eligibility for the ARChoices program, (c)(2), "Taking out," quote, "'functional assessment results in a score of three or more on cognitive performance scale'," end quote, "may have a broad effect across the state with clients in those categories." 212.200, Prospective Individual Service Budgets. One of the questions I have is, who or what entity will be keeping up with the ISB totals? Will weekly billing for services rendered be mandatory of providers? Is this being reconciled on a weekly basis by the state? In other words, who is keeping up with it, how will it be done? And then, (d)(6), under the 212.200, Adding up the total minutes per week for each task. There are many calculations under that rule, and we feel like adding up the total minutes per task for the week should be it, should be running on a weekly basis rather than a monthly cap. Last week, I was figuring overages for my office, and was amazed at the amount of visits per month that can't be made because the monthly cap runs out before the weekly cap. And that's just -- that needs to be changed. When you require providers to skip visits to beneficiaries due to the monthly hours maxing out before the weekly, this is negatively affecting client care. 212.600, Restrictions on who may provide ARChoices. You cannot do it through an agency if you reside in the same premises permanently, seasonally, or occasionally, or if you are related to the participant by blood, marriage, or adoption to the fourth degree. Why was it fine all these years and now it's not? Why is it okay for family members to work through Independent Choices but not an agency that provides oversight to the program? Our nurses are in those homes every 55 to 60 days. We feel this proposed rule change discriminates against the client, the caregiver, and the agency. If a client prefers oversight and peace of mind knowing that an agency has a pool of vetted, qualified caregivers to fill in, yet chooses to use a family member as their primary caregiver who is a certified caregiver, working through an agency with background checks, drug screens, why would their freedom of choice be restricted now? Many clients cannot self-direct and others prefer the benefits of an agency who has after-hour staff members on call and that prefer not to have the hassle of self-direction. 213.210, Attendant care services, (d), No socialization. For clients who live alone and are depressed, this is a devastating turn of events. (e), Excludes cleaning of any spaces of a home. And that's if the Medicaid beneficiary lives with someone else, whether they are someone that provides care to them or not. We believe that cleaning after a meal, bath, toileting, et cetera, is essential for health and safety. (e), Attendant care not available on dates of service when the participant receives personal care services, self-directed personal assistance, or home health services under the Medicaid State Plan for the same task. Many clients receive both personal care and attendant care and will need many of the same tasks

repeated in the evening that were performed in the a.m. So, this is a concern. If the client spends more than five hours at adult day services, they cannot have attendant care unless approved in writing by a DHS RN. We believe this is extremely restrictive and prevents a client needing assistance to get ready for ADS, and assistance with evening meals, personal hygiene assistance without care. We have many situations where we have asked for approval from DHS to authorize attendant care on the same day as adult day care, and I'm still trying to get an answer from an August 6th, 9511. It just keeps going around and around and around to an RN, RN supervisor, supervisor of RNs, and just a full circle. One of our clients has to use their respite on a scheduled basis, Monday through Friday, so they are not going to be able to use their respite in the case of an emergency for a 24-hour period, let's say, if they have to go into the hospital. And then, 213.700, Respite care. Respite care services are not covered to provide continuous or substitute care while the primary caregiver is working or attending school. So, some primary caregivers may be asked to work an extra shift at work, may be attending a class, and need respite aid one of those days because their regular person is not there to help with their -- the Medicaid beneficiary. But regardless, if the primary caregiver needs a relief period, does anyone really have the right to pass judgment on what they do during their relief time? And also, I want to know about the PAs. I understand now DHS is proposing a vendor for PAs, which I assume would add more expense. We only provide service on approval now. We haven't had PAs ever, to my knowledge, until 2018. And so, I'm wondering why do we need them? Again, we strongly object to trying to push through 600 pages of revisions to the home and community-based services and regulations as they stand. We are continually having issues with DHS stating that they did not receive our assessments for personal care that were sent to the referral's e-mail address, and there seems to also be a disconnect between DHS and Optum once DHS receives the assessments. There are a lot more things, but I will submit those in writing. So, thank you very much for the time.

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

Peggy Weatherly (Little Rock Public Hearing 10/29/2018)

Comment: My name is Peggy Weatherly. I'm not with any organization. I'm new to this game. I will try to keep it from being emotional. My mother is 93. She resides at Village Park where she receives excellent care. I'm not able to take care of her in my home. My home is not handicap accessible. She has a diagnosis of degenerative arthritis and dementia. She is well cared for where she is and is happy there, and gets the socialization that she needs. She gets everything that she needs there. I'm very concerned with what I hear tonight. I came with very little knowledge, but I came to try to learn. And what I'm hearing concerns me on many levels. Not everybody needs assisted care, not everybody needs nursing home. My mother certainly does not need a nursing home. She is caught in the gap. On Thursday, when I paid her rent check, \$500.00 of that rent will come out of my money because she will be out of money, and she is caught in the freeze and in the wait. And so, what do we do? I will continue

to try to find her the best care possible, but at some point she is going to need Medicare -- or Medicaid. I'm sorry. She is 93, she has obviously got Medicare. At some point, she is going to need Medicaid, and I'm concerned that the facility that she is at home in now will not be able to sustain the level of care that she is receiving now. I still have to work, because I'm a widow. So, having her in my home and me taking care of her, even with the pay, is not an option, obviously, from those of you who are talking about how little that you get, and that's being proposed to be cut. So, my question is, if we don't care for our elderly and our disabled, who do we care for?

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Phyllis Green (Little Rock Public Hearing 10/29/2018)

Comment: Good evening. I'm Phyllis Green, I'm a registered nurse with Step By Step Senior Home Care. I'm the owner. Big changes coming, and they are coming fast. I ask the question why, why so fast? We are not getting a heads up. It makes anybody wonder, did you know already that this was going to happen and we are just getting notice? Things are happening too fast. We all need to slow down. You are making a lot of changes at the top, and it's quite clear you don't know what is going on at the bottom. And we are boots on the ground, we know. I want to know, when you make your decisions, when you come to the table, who is at the table? Are there professional healthcare workers at your table? You have made a decision that you don't want the physicians involved with the care. You are going to delete them, when the physician is the one who makes the diagnosis and deems the patient disabled and that he needs the services. You have deleted him. Under the Nursing Board Standard Practice Act, nurses don't make diagnosis, nor do they deem somebody disabled. You have to have a physician to do that. So, I come back to that question, who is at the board, at the top, when you are making these decisions? Is State Board of Nursing there, is there any representative in the State of Arkansas from State Board of Nursing at the table with DHS with healthcare? Because they are professionals in the field of healthcare for individuals and what they need. Is there anybody there from the Department of Labor? For many years, you got -- gave hours, 64 hours a week. That's overtime. Then, you sent out letters, "We are not going to pay overtime. You are going to have to work that straight." Well, the Department of Labor in Arkansas says anything over 40 hours, that's the State of Arkansas, is time and a half. You didn't do that. So, you need the Department of Labor at the board with you. You need the Department of Workforce. The head people -- you've got to have people from

all of these positions at the top, they need to come to your meetings, somebody, a representative, to make sure that we are in compliance with every area that we are touching here. The physician board, somebody, a physician needs to be at the board with you. I want to go up -- I could be all day long, and actually, I don't need no paper to talk to y'all about what is going on. I know it, I memorized it. The PA issue, prior authorizations, initially we were told, "We are going to send a little piece of paper over and fax it in." In seven days the Optum nurse is going to contact them, from what I gave them on this piece of paper. I was told this at St. Vincent in Little Rock, in the auditorium, by Mr. Craig Cloud. I believe he was head of that. "He don't take responsibility for what goes on, he's doing his job to deliver the message, don't kill the messenger." So, my thing is, they are going to turn it back around in 14 days, everything is going to be good, you are going to have a PA to go to work. Here is what is happening, real deal, real time, this is what is happening. Right now, they have changed it over -- at first, DHS nurses were issuing out the PAs, us get them. Now, the unpaid RN at the agency -- you do not have a fee schedule for RN at the agency. I have checked with neighboring states, some of the agencies, they have emailed and faxed me their fee schedules. On the Missouri fee schedule, they have travel for the aides, they have the aide fee schedule, they have a fee schedule for the agency RN, supervisor visit, a fee schedule for the agency RN assessments. An RN is a registered nurse who is a professional and she is delivering professional services. And I don't know where and how did it come into play that one RN gets paid for and the other one doesn't in the State of Arkansas. We make three RN assessments, only two RNs get paid for doing this assessment. Why do we need three RNs to look at the one paper for this one person to see does he or she qualify? Another thing, the baseline, when it all boils down, the approval for the person to get on there comes down to an RN. She decides "yes" or "no", he gets this many hours, it goes up or it goes down. That's a problem. She is taking on a physician role. The doctor said the patient has dementia and he needs care around the clock. The RN in Optum goes back in there and snatches the hours away and says, "No. He only needs six hours." Well, what about him walking out the door and he doesn't know where he is going, into traffic? But see, we got people -- we are out of order. We have to get back in order. We've got policies and stuff already in place. We're not starting from scratch. These policies and things, we just need to connect to the right people to make the right rules and regulations. Because the rules that we got going on right now, they are all over the place. They are everywhere. Optum is coming in, you are going to contract them, and they're going to issue your PAs and decide whether or not, "Well, here is how it goes. Let me give it to you. I never gave it to you." This DMS 618 form, it starts out at the agency. The agency nurse calls the client, makes an appointment, go out and does an assessment and fill out the Form DMS 618. That is an assessment. Gas spent, a professional assessment has been done. Gets the signature from the client -- the family, client, or whomever, come back to the agency. They have to fill out a form that Optum has, provide all of her professional information that that RN gave, she gives it to Optum. So, is Optum using my assessment before it goes out there? Why do you need mine? And do you do another DMS 618? I don't know, after that. We just deliver our assessment via e-mail over to Arkansas Referrals, which I'm told that's Optum. From there, now we have been told to go into the MMIS portal and upload and generate your own PAs and don't send us one without a tracking number. Can you please tell me why do we have Optum? We have done everything you told us that they were going to deliver. And you are going to have all these nurses from Optum to be with this agency and supply all of these services, when, indeed, there is a nurse shortage and there will be one for the next 15 years. We are never going to be caught up with enough nurses in the State of Arkansas. And we are putting them out even faster now, the nursing schools. There is going to be a nursing shortage. And for God's sake, we aren't going to have

anybody to supply the care if the families are taken away from providing care to their loved ones, there will be nobody. I want to know where you are going to get them from. There is a shortage there. So, we are not on the same page. So, my biggest concerns were, who is making decisions, why are we moving so fast? It looks funny. Something is not right. And if you all would just go back to the table, slow down, re-think, reset, and just think things over, just think about what you are doing, and be within guidelines and policy. Thank you.

Response: Comment considered. DHS understands that many providers are concerned about the viability of the independent assessment process and its relationship to the prior authorization process. Optum has now performed more than 50,000 independent assessments in Arkansas. The results have supported the accuracy and validity of the IA system. Independent assessments are a federal requirement for Medicaid waivers for home and community-based services. To be clear, although Optum is responsible for conducting independent assessments, Optum does not perform the function of prior authorization. DHS has worked to improve its internal processes in handling prior authorization requests and will continue to implement changes to improve the reliability of those processes.

Shay Stevens (Little Rock Public Hearing 10/29/2018)

Comment: Thank you. My name is Shay Stevens, I own Millennium I and II Adult Day Care and Millennium Home Care Agency. I pretty much think everything has been covered about the issue of caregiving, so I won't get into that. But I will say that one of the other proposed changes that I have noticed for home care was to remove the agencies from managing finances. I think that's a huge mistake. I do have clients that we manage their finances because, unfortunately, according to them, their family has not done very pleasant things with their finances. At my day care, I currently have three clients that I have initiated with Adult Protective Services concerning what the families are doing with their clients with their loved one's money, and when they first came to the agency they were initially with Independent Choices, and that's when they wanted removed from that program so that someone can ensure that their rent is being paid and groceries are being paid, things of that sort. But I also want to talk mainly about adult day care. There is a proposed cut to our reimbursement rate. And it would certainly have a deleterious effect on our operations. And one of my co-workers is here with me, as I mentioned to you, that I -- because we are in the care of providing for people who are demented, it is very important that they have familiarity in their care. It's the only way they can really get us to -- well, get them to trust us and doing personal responsibilities. I do not pay my employees minimum wage. My program director is paid \$15.00 an hour, and the rest of the staff are being paid \$11.00. That cut would certainly compromise something. Based on what I get paid average, that is the exact amount of what I pay for professional liability insurance. Certainly need that. We don't want to cut on food costs. We do try to provide them, our residents, with a very healthy and delicious, but very healthy diet. We go the extra step by getting ground beef 90 percent fat-free. We get fresh produce rather than canned vegetables, because we understand the hidden sodium and things of that sort that would lead them to decline a little bit faster. So, in comparison with the other cuts from the assisted living facilities, our cuts are minimum. So, thank you for that. But it still will have a serious effect on our cash flow. So, I just wanted to go on record in saying that. Thank you so much, Mr. White and Mr. Cloud.

Response: Comment considered.

Bobbie Riffle (2nd Comment)(Little Rock Public Hearing 10/29/2018)

Comment: I want to make one more. I'm sorry, I don't like public speaking, I'm not trying to hog the time here. But in hearing some of your comments, it reminded me of something else I wanted to bring out. Well, in more like 17 years of dealing with having to have caregivers for my daughter, we started out -- we didn't want to get paid -- well, I couldn't, I'm disabled. I couldn't help. But my husband, he was working and he was trying to help her, and he -- we didn't want to get paid for caregiving because we felt that pay was more needed by other families. We just wanted caregivers that we needed for the help that we had to have. But on the first program, the Waiver program, before the ARChoices, we had a caregiver that -- who almost invariably missed on Monday, and we ended up talking to her about it, she began missing a lot. Well, then DHS come back and started talking about cutting her hours because we weren't using our hours. We wanted the hours, we needed the hours, the caregiver just wasn't showing up. So, the case manager suggested, "Well, if you will sign up on there, you can get paid for the hours and you won't get a cut on your hours." We were trying to save money for the agency, for other people, by not getting paid ourselves -- or my husband, I'm speaking of. But the way it was working, we were going to get cut for no fault of our own if we didn't do that. Well, over all these years, I have seen firsthand how difficult it is to get a good caregiver, to find someone who really cares and can do the work. My daughter, although she only weighs about 60 pounds, she is 47 years old, she has

neuromuscular disease and she has to be lifted for everything. So many people can't lift her, you know, got back problems or this or that. That's an issue. But it's just hard -- I mean, it's just a fact, it is hard to find good caregivers. And we have one now that is a real jewel, that has been with us for six years. She does not have the CNA, but she trains others that have come to work weekends and all that are. She is better than they are. So, DHS has made it difficult to find caregivers because on some programs you require the CNA licensure and others you don't. But the fact of the matter, if you cut out these family members that truly care, truly know, they are with them so much, they really want the best for them, the majority -- I'm sure there may be a few bad apples -- I don't know where you are going to get that from people. There are just going to be -- there is probably going to end up being lawsuits because people are going to die because they are not going to get taken care of. It's just not reasonable. Thank you. And I keep forgetting to tell you who I am, not that I think it's important. I just think this program and taking care of the clients is so important. But my name is Bobbie Riffle. I don't own any company. Right now we could be being paid on the thing we have now for some hours. And they told us we could have 24/7 hours, finally, after a big struggle for these last two years on this new program, and my husband says, "No, I don't want to give up total care of my daughter. I want to keep caring for her the hours that I am able to do it." But he just wasn't able to stay up seven nights a week, going down to help her four or five or six times a night. And at his age, which unless you are older people wouldn't understand, you go back to bed, you don't fall asleep like that. (Indicating) It might be three hours later when he goes to sleep. So, it was killing him. Thank you.

Response: Comment accepted. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this

rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules.

Lenora Riedel (2nd Comment)(Little Rock Public Hearing 10/29/2018)

Comment: I thought of just a few more things. And I know I'm taking up your time, but I really do feel passionate about this. Regarding the gentleman who had made the comments about the tax cuts. Whenever that happened, we were able to give our employees raises. So, that's where that money went to. And, you know, with the way things are, the Wal-Mart this February, they increased their clerks, the cashiers, to \$11.00 an hour. Tell me someone that would rather go into a facility or do in-home care at \$10.00 an hour than go stand behind a cash register all day making \$11.00 an hour. I mean, the level of, you know, maturity and just the experience needed to provide quality work, you know, you are not going to find for everybody. And so, you have to pay that person to give quality work. The one thing that I think I missed touching on, the \$2.00 a day difference, what that was is that the skilled nursing facilities are paid, you know, different than assisted living. They get federal money. So, it costs the state roughly around \$2.00 more to run assisted livings versus skilled nursing facilities, because we don't receive federal money, which is upwards of around \$100.00 a day in federal funding. We, as a facility, we promote their independence. We aren't trying to take away everything. I have had multiple people move in from skilled nursing facilities because they were too high functioning or their families were not happy with the care that they were receiving. And we just had a lady move in a month ago, and she is of the younger age, she is in her 50s, and she has been disabled for many, many years, and she has been in a nursing home for three years. Well, she came to our facility and one of the first things I said, "Well, we go to Wal-Mart every Wednesday." I said, "We have a big bus, we take everybody that wants to go. You can do your shopping, you know, we are there to help you." And that just floored her. Because at the nursing home, she wasn't able to do those things. So, all she has done is told her family and friends how much she loves going to assisted living versus a nursing home because she is getting to keep that independence. And she told me this Wednesday that she didn't have any money, but she just liked getting out. And just, the weather is beautiful, she is like, "I just want to get out, because I didn't get that." She has no family, so she never got to leave the facility. I think that Michelle had touched a little bit on the violating residents' rights. And I feel like this amendment that they are proposing is definitely in disagreement with that, because it's taking away their ability to choose what living they want to do. And when facilities have to stop taking Medicaid residents because they are not being reimbursed as much as they would a private pay resident, it's only going to hurt those residents that can't afford the private pay rates. And our facility, you know, we have people coming in all the time and saying, you know, "Your private pay rates are so low." And our owner/administrator, she always says, "Well, I just want to make it affordable for everyone." But, you know, even at \$3,200.00 a month, there's not many people that can pay that out-of-pocket. And, you know, whereas, you know, we are 30 minutes from Fayetteville and they are upwards of \$5,000.00 to \$6,000.00 a month for assisted living. So, I don't feel like we are over-charging people. You know, we are not in it to make millions of dollars, we are in it to provide care. Our owner/administrator has been doing this for 24 years, and, you know, she is very, very passionate about it. And then, you know, one more thing is that we love our residents. And sometimes we are all that they have. They don't have family that can take care of them, unfortunately, and so we are their family, you know, and we are their biggest advocate. So, whenever something happens to them, not only in the facility, but, you know, we are advocating for them, too,

because we don't want them to go to a nursing home, we don't want them to have to go to a senior apartment where they are not able, you know -- to receive 20 hours a week of help when dementia does not turn off at 4:00 o'clock p.m. If anything, it gets worse at 4:00 o'clock p.m. And that type of thing, I just feel like if they just kind of step back and look at this as a whole, instead -- whenever you start limiting facilities on what they can do, the quality of life, the quality of care is limited, as well. And, you know, we are like I said, we would have to cut roughly ten to 14 residents -- or not residents -- cut employees to make up for that difference from our 56 Medicaid residents. And how can I look at ten to 14 people that are in my hometown that have worked for us for years and say that, you know, "I'm sorry, but you don't have a job"? And that's tough. Because it's people I went to school with, it's people whose families, you know, have family in the assisted living. And it's not right. And I feel like that they just need to step back and look at this as a whole a little bit more and know that a 21.7 percent cut is not possible. It's not possible to keep the doors open, especially for rural facilities or facilities that are, you know, more than 50 percent on Medicaid. So, thank you for your time.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

Amanda Stone (2nd Comment)(Little Rock Public Hearing 10/29/2018)

Comment: First I would like to say -- Amanda Stone. Sorry. First, I would like to say that my aunt is a registered nurse, she has been in nursing for 30 years, and I think 28 of them she has been at the same nursing home. I won't say the name of it, because I think it has changed names. But I know how hard it is, just by listening to what she has told me, that what goes on in nursing homes. She, herself, has seen bad things happen to patients in there, and she has watched family members come in and walk out. So, for some people, at-home care really is the best care. Before my dad -- my mother and father-in-law moved in with me, my father-in-law had a diabetic ulcer on his toe. I think it was like two weeks before they moved in with us, the ulcer was so bad that if you shifted it just a tiny bit to the left, you could see

the bone. They were talking about amputating his toe. We convinced him to give us two weeks. His toe was halfway healed. We asked him to give us a little bit more time, my husband healed his toe, he has. Now my dad has this little bitty cute scar on his toe, but he has his toe. Somebody said something earlier about at-home caregivers need to have training. They have to go through training. I have been being paid as an at-home caregiver for a little over a year. I'm still waiting for my training. I keep asking about my training, I keep getting nothing. No one knows. No matter how many people I talk to, no one knows. And I heard a lady earlier say something about not being able to give the personal care rides. I sit at dialysis six days a week, taking Dad, picking Dad up. There was a couple at dialysis last Wednesday, her session was going long, she was 20 minutes running over her time. The van showed up, she was still on the machine, the van left. They sat outside for three and a half hours waiting for another van to come pick them up. Why shouldn't somebody that cares about them give them a ride? Because I have seen those vans, they will show up and if you are not ready in four minutes, they are gone. They have a schedule to keep, just like everybody else. And I told you earlier about the things that I do on my calendar. I looked them up. In the month of October, only the month of October, just scheduled appointments that's no ER trips, emergency trips, or basic grocery shopping, or anything like that I had 42 different doctors' appointments that I had to go to in 22 days. So, the money that I get, it goes for the wear and tear on my car and any other necessities that I have to have to make sure my car is able to get these people anywhere. Mom has woke me up at 2:00 o'clock in the morning needing to go to the ER. My car has to be ready. To be perfectly honest, I'm just glad my daughter was off work tonight so I could be here. I have a lot of comments that I will definitely be putting in writing and sending, because there is just no way you can take personal care, family care away from people. It's horrible.

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

Krisee Sims (Little Rock Public Hearing 10/29/2018)

Comment: Hi, my name is Krisdee Sims, and I'm the admissions and marketing director for The Manor, Assisted Living Community in Little Rock. I brought a couple of our ladies that are at The Manor. They appreciate and value the Living Choices Medicaid Waiver. This was used with permission. The Manor. In the past few years, it has been my pleasure to meet residents and their families that have participated in the Living Choices Medicaid Waiver program for assisted living. There is without a doubt not one person that I have come in contact with that has not been blessed that it exists. Through the application process, they have tried to be patient, through the waiting list process and backlog times, they have persevered. But I'm sure all will tell you that they have been so thankful by the availability of assisted living for their loved ones through the Living Choices. It has been my pleasure getting to know my families and our residents. Some are secretaries, some are plumbers, railroad men, homemakers. All are just good hard working folks, folks that could not afford to live at The Manor as a private pay resident. They are thankful for the Living Choices Medicaid Waiver. I think it's important to note that each of us will go through this process one day, whether it be for a loved one or for ourselves. With

today's medical breakthroughs, we are all going to live longer. This brings the question, where will your mom or dad go when they are unable to take their medications correctly, or simply need some assistance going to the bathroom? Prior to the development of assisted living communities, these are all reasons why normal functioning folks would be constrained to a nursing home. To the persons that read all of our comments, know that these cuts you are making will not only affect the poor and less fortunate people that you may not know in our state, one day these cuts will affect your mom, your dad, and perhaps yourself one day. When your mom is faced with having to leave home, unfortunately now a very real option to her is only a nursing home facility due to fewer and fewer assisted living communities that will be available and other available services that are being cut at alarming rates. Now your mom or your dad will live in a concrete block room with only a shower curtain between her and a stranger. Nothing in her life remains but a chest of drawers from her once beloved home and a few family photos of you and your children, decision-maker. Your decisions impacted the last years of your mom's life, along with thousands and thousands of all of our moms. I implore you, decision-maker, to please make your decisions with compassion and kindness, because that stranger behind those numbers that are now being cut, they are someone's mom and dad, and will very likely be yours one day. Thank you.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services, and that actuary developed a recommended rate. The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings.

Jonesboro Public Hearing 11/07/18

Ann Ledgerwood (Jonesboro Public Hearing 11/7/2018)

Comment: Actually, we both have comments. Do you want us to come up at the same time? He will need assistance. Can I just go ahead and give mine while he is looking for his? Will that mess anything up? Okay. While he's getting that, I would say my name is Ann Ledgerwood, and I'm a parent of a son who has severe physical disabilities, even to the degree that if he were in a nursing home he would be considered bedfast because he doesn't have the ability to sit without support, so when he is sitting in a sitting position he needs help to be repositioned to keep from slipping from the chair. He is legally blind, as well. I am here to make comments about a system that is most likely going to be implemented, a system that I have very little knowledge of, but what I do have knowledge of would be the attitudes of the persons wanting to implement the system. First, I have been told personally by members of the agency that I, as a parent, should take responsibility to care for my son who has benefited from the system pre-algorithm. I was quite offended by the statement, because I do take responsibility for my son. I care for him 24/7, as do many other parents. I do not take vacations or sick days. I have given my life up in order for him to have a quality of life. I am not legally responsible for him because of his age, but thank God have the love it takes to give someone the care they need and

deserve, because it's obvious the state, who is responsible, does not have a clue about the time and effort it takes to give someone with these types of disabilities a quality of life. Secondly, I know that with this system the state makes the claim about all the money it will be saving over a three-year period, so that says the major focus is about saving them money and not about the care of the persons who rely on the program. I know that you realize if you save money in one area and spend more money in another area, it's just a way of making citizens believe you are being wise with taxpayer money. But give people credit for being smarter than that. If you force individual into institutions, it will cost the state more money. Third, I know that you're destroying program that was designed to give individuals a better life in their homes and allow them to be a part of the community. A quality of life, whether it be recreation or just to have interaction with other persons, was a part of the time allowed previous. With the last two programs, you do not want to include these types of care. Fourth, I know that pre-RUGS, our state had a program that worked without any complaints and families were able to quit jobs, even though it was a struggle to make ends meet, and have the assurance that their loved ones were receiving the care they deserve. This was care given without any benefits, without cost of living, and no one complained. They were content with the program that was working and their loved ones were happy to continue to live in their homes. What I don't know is after the program has been presented how the program will be any better than the RUGS or how it will be effective in keeping individuals in their homes. What I don't understand would be why our state would be happy to offer insurance premiums for able-bodied citizens without children and then begrudge money being used to give very much needed care to our elderly and disabled. And I don't understand if we make cuts to the program why we would add yet another agency to help in managing the system, which will be a total of four agencies who will be coming into the home now to administer to one program. I have family members that have been confined to a nursing home, and I know personally that my son receives better care, one-on-one, and if you calculate minute per minute, he receives more time than he would if he were placed in an institution. I cannot understand the reasoning for wanting to slash when DHS has published the cost for nursing home care and it is a much greater cost for less individualized care. The new system you want to implement may be a notch above RUGS. Of course, that is yet to be determined. But it is far from a system our elderly and disabled deserve. Let's get back to the purpose of the program and focus on the needs of the severely disabled individuals and allow them a little bit of peace for a change. The disabled have suffered enough hardships without the state giving them added burdens. I believe if we were more concerned about the well-being of the clients on the program, we could work together for a better program than for what has been happening. Thank you. And this is my son's.

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

Bradley Ledgerwood (Jonesboro Public Hearing 11/7/2018)

Comment: I think this is it. My name is Bradley Ledgerwood. I'm on the ARChoices program, and I have a life thanks to this program. If I didn't have this program, I would be in a nursing home because I am a full care patient. And I don't think DHS realizes what is involved in my care. So, I'm going to give a little demonstration to everything I have to do. I prepared remarks I want to say tonight, but I can't see to

read them because I'm legally blind. So, I'm going to turn the microphone over to my mom, and she is also my caregiver, and have her read my remarks.

Response: Comment considered, please see response to full comment below.

Ann Ledgerwood on behalf of Bradley Ledgerwood (Jonesboro Public Hearing 11/7/2018)

Comment: My name is Bradley Ledgerwood. I'm here today to make comments about the new DHS system is proposing. First thing I would like to say is, I don't know why we are here, because it appears as if this is just a dog and pony show. It seems as if our comments aren't considered, or at least the comments we made in July were a waste of time. I would raise the question why the state would be so insistent on cutting hours for persons who qualify for nursing home care, because we all know home care is a whole lot cheaper than nursing home care. I live every day scared for the destiny of the disabled community. It hurts when you see a huge raise given to government employees to destroy a good system that allowed the disabled to be a part of the community. It is difficult to comment on a system when DHS does everything in secret, but we do know the nightmare we have lived the last three years. We feel, from looking at the program, that it is still designed to cut and it has cut hours in other states. I'm urging you to go -- sorry. I'm urging you to go back to the system you had pre-algorithm, back to the days before you broke a good working system. I would like to see this system you are proposing be administered and allow the disabled community to see how it works before it's adopted, because we know very little about the system, how the system will actually work, and it appears cuts can be made after the first two years. I would like to see a commission of disabled people, legislators, doctors, and caregivers coming together to design a new program that works and not just DHS making changes when it's obvious you don't know the needs. You cannot understand the needs of the disabled community when you are not a part of the disabled. I was told not to take this personally, but when it's the life you live, it's difficult not to take it personally. We feel like in your eyes, we aren't a productive part of society, and therefore, our life, health, and happiness isn't important. I'm asking you to please just do the right thing and prove to me the people behind this program have a heart and that we do matter. We are only asking for eight hours a day, since our family and loved ones are giving 16 hours a day, uncompensated. Thank you.

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

Michael Dooley (Jonesboro Public Hearing 11/07/2018)

Comment: How are you? Did the state send out packets on this program? Did the state send out packets? I have a statement, but it's not directly from the state. That's what I'm asking, did the state send out any packets? About the information? The new information? All right. My name is Michael Dooley. I have been on the Arkansas Waiver Program since 2002. I have had to fight with Medicaid, DHS a lot in the last 15 or 16 years. Before the new programs came out in the Waiver Program I got eight hours a day, seven days a week. And then, when the system changed to the algorithm, I got 37 -- I'm getting now 37 hours a week, which is about seven hours a day, five days a week, because they don't allow people to work more than 40 hours a week anymore. And so, I get care five days a week, and on the weekend I have no care. But my mother takes care of me and she don't walk out of the house on the weekend, she is there, and does it, anyway. And I feel that this new program, that it appears to

me from what I have read about it, that DHS is trying to get family members out again. When I started on the program, family members couldn't be paid to take care of me, but then they implemented that. And it seems like now they are trying to take it back away. And that's just not right. Our family members have to make a living just like anybody else does. And for any of our family members to take time out of their life to take care of us, they should be compensated for it, because it's not -- it's not real easy work. And I don't understand the DHS wanting to pay the companies -- outside companies to bring nurses into the home. And if I'm not mistaken, we are offered more hours if we use the agencies instead of a family member. And they pay them a lot more than they do the family member. And I don't understand that. That don't make sense. The algorithm which cut my hours pretty well, I didn't like it, I didn't agree with it, I stated -- made a statement about it when we were allowed to make statements then. This new one seems to be even more complicated and more steps and you still end up in the same place. It's my understanding that they have a nurse come in and ask you up to 400 questions, and then another nurse come in and evaluate you. And irregardless of how many hours they say you get, the budget limit tells you what to get at the end, anyway. So, why do you go through all those steps if you are under a budget limit to begin with? I just don't understand it. It don't make sense to me. I agree a lot with what the lady said, they should go back to the old system. I don't think it's too much to ask for a person to get paid to take care of someone eight hours a day, seven days a week, to keep them out of a home and for them to have a quality of life, which I do. And I don't think it's too much to ask for that. And I would appreciate it if the DHS would consider going back to allowing the doctors to make the decisions. And the doctor can evaluate me better than anybody else and can say what I'm able to do and what I'm not able to do, and let the doctors and the nurses make the decisions, and those decisions be final. Thank you.

Response: Comment considered and accepted in part. DHS proposed restricting the ability of family members or roommates to serve as paid caregivers to protect the integrity of the program, in recognizing the potential conflicts that can arise when Medicaid pays for services provided to a caregiver's family members. But in light of the many public comments received, DHS recognizes the potential access issues that could be created by pursuing this rule change at this point in time. DHS is withdrawing the proposed changes regarding family caregivers and roommates and will maintain the existing language in the rules. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary.

Jacque McDaniel (Jonesboro Public Hearing 11/07/2018)

Comment: Hello. I'm Jacque McDaniel, the Executive Director for the East Arkansas Area Agency on Aging. I have submitted written comments, but I just wanted to highlight a few that we feel are very significant to our program. First, the addition of the limitation on the relative. In some of our rural areas, there may be no one but a relative. Then, you get to implementation. When you start testing your compliance, how are you going to check that? I mean, some of us may not even know who our fourth generation is. At a time when there is a shortage in caregivers, we have low unemployment, and we have 10,000 to 11,000 individuals a day becoming 60 plus, it's going to get harder and harder to fill these roles of caregivers in our homes. Again, back to compliance. Who is going to be at fault? If an aide is working for a relative that's within the fourth generation, are they committing Medicaid fraud, are we going to have to do DNA testing, are we going to have to check court records? How are we going to confirm the fourth generation? It seems very unrealistic and difficult to manage. The second item is the Task and Hour Standards. I do know from the struggle that the ArPath has to be replaced, the RUGS is being kicked out, something has to be done The Task and Hours may be the standard in Texas

and it may be a standard that can be used in Arkansas. I tried to compare the two. They are real similar, but there are some changes. But again, once you implement a system, what about the documentation? If it is only used to determine the level of services, that's understandable. But what I fear is it's going to go further than that and also go to extreme efforts to document tasks, "Did you do two baths today?" If you didn't, do we have to leave that 30 minutes early? You know, how far are you going to take it into the day-to-day? I know in the statements that were sent to CMS, it talked about the individual and their needs and meeting their needs to the best possible services for them. But if we can't meet the needs of a client in their home based on their needs that day without having prior approval, it's really going to lead to difficulties of serving the client, it's going to reduce the services to client, and I think also send an individual into the nursing home prematurely. On the subject of the individual service budgets, again, I don't know, you know, it's complicated. I don't understand it all. I know from billing issues that we have had in the past, when you look at a care plan, you're going to have more than one provider on that care plan. One may be doing the PERS, one may be doing the home delivery meals, one may be doing the attendant care. How are you going to allocate that care plan? How am I going to know as a provider that the services that I provided will be reimbursed, that someone didn't jump in ahead of me, because they may be on a quicker cycle, bill out those services, and again our agency be left with unreimbursed services? So, that is one of my concerns with that option. The Personal Care Rate is not scheduled to be increased. When you look at our services over the last 20 or 30 years, in 1999, the ARChoices and Personal Care Rates became the same. In 2003, the unit definitions became the same, which is a 15-minute increment became a unit. For our agency, what we deal with is the aide serves clients, the supervisors are the same, the aides go to a personal care client, they may go to an ARChoices client, their certification is the same. I don't understand what the difference is for considering an increase in the ARChoices rate and not considering the personal care. In light of the election results last night, we have minimum wage to deal with. So, the situation just became even more complicated. The current rate for personal care is \$18.00. For our agency personally, we are losing money every time we serve an ARChoices client, we are losing money every time we serve a personal care client. And there is just so long that you can do that without shutting your doors on that program. So, I would like to encourage the consideration of a higher rate for both services, and for them to remain the same. Let me see if there is anything else. There is very positive change on the PERS, I want to give kudos where they are due, to go to a monthly rate. My one comment is to go -- again, implementation. If you pay me for a monthly rate but then you prorate that because someone goes into an institution, then we are back where we started. It would be good if there was language to exclude that service for additional billing when someone goes into an institution. There is no way, really, to recoup that money or remove the unit in that short a time frame. When we talked about the rate, I will backtrack a little bit, we have had a minimum wage increase after we got the \$18.00, and now we are facing three more years of rate increases. And also, reading through the CMS comments and looking at the federal law, we also know EVV is staring us in the face. So, the implementation of that additional documentation, technology, our aides are going to be required to do more, and I also fear -- well, I know our costs will be more, and I'm afraid an outcome of that also will be the clients receiving less services. Thank you.

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

Representative Dan Sullivan (Jonesboro Public Hearing 11/07/2018)

Comment: I'm State Representative Dan Sullivan, really glad to be here tonight, and appreciate the comments. We are listening and hearing what everyone has to say. And the comments that follow are going to be my perspective of what has happened. You talked just a moment ago about the providers expanding. When the federal government decided to reimburse a hundred percent on expanding Medicaid to able-bodied working age adults with no children. Now think about that again. These are working age, able-bodied adults with no children, and we are paying their insurance, \$500.00 to \$600.00 a month. Just recently, we found out that we had a -- forgot to submit a report. 18,000 people we found live in multiple -- are receiving Medicaid in multiple states, 18,000 that we are paying that for. In 2017, we found 35,000 people that lived in other states we are paying for. We have, as a legislature, refused -- and it has been the medical society behind this, refused to reduce your cost by allowing advance practice nurses to be a PCP, your primary care provider. The Governor just now is allowing that in the PASSE, but it looks like we are going to tie their hands and not let them practice to the full scope of their licensure. Folks, we have run that bill three sessions in a row, that's six years, and we cannot pass it. It would reduce your cost, it would reduce your patient cost, it would improve care. The medical society has also prevented us from allowing full tele-health to go through. We passed some limited tele-health bills. All of those things for your disabled population would be tremendous. But the medical society has stood in the way of that. There are a lot of things that we can do to reduce your costs, there are a lot of things we can do to improve your access to care, but the money has gone into Arkansas Works and the Private Option, able-bodied, working age adults. And while the feds federal government was paying a hundred percent of that, it looked like a really good deal, and it was, because everything we wanted to do was your federal tax dollar, not your state tax dollar. Well, guess what, those of us that didn't support that, and I never did, I never voted for it because I knew some day it would come out of state money, and when it did, we were going to start reducing programs we had just expanded to where we can't afford them. So, we paid a hundred percent. We had a meeting on Thursday of last week, and the heads of DHS agreed and said, "Yes, our budget is going to be hit significantly, especially in the next 12 to 18 months." So, the federal dollars coming into the state are being reduced. We also pay higher than some of our surrounding states in the rates that we pay. So, not only are we receiving fewer dollars from the feds, the rates that we are paying in some cases are higher than our surrounding states. And the feds are asking us to reduce our rates. So, you know, I will say this on behalf of DHS. I have been in their office a bunch in the last month, they are working hard. It's not for a lack of effort on their part and some of the ideas they have, it's what we can afford. Now, how can we afford to run the programs on a scaled-back dollar? That's what we are going to have to work together on. My position is this, I will never vote for Arkansas Works until we first take care of our disabled, our elderly, and But we need your help, we need your help. When we -- you have heard the phrase, probably when we passed Arkansas Works, "We've got lemons, let's make lemonade." Well, now we've got rotten apples. And what are we going to make out of that? We are going to have to scale and change our programs. You know, I don't -- personally, I have worked closely with the people that are here at DHS, and although we do have disagreements, we have worked well together and they are making every effort to do the best they can. But we've got to change the model of how we operate, we've got to change what our priorities are in Arkansas, and we need your help to do that. I'm working right now with several people here with our senior centers and our Area Agency on Aging to change the model and change how we do our programs. Somebody said tonight, "Contact your legislators." Amen. We can do this together, we can work with DHS, you can work with your legislature, but we have to get our priorities right. And until we do, this problem will get worse. Thank you.

Response: Comment considered.

Melanie Sparkman (Jonesboro Public Hearing 11/07/2018)

Comment: My name is Melanie Sparkman, and I'm with Superior Senior Care, also. You heard from my mother a few minutes ago who speaks very eloquently and from the heart. I'm going to be brief, but I'm going to speak directly to DHS. The constant thing I'm hearing from our legislators, from other providers, from our clientele, is, "Why? Why is all this happening?" And everyone in this business knows that there has been problems with DHS for several years now. The algorithm lawsuit caused a backlog of you not being able to even produce current Plans of Care to us as providers. Some of our offices, half of our clients, we are operating without an actual Plan of Care from DHS because you are so backlogged. Why would you want to implement such a drastic change in these programs when you can't even get done what you have already got? So, that is my biggest question, and that is the question I'm hearing from legislators as to, "Why are you driving this so hard, so fast? Why is there a sense of urgency to this?" Why can we not step back and look at this a little more closely and see the impact it's going to have? Why are we doing this so fast? So, again, I would respectfully request, give us our Care Plans first on our existing clients before you go making these changes. One lady spoke earlier, Ms. Chitwood, I believe, about how clients, when the DHS nurse goes out to evaluate them, almost every time, if there is not a family member to speak up on their behalf, that client, when they are asked questions about their abilities, which determines whether they qualify, we are told consistently by many DHS nurses, over 20 or 30 years of history, "If the client does not answer the question correctly, I'm gone, I'm not approving them. They have to answer the question correctly." Sometimes that DHS nurse is telling us, "I clearly see that this person needs help, but she didn't answer the question correctly." So, again, another problem I would say needs to be addressed before we go making any more of these changes. You know, Arkansas used to be just -- and not that long ago, a leader for our country. We were probably one of the top three states in the country in regards to services for our elderly and disabled. I don't know where we rank now, but I would gather it's not in the top three. Fraud. You know, we all report fraud and we don't get much response, we don't see much action. You have situations where agencies are going out of business, leaving their caregivers holding the bag, not paying them, they turn around, submit another application under another business name and they open right back up. I don't know how many times we have called and reported things, and other companies, reported the same thing occurring. Nothing happens. You have situations in certain areas of the state where clients are signing caregiver service records and agreeing, "If you pay me part of your check, you don't have to do anything for me." You have agencies that are signing people up to get some of these services that don't qualify, they just want a housekeeper. Now, a company like Superior Senior Care who has been in business over 30 years, we didn't stay in business for 30 years by doing fraud, so we are not one of those. And most of the people represented here are not committing fraud. So, you know, I'm not speaking to anybody here. But we all know that this happens, and we all know that we are getting no, you know, consistent reaction from the state to address these problems. Why can't we address these problems instead of cuts to save money? You are going to move thousands of people from this Waiver program across the state into three categories. They are either going to wind up on the PACE program, in Independent Choices, or a nursing home. That's basically what is happening; right? So, the PACE program is capped at a limit to what they can sign up. That's not going to address all the needs. Independent Choices is wrought with fraud, because family members -- yes, I agree there are many situations where family members need to be paid to take care of their loved ones because they do need to make a living. But there are so many cases that are going on that family members are getting paid for basically doing nothing. Why can't we have more oversight on these programs? We, as agencies, certainly feel inundated with oversight, added bureaucracy, added paperwork. We are hiring additional employees to deal with these demands from DHS with little or no complaint. Ten years ago, DHS was begging for providers in this state. We were -- besides Area Agency and the Health Department, we were the first one, so we go back a long ways, so we know this history. So, ten years

ago, when numerous companies started opening up in the private home care industry, we saw that as a plus, because we have always advocated that competition breeds better quality care. Now, you have all these providers in the state and numerous options for clients, but DHS is having to deal with more agencies. I, for one, have heard complaints from DHS employees complaining about, "Oh, I've got to deal with so many different providers now." Well, you know what, you asked for it. You asked for more providers a decade ago, now you've got it, and now you are wanting to put half of us out of business? Because that's basically what I have read has been said in the paper, that's basically what I have heard from various other sources in meetings and so forth. So, I just say, this is ridiculous, absolutely ridiculous

Response: Comment considered. DHS understands that many providers are concerned about the viability of the independent assessment process and its relationship to the prior authorization process. Optum has now performed more than 50,000 independent assessments in Arkansas. The results have supported the accuracy and validity of the IA system. Independent assessments are a federal requirement for Medicaid waivers for home and community-based services. To be clear, although Optum is responsible for conducting independent assessments, Optum does not perform the function of prior authorization. DHS has worked to improve its internal processes in handling prior authorization requests and will continue to implement changes to improve the reliability of those processes.

Melissa Prater (Jonesboro Public Hearing 11/07/2018)

Comment: Hello. I'm Melissa Prater, I'm with the Area Agency on Aging, as well. And everybody that has spoke tonight has been -- made very valid comments. I don't think anybody in this room disagrees with it. I'm going to talk a little bit about senior centers, and you are probably going to wonder how that applies to what we've talked about tonight. And how it does apply is, our senior centers in -- across the State of Arkansas provide the home-delivered meals a lot of times for the ARChoices clients. And those of you that are in the home care situation know that that sometimes is the only meal that they receive during the day, during the week. Those that receive frozen meals receive them during the weekends, also. One of the new regulations that is proposed with the ARChoices home-delivered meals is that for those clients that receive frozen meals, if they do not have an in-home care attendant at least three days a week, then the senior center has to call daily to check on that client. Now, in reality, that sounds like a great idea. We in the senior center business would love to do that. However, like any other entity, we have suffered very much so cuts in funding, we have had to close senior centers, we have had to cut our hours. It is all we can do to deliver hot meals, much less frozen meals. And I will say the senior centers that we oversee in northeast Arkansas do not use frozen meals unless we have to, which means that's in the most rural parts of our counties. So, that's a huge undertaking on our staff to make those phone calls daily to those clients. We would love to -- we would love to give hot meals to every client in northeast Arkansas if we could. But that is, again, kind of an unfunded mandate, like we have all talked about tonight, that is required of the -- would be required of the senior center staff. You know, I have been at the agency for almost 19 years, and I have been under the directorship of many great people. I'm the third director since I have been there, and we have had good leadership. And one thing that I have, I guess, experienced with my time at the agency is, over the past couple of years it seems that DHS has wanted to strengthen, as someone said a while ago, the home and community-based services. And a couple of years ago there was talk that there should be savings -- there needed to be some savings in the long term care services, and it was almost agreed upon to some extent that that really couldn't come from our services, our home and community-based services. You know, where are you going to cut, there is nowhere to cut; that, really, that should come from the nursing home industry. And with these new changes, it doesn't appear that that is happening. The cut is not coming from the nursing homes. It's almost like they are trying to push more clients to the nursing home and make those

cuts come from the home and community-based services. And that's really not right. You know, our clients are not going to benefit from that, as we have heard tonight. And, you know, we try to work our best with DHS and the rules and regulations that are asked of us, but like Kathy and Jacque and everybody else has said before me, it's -- these new rules and regulations make it very hard to serve a client adequately. And so, when you look at the full circle of services from -- whether it's in-home services, or PERS units, or home-delivered meals, the cuts seem like they are trying to come from our end of it as opposed to the nursing home end of it. Thank you.

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

Becky McDaniel (Jonesboro Public Hearing 11/07/2018)

Comment: I just don't think I could leave here tonight without saying -- Becky McDaniel, and I'm Director of the PACE organization here in Jonesboro. There are two PACE organizations in Arkansas, one here in northeast Arkansas in Jonesboro, and the other in North Little Rock, one opening soon in January up in northwest Arkansas. PACE is a program of all-inclusive care for the elderly, it's for folks 55 years of age and older -- and older, that qualify both medically and financially. It is an all-inclusive program, we take care of all needs that a patient has. It is comprehensive. I just want to thank the State of Arkansas for letting PACE come to Arkansas. Craig Cloud has been there, he knows what we do. I want to invite Mark to come and see who we are and what we do. It makes a world of difference. We are a radical program, we do things a lot different. The patient gets more than they would ever get. We save the State of Arkansas about 14 percent right now when we keep a patient out of the nursing home. And our goal is to keep them living independently at home as long as possible. So, I'm just a really big PACE supporter. We provide personal care, anything that that patient needs. So, thank you. And I appreciate you guys, and thanks for coming tonight.

Response: Comment considered.

Belinda Davenport (Jonesboro Public Hearing 11/07/2018)

Comment: Hi, my name is Belinda Davenport, and I work for Ozark Adult Personal Care. We have about ten notarized statements from patients who are against the possibility of not being allowed to have their family members as a paid caregiver although they are qualified to do so. Some of the statements are from patients' family members because the patients have dementia or head injuries and they do not well -- do well with strangers. Not allowing a family member to go and take care of those patients, it really hurts them, because, as you know, family members are the ones that are going to go above and beyond to keep them in the home. They are going to do extra work without being paid for. Some of our patients just get three hours, and the family member is there for the entire day trying to help them survive, basically, each day. The places that we serve are counties that -- where patients live that they are -- they only have one family member, they are the only option that can serve them. So, not allowing this family member to take care of them, what will happen? We won't have anybody to go drive miles and miles. We even have a patient that you have to leave your car down the hill and walk two miles to get to them. So, if it's not a family member, how can we tell an aide, "You are going to" -- "We are going to give you this patient, but you have to walk two miles in order to get to them"? As you guys know, it

won't happen. In my opinion, if an aide is qualified to be a caregiver, regardless if they are related or a stranger to the patient, the patient has the right to decide who they want. I believe if you put a family member as an aide, or versus a stranger, we get more calls from the patient, say, complaining about this aide saying that doesn't show up or doesn't know them very good or doesn't cook what they want. A family member does all those things. Family members are more dependable, reliable. So, basically, the bottom line, to me, is that each family, each person, each client, has the right to choose a family member to be their aide as long as they are qualified caregivers. How can we tell somebody you cannot take care of your own son, your own mother, when you are a qualified caregiver, but go take care of a stranger? So, like I said, we have those letters, we can give them to you. Because we really believe that it will make a big impact not allowing a family member to take care of their own family. Thank you.

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

Eva Chitwood (Jonesboro Public Hearing 11/07/2018)

Comment: I'm kind of like Gary. My name is Eva Chitwood. And the reason I'm like Gary is because Cliff told me to keep my mouth shut. But anyway, the one thing I have to say is, shame on us, shame on the government, shame on the feds, shame on the state. We have known since 1950, after World War II, what was going to happen with the baby boomers. They were going to hit about now. And every year from now until -- through 2030, there will be 10,000 a year coming on board. Now, with those 10,000, I guess what we are going to do is essentially send them to death camps. I mean, actually, sometimes I will be driving down the road and start thinking about these changes and where we are headed, and I will actually start crying, because I can't believe it. Some of these people that we serve were veterans, and for some reason, they can't get the benefit so they can go to Memphis. A lot of our seniors are making, in Social Security, less than \$1,000.00 a month. They still have to pay rent in the project, it's not free, they have to pay utilities, they have to buy -- do the co-pay on their meds, pay what they have to do to the doctor. Many, many, many times, if our CNAs didn't take them a sandwich when they did their shift, they wouldn't have anything to eat that evening. So, you know, what we are saying now is, "We are just really going to pull the rug out from you guys." I mean, my girls don't make that much. I mean, I pay more than the minimum wage, I pay their fuel, I do what I can to keep them going. But our reimbursement is -- I don't know many businesses, even a Dairy Queen, that could operate and make profit on what we are given. The continued adding of more work for our offices with all these changes is going to put us out of business. I am a very small business. We are really hands-on. We know all of our clients, we know -- as they say in my neck of the woods, we know all their peoples, and we take pride in caring for them. I don't know -- I know the state is looking to save money. For every dollar of Medicaid money, and I'm sure everybody here knows it, we get some from the feds. And I pay enough taxes, I would just soon come -- have it go to Medicaid as overseas. But I can't understand how we are saving money with any of these programs. If you have to hire a company to watch a company to watch us, you've got to be paying them something on top of our \$18.00 an hour. So, where is that coming from? I mean, if we got an increase, I mean -- and I do think we all know there is fraud in this business, we have to watch our people carefully, and all of you know that. But we report fraud, we don't get any reaction. I have reported the same thing about nine times and I don't get phone calls; send e-mails, don't get an answer. So, I mean, we've got a lot of problems in Little Rock, we really, really do. And I guess, you know, the one thing that I can say is, you know, we just have to all get on our knees from

now on and just bless each client we've got to take care of them. I guess I broke my teeth in on VA. I was with the VA in Fayetteville for many, many years, started very young, and they trained me and raised me. In some of -- the Patients' Bill of Rights was always key in anything, when the Joint Commission was coming, you had to make sure that was posted everywhere. I can remember talking about patient-centered Care Plans, all of the things that we are throwing down the tube now. You can't -- the one thing that I have found most disturbing, and I think -- I think you probably were in on a conference when we had a hearing, and I did say in this hearing, an Optum nurse can go to the same client five times and get a different opinion or a different answer on every question. You know, I have a man that I love dearly and I visit him a lot, he is a double amputee. And every time I go see him, he tells me he just got back from fishing, he is glad he got there in time to see me, and he tells me about how many he caught, where he caught them. We go through this whole thing. And I agree with him. I ask him if he has got any left over to give me I can cook for supper. Well, he has given them all away by then. The thing that is wrong with that story is, he tells about driving his truck. He doesn't have a truck, he hasn't been fishing. But I do believe if an Optum nurse had come there that day, might go away thinking that man could do for himself. And that's a big concern of mine, that on any given day -- even my parents were that way. But anyway, that's -- I hope Cliff doesn't read that I said something. But anyway. Thank you.

Response: Comment considered. DHS understands that many providers are concerned about the viability of the independent assessment process and its relationship to the prior authorization process. Optum has now performed more than 50,000 independent assessments in Arkansas. The results have supported the accuracy and validity of the IA system. Independent assessments are a federal requirement for Medicaid waivers for home and community-based services. To be clear, although Optum is responsible for conducting independent assessments, Optum does not perform the function of prior authorization. DHS has worked to improve its internal processes in handling prior authorization requests and will continue to implement changes to improve the reliability of those processes.

Ruth Cullum (Jonesboro Public Hearing 11/07/2018)

Comment: I was hoping for a larger turnout tonight. The small turnout, to me, personally, as a home care provider, makes me wonder why aren't we out saying more and doing more. By the way, I'm Ruth Cullum, Superior Senior Care. I am a franchise owner of Superior, and I have seven offices, Jonesboro is one of them, I have in the northeast corner of the state. I am also a social worker. So, as a social worker, I have a real passion for those people I serve. I have worked on both sides of the coin, I have worked in nursing homes, I have worked in home care. I tell people I cut my teeth in nursing homes, and I did. It was the hardest work I've ever done in my life, I wouldn't go back to it for anything, but I wouldn't take anything for the time I spent. It was the greatest learning experience of my life, and it literally prepared me for what I do now. I would not be the person I am were it not for that nursing home experience. I do not knock nursing homes. There is a time and a place for them, and there are instances where that is really the only choice. But with that said, having worked for the last 23 years on the side of in-home care, I have become a very strong advocate for in-home care. I see what it does for people, I see that it works. ARChoices has been working. Why we're trying to make it broken, I don't know. It wasn't broken, people. Why are we trying to fix something that was not broken? The changes that have been coming -- and I will tell you, as a provider, probably the last six years, I have seen every year the hours go down and down and down and down and down. (Indicating.) We providers have been living with cuts. This is not anything that has just happened, we have been living with it. So, it has been coming slowly and gradually, and we have endured it. But this is something altogether different. And this is not only hurting us as a small business as a provider, but it's hurting these people. Why anyone would want to do that to them, I don't know. It's beyond my comprehension. This has been the hardest thing I have had to deal with in my career as a social worker and as a person owning a home

care agency. I believe it's unconscionable that we would even think of not wanting to take the best care of our senior citizens, our elderly, our disabled. They are a forgotten segment of society, people. Are we going to pass them off and say they don't count, they don't benefit, and force them to nursing homes? Don't fool yourself. This is going to force people into nursing homes whether you like it or not. And if we allow it to happen, we are part of the problem. We are part of the problem, and we have to live with that on our conscience. I hope each one here will go out and spread the word to anybody that will listen, in particular, your legislators. I have talked to a numerous amount of them, and they are very sympathetic, they will listen openly and honestly to you. And I suggest you talk to each one of them that you -- and bend their ears. We need our voice to be heard. We don't need these changes, we don't need it. I loved what the lady said earlier about choices. You know, I thought the same thing, when they merged Elder Choices and AAP, the adults with physical disabilities, someone had the forethought of calling it ARChoices. That didn't come by chance, people, it did not come by chance. Someone knew that these people needed choices, they needed options in their life. And as the lady said earlier, we were a few years ago all about giving options, from in-home care to independent choices where they get their own person, to assisted living. By the way, they are going to be hurt dramatically, too, don't think they are not. And all these other ways that we can creatively give someone a choice. We are taking that away with this, we are taking it away. And I will just tell you, as a provider, the changes that we have been enduring for the last year with the addition of Optum and the algorithms and all of that the last few years, it has been nothing short of disastrous. It has not worked, it has not worked. It is very hard for me to put my trust in DHS when so many things have happened that have told me quite the opposite, that they don't have it all together because it hasn't worked, I'm having to put on more staff just to handle all the aggravation and the extra time to be able to keep these people on the program, keep their prior authorizations going, and make sure we provide the care. So, it hasn't been easy. It has been difficult, it continues to get more difficult with every passing day, and we have dealt with it. But this is enough. It's enough to do it to us, as providers. Don't do it to these little people. Why would you want to do that? The heart has been forgotten in this. We are thinking with our pocketbooks, people, we are not thinking with our hearts. If you ever had a mother, a father, a grandmother, or grandfather you ever loved and adored, I suggest you put their face in front of you and keep it there from here on out and remember what they were about and what they would have wanted. I promise you they would not want to be forced to a facility. I will give you a couple of examples. Again, I'm drawing on my nursing home days. I worked in a small nursing home in the suburbs of Chicago when my husband was working up there. Looking back, it was a good facility, well run, and small, so it was easily managed. But I was green, I was -- I didn't know a lot, but I learned a lot and learned quickly. One day a nurse told me, "I will take enough medicine when I leave this place that I won't come back here as a patient, I won't do it." Now, at the time I thought, "Oh, how horrible. How can she say that?" But as I've lived this life and done the work I have done, I understand why she said that. I may not agree with it, but I understand why she said it, I do. I will give you an example of a client years ago in Mississippi County. She was reaching the point where we weren't sure if we were going to be able to keep her at home because the care. And we were getting as creative as we could. Someone mentioned split shifts. That's a nightmare for scheduling for an agency. But you know what, if that's in the best interest of the client, we are going to do it, and we do it. We'll go in in the morning, get them up, get them going, fed, dressed, meds, and put them in a chair, come back late afternoon, get them fed, get them cleaned up, get them ready for bed, and come back the next day. Don't think these people are getting exorbitant amount of hours. They are not. They are getting by on the bare minimum right now. Don't think they are getting a lot. But this little lady in Mississippi County, when I suggested that maybe she needed to consider nursing home, she said to me, "Ruth, I will kill myself before I do that." She meant it, she meant it. Again, I have nothing against nursing homes, and there is a time and a place for them. But I do know that if you can live your life out in the comfort of your home, you are

going to do a lot better. I don't know anyone that wants to go to a nursing home. Do you? Not one person. So, what I say to you is, and to DHS, think with your heart for a moment, not your pocketbook. Think with your heart and think of the people you will be harming. Everyone has done a wonderful job of listing all the reasons why this is not going to work, so I'm not going into that. But you are going to hurt a segment of the population that couldn't be here tonight or they probably would. And I don't think anyone wants that to happen. I will relay one other instance that has happened in society that when all of this started happening came to my mind, and this was straight from social work class in college. Back in the '50s and '60s, the mentally ill were what we called warehoused. We didn't know what to do with them, so we stuck them in a facility, forgot about them, and we did what is called warehousing. Now, you Google online if you want to and you Google that subject topic and read for yourself what a disaster that was. There was someone that thought, "Oh, let's release them, we will save lots of money," and that's what it was about, "We will save lots of money." They did that. And now, the mentally ill are in prisons, they are on the streets. We made no provision to try to take care of them. This is basically the reverse of that. We are forcing our elderly and our disabled into nursing homes. That's the bottom line. It's going to happen, people. If we allow it, that is what is going to happen. We providers may not be able to survive. I don't know. There will be people out of work, there will be businesses shut down, people can't pay their bills, nursing home -- assisted livings, you know, some of these places borrowed money to get started on. Do you think the bankers are going to be happy when they have to shut their doors? There is so much that's going to happen. This is so, so wrong in every shape and form. If we don't fight it, we are part of the problem. I care. I care enough to come tonight and say this, care enough to speak out, care enough to talk to people and help fight this. I hope you care, too. I hope you care about those people.

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

Kathy Frames (Jonesboro Public Hearing 11/07/2018)

Comment: My name is Kathy Frames, I also am with East Arkansas Area Agency on Aging. Most of the comments I had have kind of been addressed. I have been in the home care industry for over 25 years, and I don't think I have ever seen as many changes roll out at one time than I have the past two years. The new proposals, there is too much to consider, not enough time for us to soak it in, understand it, much less try to implement it. One of the things I wanted to mention was -- that has not been addressed, what happens if someone does get assigned a Tier 3? This is somebody who has been on ARChoices and now they are getting assigned to Tier 3. It's clear to me that they have the option to wait it out and stay home, not go into the nursing home. The beneficiaries that do hold out and they are steadfast, they are trying to stay in their homes, they are going to suffer physically, mentally, and socially. They also are refusing to go to that nursing home. So, what happens to their Medicaid and the benefit of that Medicaid that they had? Will they lose their in-home care services? Will they lose the Medicaid benefit altogether? If so, how will they pay for their medicine, their medical bills? They will lose the \$120.00 that they are not having to pay out for their Medicare premium. Then, their doctor bills, hospital bills are going to mount up. So, they are going to be forced, then, to decide between medication or food. They will have mounting bills at their physician's office due to not having the

Medicaid to be that supplement. How will they pay for incontinent supplies, DME? And so, basically, what happens then, the state will have starved them to death because of the lack of these services. And at that point, they will either die at home or they will be forced to a nursing home. In the home care industry, we do feel like there needs to be some changes. About five years ago, it seems as though the big talk with LTSS was that it costs more to be in a nursing home, so let's improve services, quality of care, and do the best we can to keep these people at home. But now, it's like the pendulum has changed, and now the swing is to force you into a nursing home. And we strongly disagree with this. And I just was sitting there thinking as we were speaking about all the different problems and the name "ARChoices" has the word "choice" in it, but I feel like the choice of those who are receiving the care is being taken away and it is being dictated as to what their outcome will be and what is going to happen to them. Thank you.

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

Kevin Deliban (Jonesboro Public Hearing 11/07/2018)

Comment: Good evening, everybody. My name is Kevin Deliban, I'm an attorney with Legal Aid of Arkansas. As some of you know, Legal Aid has had over 150 unique clients with around 180 cases over the last three years, all around Arkansas -- or ARChoices. Through that time, we have learned an immense amount about what works for program beneficiaries, what doesn't, what is important to them, what isn't. And we are very gratified that actually two clients could be here tonight to express personally what this means. Now, it's important to note that this is the first time that DHS has solicited any sort of input from beneficiaries or beneficiary advocates at all in the process. We have been fighting with DHS over their unlawful use of the RUGS algorithm for the last three years. It had all sorts of problems, not giving people enough care, not being able to be understood by the agency, itself, let alone the nurses who administer it, and, of course, not the beneficiaries, who are the ones who have to live with its determination. So, again, by proposing something that is essentially in final form before receiving any sort of input from the people most effective -- most affected by the changes, DHS, again, displays a troubling attitude towards the people it serves and disregard of the people it serves. Now, through all of our experience, we have learned essentially that people care about two things -- people on the program care about two things. And if I say anything wrong, I invite Michael or Bradley to come up and correct it. Number one is, folks want something that's going to give them the care that they need to exist independent of a nursing home in a minimally dignified manner: Just getting enough to get yourself cleaned up after the bathroom, not having to sit in a wet diaper, being able to be turned when you are getting a pressure sore, being able to take a sip of water because you can't reach it on your own. These are not extravagances. These are things that all of us take for granted in our day-to-day lives. Now, with eight hours a day of care as it was before the RUGS algorithm, folks like Michael and Bradley were able to just barely get by. They have family members who come in and occasionally provide free care. Is it strange at all that nobody here who is on the program who doesn't have a family member didn't show up? How would they? How would somebody who doesn't have a family member come to this meeting? How does DHS propose to get any sort of information from them? They don't. And with the changes that DHS is making to what attendant care can be used for, that person, if they

wanted to show up tonight, could not. Their attendant could not be paid to help them participate in any sort of community activities, let alone this, because of DHS' changes. I don't know any irony greater than that. Perhaps Mr. Cloud or Mr. White could go drive them and bring them here with their personal vehicles. Now, let's get into the details -- oh, the other thing that people care about is something that's understandable. A lot of clients understand maybe if their condition has gotten better, that maybe they should get a little bit of reduction in hours. And they understand that if their condition has gotten worse, they should get an increase, and maybe the increase can't be as big as they want. Clients understand that. But you know how they understand that, is when it's explained to them. There is legitimacy in transparency. Because suddenly, if I'm on the program and I know that the reason I got cut is because, you know, I got a little bit better and my bed sore isn't as bad and I don't need quite as much care -- wound care, well, then I can accept that. But if I don't know why I'm being cut or why I'm getting a particular cut of hours and it's a black box, there is no transparency and there is no legitimacy to that. So, again, two main client concerns, enough care and something understandable. Now, these proposed changes have problems on both counts. First of all, remarkably, after we've been through three years of a fight over an algorithm, DHS does not have, or has not provided, despite multiple FOIA requests, the algorithms that are going to translate that 400-question assessment into scores for the needs intensity tool and the budget level. So, what DHS is going to do, right, is for somebody like Michael or Brad, they are going to say, "Well, how well can they eat on their own?" You get a score between a zero and three. That score is determined by an algorithm. DHS does not have or has not provided that algorithm. It is certainly not part of these published rules. Multiple FOIA requests over time. Secondly, that -- another algorithm, a separate algorithm is going to decide which individual service budget you get put into. There are three possibilities, \$30,000.00 a year, which is \$2,500.00 a month, \$20,000.00 a year, which is \$1,667.00 a month, or \$5,000.00 a year, which is, you know, 400 some-odd per month. DHS does not have or has not provided, despite multiple FOIA requests, the algorithm that is there. So, we have been battling for three years over an algorithm where everything is foreseeable based on how that algorithm works. You can look at who gets put into what category, everything else, based on what you know. DHS hasn't provided that or made it part of the public promulgation. So, we can't know how likely it is that somebody like Bradley or Michael end up in the most severe categories. And if they don't end up in the most severe categories, where do they fall and how much care is possible under that? We have no way of knowing that, which also means that DHS has not projected what the impact of these changes will be on individuals at that level. So, they are repeating the mistakes made before of driving blind into a system, they are going to impose it on a bunch of beneficiaries, hope that they don't holler like they should, and maybe try to get this in fly by night, just as it was under the RUGS system. Now, moving on beyond the lack of transparency and understanding of the algorithm. You have this individual service budget that appears to arbitrarily limit services that are deemed medically necessary. So, let's just assume for argument's sake that Bradley, under the Task and Hour Tool, can get eight hours a day. Let's just say the algorithm works in such a way that he is actually assigned eight hours a day of care. Well, Bradley's budget might not allow him to actually purchase those eight hours a day of care. In fact, at the rate of \$18.12 per hour, DHS, in their own estimates, has said that the maximum number of hours that will be available, at least through a care agency, would be -- again, this is best case scenario, which means it is probably not going to be the truth for everybody -- 201 hours a month, 46 a week, six and a half a day. That means that if somebody in Bradley's situation is medically determined through DHS' own obtuse tool to need eight hours a day of care, it's medically necessary, the budget is going to cut him off and say, "No, you can't get more than six and a half." So, the budget arbitrarily limits care that is deemed medically necessary. Now, DHS came up with these figures doing funny math. They say the \$30,000.00 budget limit is derived from the cost to the state of nursing home care. Now, in other places, the state estimates, very recently, when they want to penalize anybody, right, they estimated that the cost of nursing home care

is approximately \$5,500.00 per month. So, if the cost of nursing home care is \$5,500.00 per month, why are people only able to get \$2,500.00 a month of services? And if they can't maintain on whatever that \$2,500.00 a month can buy them, if they are lucky enough to get into the category that gets \$2,500.00 a month, DHS says, "Well, you've got to consider other options." Like what? Nursing home. We can turn this into a call and response night, right? Which is in blatant violation of a Supreme Court decision called Olmstead, and community integration mandates, and just basic human decency. So, DHS would rather force somebody into a nursing home instead of consider adjustments to the amount that people can get. Now, DHS might say, "Well, look, we've got an exceptions process, a one-time, one-year, we can adjust that \$30,000.00 limit, that \$2,500.00 a month limit if exceptional circumstances are there." What are those exceptional circumstances? Death of a family member, death of a caregiver, you just got discharged from the hospital. Those are exceptional circumstances. That doesn't address somebody who might be in fairly stable shape but who simply has needs in excess of six and a half hours a day of care, which many of us in this room know about. So, there is the arbitrary limitation. Now, people are going to be particularly hard hit who choose agency care. DHS has been unclear on the math that they are going to use for people who are self-directing their care. DHS in formal documents has said, "Well, people get to decide how much to pay their caregiver, and therefore, that might affect how many hours they can buy under the budget." Okay. Now, again, that's not totally clear and transparent, but let's assume that those folks can get a little bit more. People who are going through agencies will not be able to get any more than 201 hours a month of care, if everything falls perfectly and the stars align and, you know, the river rises to 27.2 feet. So, they are going to be the ones hardest hit. Now, it also discriminates against them because if people who self-direct can get more care than people who don't self-direct, there is some artificial distinction going on. Now, Legal Aid of Arkansas supports fully the ability of people to self-direct their care. That's an important option. Brad should be able to hire his mother, right, Michael should be able to hire his mother. You should be able to hire who you want. But the fact that there would be these vastly different outcomes based on an arbitrary price differential seems ridiculous, which means that DHS has multiple options that it could consider that is not evidenced, it has not provided any evidence of considering; right? One is, it could increase budget limits for people who are on agency care. But then, you have a different budget limit for that than you do for people who self-direct, but maybe it could be equalized. You could just increase the budget limit for everybody, which is probably the -- to make sure that everybody can purchase enough care no matter what their hours are, and trust that the Task and Hour Standards will limit the amount of services to what is medically necessary, which I think is the purpose of them. The one thing I would, of course, suggest that would be problematic is if DHS tried to reduce the personal care rate or something like that in order to equalize the services because of the impact that would have. DHS' proposed rule eliminates assistance with community participation. So, what the proposed rule is, it re-defines what attendant care is. So, it has historically been available to help people communicate, to travel, to do errands, and also for community participation in community activities, because, by God, getting out once a month might help you keep your sanity if you are disabled and stuck in a home with very little independent mobility or agency. DHS' definition explicitly eliminates community participation, it explicitly eliminates errands that are not for somebody's, basically, food or medical needs. I don't even think it includes medical. And it eliminates attendant care for traveling. There is, of course, no evidence that beneficiaries are using their care excessively for these things. Beneficiaries that we know are barely able to get by with what they have. So, if they want to have that once-a-month meeting with a friend to meet up for lunch and they want to use their attendant care for that three-hour period, why not? DHS has no evidence that people are misusing that, such as to restrict the attendant care limitation. They are taking a narrow, short-sighted view of what it means to be in a community living environment. And by the way, there's also problems with that under Olmstead. Many decisions implementing Olmstead have recognized community participation as part of the integration mandate. Then, you have DHS'

proposed rule limiting care choices and care hours for individuals who receive care through family members or friends. So, first of all, through care choices, currently -- of course, there are many valid reasons people choose an agency over self-directing; right? One is, people who go through agencies are trained, people if you self-direct are not. You might need somebody to come in two or three separate shifts during the day; right? If you are on your own and you have eight hours of care, well, maybe you have two hours in the morning to help you get out of bed, a couple of hours at lunch to help you around that, and at night to help you get back into bed. You can't do that self-directing. Most people can't, especially if you aren't hiring a family member. Agencies can. Agencies vet people, agencies handle all the payroll and the things that an individual who is self-directing just may not want to. So, people who choose to go through agencies, of course, will no longer be able to have their family member be hired through the agency and assigned to them. That will no longer be legal. It doesn't make any sense. DHS doesn't provide any reason for this, it doesn't seem to make any sense. If it works for the person, why shouldn't it be possible? Care hours. For all of those people who live with a family member, your care or the care that the beneficiary receives can be reduced by what family members voluntarily do, right? So, if a family member will voluntarily bathe somebody once a week, and I think unless all of us have terrible family members, right, and they are close by, probably will. That can actually reduce the amount of care that you are allowed under DHS' new system. Now, at the same time, DHS doesn't consider that that's part of the care that you need; right? So, they are not factoring that informal care into your overall care needs. They are just subtracting it from what they determine that you need. So, it's imbalanced that way. And, of course, if you live with somebody, DHS -- the person's attendant care allotment will be reduced for any sort of joint cleaning areas or joint food prep or anything like this. Again, these show that DHS' approach is biased towards hour reduction, not towards meeting people's care. The complexity of the process by now should be clear. An individual has to go through a 400-question assessment from one nurse from Optum, who, by the way, in the personal care and mental health settings where Optum assessments are already employed have been facing massive, massive problems, missed appointments, people getting cut off inappropriately, nurses who are not sufficiently trained in assessment to accurately obtain information from people. All sorts of madness going on with Optum. DHS is going to reward them by extending the long-term care situation in ARChoices to them. So, that's the first step. Step two is, then the DHS nurse comes out, right, and then the DHS nurse supposedly takes some of those 400 questions and what the algorithm says and completes this Task and Hours Tool. And then, somewhere in there, there is some mention of the individual service budget. So, for people who are affected by this, there's a bunch of things they have to understand that DHS has never shown any sufficient capacity to be able to explain. Again, why are you ranked a three in eating, or why aren't you ranked the most severe in eating or bathing? Why are you ranked the second most severe? DHS has to explain that for each activity of daily living, and then DHS also has to explain why you are in a particular service budget. So, for people on the program, they are going to get this and they are not going to know why they are reduced or not going to necessarily know how to fight it. And again, there you go to that undermining of any sort of legitimacy of a process and putting the burden on beneficiaries to just deal with it or suffer. So, the -- and the last -- hang on. The last thing is, DHS has introduced a little bit of flexibility into this program. And those are welcome changes, because as you all know, RUGS offered no flexibility. But we cannot -- we should not over-state the benefits of that limited flexibility. What this flexibility is, is the nurse comes out and says, "Well, I can give -- the tool says I can only give 35 to 45 minutes to Michael to bathe." And the nurse can see that, for some reason, Michael requires more than 45 minutes to bathe. The nurse can ask the nurse's supervisor, "Can I give them 55 minutes, instead"; right? So, that's one area of flexibility. But then, you are playing at the margins, a few minutes here or there. And mind you, again, Michael couldn't get that 55 minutes if his budget wouldn't allow any more. So, this promise of some sort of flexibility is really -- again, it's a welcome move, but it's a very, very small and probably not a very meaningful step. The other area where there is

flexibility is that one-time exceptional circumstances exception where the budget limit can be increased from \$30,000.00 to something more for a limited period of one year, as long as those circumstances exist. And that's really missing the point. Because the greatest need and the reason this program has been so beneficial to so many people is that in the past, prior to algorithm use, it provided care actually appropriate to people's needs. That's the issue. If DHS considered raising the budget limit so that people's needs could actually be met and not artificially limited, then a lot of these problems wouldn't be present and there wouldn't be the need for this kind of flexibility, however limited it is. So, in conclusion, as the thing is now, it doesn't -- as the proposed rule is now, we don't know the full workings because DHS hasn't offered us the algorithms. From what we can know, the best case scenario looks like people will still be not receiving enough care to meet their actual care needs, and whatever the decision is, it does not appear that it's going to be something that people can understand and have a fair chance of fighting. Thank you.

Response: Please refer to response above to the similar written comments from this commenter.

Gary Johnson (Jonesboro Public Hearing 11/07/2018)

Comment: Well, I said I wasn't going to do this. My name is Gary Johnson. And the attorney over here gave a real nice talk, and this young lady that just finished, she did, too, and the young lady from East Area earlier. But here is the deal, guys. This stenographer we are paying over here, she didn't need to be here tonight. And I don't want Craig or Mark to take this personally, but DHS and the government and Asa, they don't care. If you think they care You folks here that are disabled, what are you doing? We don't need you, what do you contribute? What do these old people contribute? You know what, people nowadays, their kids put them in the nursing home, they leave them there, they are nursing home orphans. We are all -- us providers, the lady that just spoke, you know, we are out there doing what we can, and you talk about split shifts, we do 24/7s a lot, probably more than anybody around, and it is a nightmare. My wife does it. And I will tell you what, I wouldn't want her job for nothing in the world. But the truth of the matter is, as I said, the stenographer don't need to be here because we are just paying money out of taxpayers' money. And DHS and the Health Department, they have never known -- you know, one of them comes and says, "Oh, your time sheets should look like this," "Oh, they should look like this." And you got two people telling you two different things and you say, "Well, why don't you make us one that you like?" "No, we don't want to do that. We don't want to get involved with that. That's federal. You are getting into federal now." Guys, nobody cares.

Response: Comment considered.

Hope Kessler (Jonesboro Public Hearing 11/07/2018)

Comment: My name is Hope Kessler. And from what I'm hearing, the people who are a part of this program want to know why DHS is using the algorithm to cut hours when the consequences are more costly, human and financial, in the long run. I think this is an excellent question and it needs to be answered. Also, eight hours is not too much to ask. I have met the Ledgerwoods. They are delightful people, and they are working very hard, and, you know, they just -- they are not rich, they just get by. They are not taking advantage of the system. Also, from what I'm hearing, the level of surveillance of these people is disturbing. 400 questions, that's invasive. The last thing I want to say is a quote. "A nation's greatness is measured by how it treats its weakest members." Mahatma Gandhi. Please be a great nation.

Response: Comment considered. DHS is proposing to completely eliminate the current system of allocating attendant care hours, the RUGs computer algorithm. In its place, DHS is recommending a system that relies on consistent statewide standards and includes an element of nurse professional judgment that is informed by objective results from an independent assessment, but also by input provided by family members and

caregivers. The proposed new system, the Task and Hour Standards, includes multiple opportunities for flexibility in allocating hours, so that the end result will be tailored to the specific needs of each individual beneficiary.

Ed Holman (Jonesboro Public Hearing 11/07/2018)

Comment: My name is Ed Holman. I'm here as almost a consumer, I'm almost -- I will be 65 here soon, so I will be in the Medicare generation, and I have been a customer, because my parents have both been in nursing homes. My mom died in a nursing home a few years back, both of my grandmothers died in nursing homes, my father was in a nursing home. And I'm in the nursing home business, assisted living and residential care. These cuts that are being proposed in these rules are just really, really difficult. And they are going to limit access, you have heard, for home health, for people with disabilities, for residential care, personal care, assisted living. And this is making it real, real difficult. It's just not right. The cuts for assisted living are up to 26 percent from the highest rate, and people have built their businesses with this model that the state provided us, and they have got a business model that works. But think about it, is there anything that you could operate and go in and say, "We are going to cut 26 percent from your budget?" You couldn't do a hospital that way, and I don't think, Brian, you could do that, I don't think my local McDonald's could do that, I don't think my school district could do that. So, these kind of drastic cuts are just really tough. I did visit with the Governor this past Thursday and told him, but they've got a budget, somehow they've got a bunch of these guys at DHS that are working with a \$7.6 billion budget, I believe, and they have had to make some cuts. But this is real drastic here. It needs to be a fraction of what they are talking about. So, what y'all need to do is, everybody needs to send in their comments if you haven't already. Mark is still taking comments tonight, his e-mail is mark.white@dhs.arkansas.gov; right? So, get them in tonight, get your comments in. They will review the comments. The other thing you can do is get a hold of your legislator. They are going to be going to Public Health and then to Rules and Regs. So, let your legislator know that you don't like this, that you are opposed to it. There's a lot of them that have heard this, and that's about the only way you can stop it. You need to get on -- call your local people. They are done with the election, they have gotten all the money they are going to get, and now they can get back to governing. And this is your last chance. So, if you don't -- don't let your voice out, don't let it be heard, nothing is going to happen. But if you do, there is a chance. So, be loud, let them all know. Thanks.

Response: Comment considered and accepted in part. The current assisted living rate for Medicaid clients is based on a rate that was set 16 years ago and then repeatedly increased automatically. The current rate is now markedly higher than the per diem rate of surrounding states, and more importantly, the rate does not have any evidentiary basis to show that it is reasonable and appropriate. CMS, the federal authority that authorizes the Living Choices waiver program, has directed Arkansas to develop an evidence-based approach to its assisted living rates. When CMS approved the renewal of the Living Choices waiver program in 2016, it was on the condition that DHS would implement a new payment methodology with a rate that was based on evidence and actuarial soundness. This summer, DHS had an actuary review the costs of providing assisted living services. The actuary reviewed licensing standards, regulatory requirements, BLS wage data, and other factors to determine the actual costs of providing care in assisted living. Federal law prohibits Medicaid from paying assisted living facilities for room and board costs. In Medicaid, room and board costs include the cost of buildings, equipment, furnishings, mortgages and financing costs, grounds, utilities, maintenance, related administrative expenses, and food. Therefore, the actuary correctly excluded these costs in the rate analysis. The actuary then surveyed existing providers as a way to validate the conclusions reached from the data. Based on the survey results, the actuary worked with DHS to modify the components of the rate to reflect the increased personnel costs reported by the providers. The final rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is

being modified to phase-in the rate over time, giving providers time to adapt while still achieving savings. DHS is also increasing the cap on participation so that available slots may be reused more often through the year, allowing greater participation.

