

# DHS Responses to Public Comments Regarding ARChoices in Homecare Renewal

**Catherine Burks, RN, Compliance Officer**

**AbsoluteCare Management Corporation**

**Comment:** Will the provider be able to get a copy of the THS used by the DHS PCSC/CC Nurse? When this form was first developed, we had no problem obtaining a copy. Recently, some DHS nurses have told us that they are no longer permitted to provide this to us. In the past we have found the THS to be very helpful in working with waiver participants to set up their plan of care. As the T&H indicates the tasks, and time per task, the DHS-RN used to determine the number of hours the participant is eligible to receive it greatly assists the client, and the provider, with the development of their individual service plan. We feel the T&H is an excellent tool that allows for good continuity of care for waiver recipients. We respectfully request that this form be available to providers.

**Response:** Yes, providers will be able to access the Task & Hours Standard online. Thank you very much for your comment.

**Robert Moore**

**Comment:** My name is Robert Moore and I've been on the ARchoices since 2004, and it has been the most important factor in staying as healthy as possible for as long as I have. I live with locked-in syndrome, meaning my mind is lucid but my body is totally bereft. I'm unable to walk or speak, I can't chew and can barely swallow so all my food must be pureed, meaning I require total assistance with all activities. So getting the excellent care I receive at home is vital to my well-being since I wouldn't get that level of care anywhere else. I love this program because it affords me the opportunity to stay in my home, receive the best care possible, and have some quality of life. I am able to be involved in activities inside and outside the home I wouldn't otherwise be able to if I wasn't able to live at home.

Every year that I have been in the program DHS has deemed me totally dependent on others for all my needs, and I have been placed in the highest benefit allotment. Any reduction or deviation in my benefit would radically alter my quality of life in a negative way. Because of the severity of my condition and my immense height I require special equipment for my care that isn't available anywhere but my house. The ARchoices program helped me in a big way acquire this specialized equipment. The intent of this program is to allow those with the most severe, chronic conditions to live where they choose, not force them into living somewhere ill-equipped to take care of them. In the past, I have always been grandfathered in so to retain my original benefit allotment, any deviation to this would affect me greatly in a negative way.

**Response:** Thank you for your comment. The Waiver Renewal provides a "Process for Granting an Exception to the \$34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

## **Ann Ledgerwood**

**Comment:** It is with a heavy heart that I am again writing a public comment on the AR Choices program. I can't understand why we are continually having to address the same issues waiver after waiver, with each waiver threatening a shortage of hours, services or budgets. We are talking about total care patients, patients who could face being put into an institution. The latest proposed waiver has removed the grandfather clause on budgets. Clients who depend on these budgets are facing a fear of stability in their lives, which adds anxiety and fear to an already difficult life. I understand there is an avenue to "possibly" receive a higher budget, but there are not any guarantees that anyone will receive the higher budget. I am speaking of persons who have received a level of care for years and have become dependent on these services in order to maintain a quality of life at home and among the community, rather than being placed in an institution.

I believe every parent has hopes and dreams for their children. I feel confident in saying that most parents want their children to be God fearing, good citizens who had a good childhood with school activities, college a career, a family etc. What if you were told when your child was born that he or she would never walk, or sit up and would need to be cared for all of their lives? This was our life. Our prayer became that we could give him the closest thing to a normal life possible. The AR Choices program was a wonderful program that enabled our son to be an active part of the community and gave him a quality of life that most take for granted. Our biggest fear as a parent, has been that he would end up in a nursing home and would lose what bit of normalcy that he has been able to enjoy. He has been on the program since 2002 (different names of course) and has been thankful for the program. We were blessed for years to receive services without any fears of keeping him in his home and giving him the best care possible, but the last few waivers have threatened that care. We are not unique in our situation, as we know many others who have compelling stories. I am pleading that you add the grandfather clause or give assurances to those who rely on the budgets they currently receive. Arkansas has a surplus, yet we are looking at possible cuts to a group of our most vulnerable population AGAIN! I believe we can and should do better than this.

**Response:** Thank you for your comment. The Waiver Renewal provides a "Process for Granting an Exception to the \$34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

## **Bradley Ledgerwood**

**Comment:** My name is Bradley Ledgerwood, I am very upset that I'm having to make public comments again on the AR Choices program. The old saying "if it aint broke don't fix it", comes to mind. We had a program that worked very well and it seems as if we have come full circle trying to fix a very well ran program, is it any wonder that we feel as if the state just want cuts to be made? I have been on this program since 2002 and it worked perfectly until 2015 when changes started being made to improve a well working program. I have yet to see any changes for the positive. I have always received a minimum of 8 hours a day 7 days a week of care. I can not understand how I have received this care since 2002 and my condition has only worsened but now I am being told I might not receive the care that has always been deemed necessary. I am sure if you are not a recipient of this program, you can not know or understand the frustration level of those of us who rely on these services. AR Choices give meaning and

purpose to so many of the disabled community. I am able to serve on the Cash City Council, I am able to serve on the Client Voice Council and I am able to be very active in the community. The struggles a totally dependent person incurs would sometimes make us feel as if we are worthless and can not contribute anything to society, but because of this program we can have meaning and feel like part of the community, whether it be cheering for someone at a ballgame, attending worship services, or being active in politics. A very insignificant thing such as going to the store or watching family ballgames can be a highlight for someone who lives their lives on the sidelines.

I know that it was mentioned that the grandfather clause was not fair to someone new coming onto the program. I would address to that comment, why can we not give everyone who qualifies for total care enough hours to keep them comfortably in their homes, secondly although I would want everyone to receive the ability to live in their homes, I also realize that many of us have an expectation of the care we have received and taking away our budget would take away our stability. Nursing home care is considerably higher than in home care, which actually saves the state money. I am aware that your estimates for nursing home care are 69,190, which is less than what we find in our areas. I have had elderly family that lived in a nursing home and I speak from experience when I say that I receive much much better care and a better quality of life living in my own home for less cost. My parents are my hands and feet and are available 24/7. I have one on one attention to my needs, there is not any possible way to receive this care in a nursing facility. I implore you to please add the grandfather clause into this waiver or change the budget limits. I can not understand if a nursing home cost is near 70,000 why we would cap budgets to less than 35,000. I am also aware that the DDS waiver now allows clients to keep their caregivers when they are in the hospital and I would like to see this in the AR Choices program as well. A caregiver does so much more than hospital staff. Would it not be in violation of the Olmstead Case to say a person needs a certain level of care and cap the budget and not allow the person to receive the care they need, forcing them into an institution?

The state has a surplus, why would we want to with hold care for individuals who only want to live comfortably in their homes rather than live in an institution? I hope we get direct answers to our comments rather than a canned answer, like we have received in prior public comments. Finally the public comment period should be advertised to all participants, so that everyone who would want to make a comment is able to speak, I know many people who are unaware of the changes or the need for public comment.

**Response:** Thank you for your comment.

- 1) The Waiver Renewal provides a “Process for Granting an Exception to the \$34,000 Maximum SBL” at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.
- 2) Currently, DHS has begun the process of seeking a Waiver Amendment from CMS to allow for the provision of Attendant Care Services in Inpatient Settings for ARChoices clients.
- 3) Public comments are sought pursuant to current Arkansas law, including publication of notice in a statewide newspaper and public notice and access at the DHS homepage.

**Luke Mattingly CEO/President**

## **CareLink**

### **Comment:** Selection of Entrants to Waiver Appendix B-3 f

The services are provided on a first come first served basis. The state combined the Adults with Physical Disabilities (AAPD) and Elderchoices (EC) waiver programs into one waiver (AR Choices) in 2016. Prior to the combined waiver the Elderchoices program, those age 65 and over, constituted approximately 70% of waiver slots. The combination of the waivers and the first come first serve approach over time will have a disparate impact on the elderly population. The length of time a participant receives services is vastly different between these two populations. The younger disabled population receives services for many years while the elderly population only averages a couple of years. As the elderly population drops off services and frees up open slots much more frequently than younger disabled participants the first come first serve approach will severely restrict the elderly populations availability to maintain waiver slots over time.

It is unlikely that the state of Arkansas will uncouple these two populations for purposes of the waiver. However, it should be a requirement that the Arkansas Department of Human Services produce public reports at least quarterly that detail the number of active cases by county and how many of those cases are in the age categories of 21 to 64 and 65 plus. Further, the impact on the elderly population since 2016 should be analyzed for disparate impact and a future trend analysis established on the likelihood of the younger disabled consuming a larger statistical portion of slots over time compared to statistical percentages prior to the waiver merger.

Of course, another solution to offset any potential disparate impacts would be to significantly increase the number of available participant slots.

**Response:** Thank you for your comment. Under this waiver, as indicated in Table J-2-a, the Total Unduplicated Number of Participants increases by 75 with each successive Waiver Year.

### **Comment:** Barriers to Entry Appendix B-6

Elderly applicants and their families seeking in-home services endure a lengthy, multi-level, highly bureaucratic process. The elderly who requests these services are most often in a place where receiving timely care is critical. Applicants face the following approval layers: 1. Assessment by a nurse at the county office, 2. Assessment by the selected providers nurse, 3. Assessment by the third-party nurse (Optum), 4. Review by a DHS nurse to approve the plan of care. 5. Financial review by DHS. 6. Approval and PA assignment. This process is highly redundant and seems unnecessary. As a result, applicants are neglected of critical care in a timely manner. Our records reflect an approximate 120 day wait period for services. This is too long, especially for 90-year-old applicant who is in desperate need of services. Often the case, frustrated, applicants resort to what they see is the only option left, institutional care (skilled nursing facilities) where the process is far more simplified and timely.

**Response:** Thank you for your comment. DHS is currently conducting an internal Long-Term Services and Supports process review to further identify and address efficiency and timeliness.

**Comment:** Additional Limits on the Amount of Waiver Services Appendix C-4 Methodology for determining the SBL(Service Budget Limit) C

DHS will monitor and take steps necessary to update these SBL amounts when waiver rates change.

SERVICE BUDGET LIMIT (SBL) means the limit on the maximum dollar amount of waiver services that may be authorized for and received by each specific participant.

First, the service rates should be changing with this waiver submission which would affect the SBL's. (See comments for section Appendix J-2) Secondly, the service rates should not be the only driving factor which constitutes SBL amounts. DHS has always taken the position that the SBL limits, specifically the maximum limit, cannot exceed the Arkansas expenditure portion of the cost for institutional placement. It is abundantly clear that institutional costs have skyrocketed over the last three years. (See Appendix J-1 plus numerous published articles) Additionally, the Arkansas Legislature recently changed the bed capacity limit for institutions from 80% to 60%, with a gradual increase up to 70% as a new set point, which equates to an additional sixty million dollars of annual costs reimbursement for institutions. (Exhibit from the Arkansas Legislative Public Health Committee 7/5/2022) This will further increase the divide on what is spent on institutional care vs HCBS in Arkansas. Analyzing and reviewing this new data on institutional costs should trigger an increase to SBL's to provide equitable adjustment for HCBS participants. Since the waiver is being amended at this time, DHS should increase each tier of HCBS SBL's to be more equitable with increased expenditures on institutional care. Further, institutions have a built-in rate adjustment based upon inflationary factors and actual expenditures. (2.5% inflationary costs is referenced in Appendix J-2) To make services equitable the SBL's should also be changed annually to reflect inflationary factors and service levels available to participants.

Question: In Appendix J-1, when considering the inflationary factors of G and G' – was the bed rate % reduction approved by the legislature calculated into the projections?

When analyzing data from Appendix J-1 (which was mostly based upon 2019 data prior to an even greater increase in institutional costs in 2020, 2021 and 2022) it is clear that the disparity between Nursing Home care costs and AR Choices waiver costs continues to favor the institutions.

When comparing year 1 column 4 (Total AR Choices waiver cost per participant) to year 1 column 8 (Difference in total nursing home costs vs waiver costs) the variance between nursing home costs and AR Choices average costs is 52.6 %. Year 5 brings the variance up to 55.5%, further exacerbating the division of funding spent on nursing homes vs HCBS. (Column 8 – column 4 / column 8) This limits the amount of care HCBS participants can receive.

Also, Waiver service costs are projected to increase by 5.6% over the 5-year period while inflation indicators, especially in healthcare, are much greater. If the state is committed to HCBS the variance would be getting smaller and SBL limits would be increasing and reducing the divide between institutional expenditures. Increasing SBL limits and HCBS rates would rebalance this disparity.

**Response:** Thank you for your comment. DHS will continue to consider balance of service delivery models across various levels of care and numerous unique populations in need.

**Comment:** Rates for services Appendix J-2 6 through 14

A waiver amendment is being submitted, which is the perfect opportunity for the state to present to CMS adjustments to rates to combat current unprecedented inflationary and labor cost increases and labor shortages. These comments will address the Home Delivered Meal, Attendant Care and Respite rates. The most striking indicator from the five-year plan is that the rate for all services remains the same, not accounting for or allotting any funding for inflationary considerations whatsoever over the five-year period. This implies providers will have a zero increase in labor costs, health insurance, transportation, compliance related matters, software, PPE, communications, supplies, and other needs required to operate. Economic conditions are quite challenging for providers at the moment, so we encourage DHS to review this assumption.

#### Home Delivered Meal Rate:

This rate has remained unchanged since 2009. Everyone is aware of cost inflation impacting food, fuel, and labor costs – the main components of meal rates. Two providers, Baptist Health, and Mom’s Meals have stopped providing this service due to untenable reimbursement rates. A rate review and update is overdue. Per Appendix J-2, the number of meals served through the program have declined, despite the aging population of Arkansans. If the CPI food index from 2010 –2022 percentage of increase/decrease (<https://www.in2013dollars.com/Food/price-inflation>) were applied to the 2009 \$5.97 rate the new rate would be \$8.19. Of course, HDM costs are primarily food, labor, and fuel. Providers are losing money on every meal served therefore a rate increase cannot be delayed.

**Response:** Thank you for your comment. DHS’ Division of Medical Services is currently considering service rates and adjustments thereto.

#### Comment: Attendant Care and Respite Care Rate:

The rate setting methodology for In-home services is derived from “what is the minimum Medicaid can pay for this service” resulting in low wages and minimal benefits for workers. The rate setting process does not provide the opportunity to build a career ladder for in-home Aides nor does it focus on paying a wage that attracts high quality candidates. The rate is such that providers can only offer minimum wage or close to minimum wage pay. This is not conducive to providing high quality services and results in high turnover rate for this occupation, which is detrimental to participant care. Labor shortages and inflation, on top of the Arkansas minimum wage increases that resulted in an \$11.00 per hour minimum, have severely impacted the ability of providers to recruit and retain workers. Individuals can make \$14 to \$18.50 working at a fast-food restaurant or retailer, and those entities can raise prices to offset the increased labor costs. In-home Medicaid providers have no such ability to pass along increased costs to the consumer. Providers rely on Medicaid to recognize the market shift and increase the rate paid for in-home services. To this end Medicaid in Arkansas has ignored the plight of in-home services providers. The rate needs to be set so that providers can compete in the local marketplace against other industries that hire workers with similar education and skills. It is clear, when reviewing restaurants and retailers starting wages, that the lowest possible wage that should be offered to a Home Care Aide is \$14.00 per hour. The Arkansas Human Development Centers are starting their Aides at \$14.42 per hour. The state recognizes these wage pressures at services that it provides directly but does not reciprocate that thought process to providers in HCBS. Using the Milliman formula from the 2018 rate assessment a \$14.00 per hour wage would provide for a \$6.40 unit rate or \$ 25.59 per hour. (Providers assert that this

is still too low, but it was the methodology utilized by the state in the previous review) Another simple projection is to take the current rate of \$20.48, divided by the minimum wage of \$11.00 to produce a 1.86% variant. Apply the current variant from minimum wage to the proposed new minimum of \$14.00 per hour and a new the hourly rate would be \$26.04 per hour or a \$6.51 unit rate.

Medicaid services are steeped in heavy regulatory burdens and mandated positions other than Aides, software, and various compliance costs in addition to normal operational costs such as payroll, billing, human resources, and administration. These factors drive the need for the cost of business variant between what service workers are paid and the total reimbursement rate. The current 86% variant, as demonstrated in the paragraph above, is the lowest in the nation. So, the stipulated \$26.04 per hour reimbursement rate is still not adequate, but that is the methodology DHS utilized during the last rate review. There are several states that mandate what the minimum rate is for a Home Care Aide, separate from the overall state minimum. If the rate were adjusted appropriately (around \$26.00 per hour) CareLink would support placing the \$14.00 per hour minimum rate for Aide in policy or statute. Also, all other payors for this service, already pay a rate of approximately \$25.00 to \$27.00 per hour. There is a real problem when the Medicaid rate pays a 20% to 25% lower than rate for the same service. This is unsustainable.

Since it is already submitting an amendment to the waiver, this is a unique opportunity for Arkansas DHS to immediately respond to unprecedented wage and inflationary pressures affecting the Home and Community Based sector. It is assumed that DHS will ignore this request and indicate that a rate study was conducted in 2019 and these rates were adjusted in January 2021. To counter that, I would point out that the rate study utilized old data and did not even fully account for the final minimum wage increase that went to \$ 11.00 per hour. (Also, providers contend that the study was flawed) There have been unprecedented inflationary pressures since this study was completed. Additionally, it is based on minimum wage! Workers in this field deserve to be recognized for their considerable achievements in keeping participants at home. Now is the time to act. To further demonstrate market labor pressure, see below:

Starting pay facts for retailers and fast food:

Human Development Centers run by the state of Arkansas start a minimum wage \$14.42 per hour  
<https://humanservices.arkansas.gov/careers/job-listings/job-opportunities/human-development-centers/>

Hobby Lobby as of January 1, 2022, started a minimum wage of \$ 18.50 per hour for full-time employees.

<https://www.usatoday.com/story/money/shopping/2021/12/14/hobby-lobby-minimum-wage-increase/8897355002/>

Amazon has a minimum starting wage of \$ 15.80 per hour

<https://hiring.amazon.com/jobDetail/en-US/Amazon-Fulfillment-Center-Warehouse-Associate/Little-Rock/a0R4U00000DKQ6gUAH#/jobDetail?jobId=a0R4U00000DKQ6gUAH&locale=en-US&seoIndex=1>

Target has a minimum starting wage of \$ 15.00 per hour  
<https://corporate.target.com/press/releases/2020/06/Target-Increases-Starting-Wage-to-15-Thanks-Frontl>

Best Buy has a minimum starting wage of \$ 15.00 per hour

<https://corporate.bestbuy.com/best-buy-provides-updates-on-evolution-of-employee-pay-and-sales-performance/>

Costco has a minimum starting wage of \$ 17.00 per hour.

<https://www.4029tv.com/article/costco-raised-its-minimum-wage-to-dollar17-an-hour/38093969#>

MacDonald's \$15.00 per hour minimum starting wage at company stores

<https://www.arkansasonline.com/news/2021/may/14/mcdonalds-setting-15-an-hour-wage-at-company/>

Taco Bell \$ 15.00 per hour minimum starting wage at company stores

<https://www.forbes.com/sites/aliciakelso/2021/12/14/taco-bell-commits-to-a-15-an-hour-minimum-wage-at-company-owned-restaurants/?sh=306037095d0e>

**Response:** Thank you for your comment. DHS' Division of Medical Services is currently considering service rates and adjustments thereto. DHS can confirm the wage, costs, and inflationary pressures you mention are all too real and present significant difficulties in all areas.

**Comment:** In conclusion, Arkansas does a really poor job of supporting Home and Community Based services. As evidenced by the CMS Medicaid Long Term Services and Supports Report, December 9, 2021, based upon data from Federal FY 2019. Arkansas ranks in the bottom ten of all states for spending on institutions vs HCBS. In fact, the national average is that states spend 58.6% on HCBS and 41.4% on institutional care. Arkansas only spends 44% on HCBS but spends 56% on institutions, the reverse of the majority of the rest of the nation.

CareLink implores DHS and the Arkansas Legislative body to insist that the service budget limits and rates be adjusted during committee review prior to being submitted to CMS. Further, we ask CMS to thoroughly review the waiver Service Limits and Service rates in the spectrum of rebalancing institutional care and HCBS and require Arkansas DHS to stipulate how this waiver plan moves Arkansas closer to the CMS stated goal of a minimum 50/50 split between HCBS and Institutional care. Without a HCBS increase spending offset the percentage of spend on institutions will only continue to grow and move Arkansas even further away from the national rebalancing goal of a 50/50 spend.

**Response:** Thank you for your comment. Please be assured DHS continues to strive for improvement in all service delivery areas and to maximize results for clients, providers, and taxpayers, while responsibly managing budgetary allocations.

**Kevin Hoover**



**Comment:** Below you will find my comments and questions about the changes that you are wanting to make to the AR Choices program regarding the budgets of people on the program.

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 us elderly, disabled, and our caregivers who provide the care we need. The purpose of the AR Choices program is to help us stay in our homes and get the care we need and be an active part of society instead of being confined to a Nursing Home or other type of facility. With these changes we have to worry about getting an infection, bedsores, laying in filth and even our own body waste for extended periods of time due to our budget/hours being cut. It seems to me that the real purpose of these changes are for us to be put in a nursing home so that more of the state's money can be spent on our care and make us feel useless and unwanted.

I have been on the AR Choices program for 13 years and have never seen something as crazy as this is. I am paralyzed from the waist down and my condition has not changed other than a pressure sore reopening. If these budget changes go into effect my hours will drop significantly when nothing has changed. The changes to the budget that is proposed would drop my care budget from around \$45,000 down to around \$20,000 a year at the least. This would be because of the changes to my budget when this is not currently an issue because my budget is grandfathered in because I have been on the program since 2009. My caregiver does not get to just work 6 hours and go home or to another job because she lives here and is on call 24/7 to take care of my needs that could include turning every 2 hours, changing my bed if I have an accident, dumping a urinal, or changing the bandage on my pressure sore, and fixing me something to eat if I get 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 myself have had regular jobs with benefits, and they were not as stressful as it is being on this program and having to worry about my care being affected because of a money number. With this new Budget and taking out the Grandfathering in clause you are proposing it would drastically affect the care I receive as well as make my caregiver have to look elsewhere to make ends meet because the budget will differ dramatically, talk about discrimination and a bullying tactic.

You can not just group people into 3 categories and set a budget limit for their care because everyone's care is different and it takes some people more time 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 care I receive by basically putting a value on the care we receive and the time it takes to take a bath, get dressed, eat, and even how often they can take a shower which is totally unacceptable. These changes are putting the people's health at risk and takes more time away from me being able to live my life. 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 budgets/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 budget for tier 3 is \$34,000 a year and tier 2 is roughly \$20,000 a year which is totally a slap in the face to both the caregiver and 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 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 what amount of money someone's health is worth. What if it was your family member? Putting budget limits on a person's care and health is not just wrong, it's wrong and says hey your life has a price and that's all you're worth a year to us and causes unwanted stress on both the client and caregiver and causes them to rush and puts the client at risk of injury. If anything make the budgets 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 and stop putting a price on people's lives. If you want the system to be fair do away with the budgets so that everyone is equal.

**QUESTIONS:**

Do you think these budgets will provide people with the care they truly need?

**Response:**

The Waiver Renewal provides a "Process for Granting an Exception to the \$34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

**Comment:** 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 set a budget cap when every person's care is different? Is this because you are trying to save money to put in your pockets or you just don't care? Why are you not only discriminating against the people on the program but their caregivers as well? Since budgets are not currently in place why change it after 20 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 Budgets? If his condition hasn't changed then why is his budget being threatened? What about all this surplus money that DHS has? Where is it going? What's it being used for? Why place a dollar amount on our care now? What if it was your family being treated this way? Do you all not want to take care of the disabled?

**Response:** Thank you for your comment. Please be assured DHS continues to strive for improvement in all service delivery areas and to maximize results for clients, providers, and taxpayers, while responsibly managing budgetary allocations. The ArChoices program was designed to address care and client benefits while still allowing for individual flexibility. The Waiver Renewal provides a "Process for Granting an Exception to the \$34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

**Tracy Baxter RN**

## **Education and Compliance Manager, White River Area Agency on Aging**

### **Comment:** Selection of Entrants to Waiver Appendix B-3 f:

At one time the ElderChoices program, those ages 65 and over, constituted approximately 70% of the waiver slots. The combination of the waivers in 2016 and the first come first serve approach over time will have a disparate impact on our senior population. It makes sense that a younger, disabled population would receive services for many more years than a senior would. As the elderly population drops off services and frees up open slots, if the first come first serve approach is used, it will restrict the senior population's availability to maintain waiver slots over time.

To offset any potential disparate impacts on seniors, the available participant slots could be increased. The Arkansas Department of Human Services should monitor the number of active cases by county and how many of those cases are in the age categories of 21 to 64 and 65 plus to avoid the loss of slots for our seniors. Our seniors must have the choice to remain in the community with home-based services.

**Response:** Thank you for your comment. Under this waiver, as indicated in Table J-2-a, the Total Unduplicated Number of Participants increases by 75 with each successive Waiver Year.

### **Comment:** Barriers to Entry Appendix B-6:

Applicants and their families seeking in-home services endure a lengthy, multi-level, 'long road to approval' process. We need to remember that applicants who request these services are most often in a place where receiving timely care is critical to remaining in the community and as independent as possible. Its basic knowledge that seniors avoid asking for help until they are facing tough choices because they fear losing their independence and they fear institutionalization even more. The application process is highly redundant and as a result, applicants face institutional placement and sometimes even death before being approved. Arkansas - We can do better!

**Response:** Thank you for your comment. DHS is currently conducting an internal Long-Term Services and Supports process review to further identify and address efficiency and timeliness.

### **Comment:** Additional Limits on the Amount of Waiver Services Appendix C-4 Methodology for determining the SBL (Service Budget Limit) C:

The service rates should be changing with this waiver submission, which would affect the SBL's. The service rates should not be the only driving factor, which constitutes SBL amounts. Analyzing and reviewing this new data on institutional costs should trigger an increase to SBL's to provide equitable adjustment for HCBS participants. Since the waiver is being amended at this time, DHS should increase each tier of HCBS SBL's to be more equitable with increased expenditures on institutional care. Further, institutions have a built-in rate adjustment based upon inflationary factors and actual expenditures. (2.5% inflationary costs are referenced in Appendix J-2) To make services equitable, the SBL's should

also be changed annually to reflect inflationary factors and service levels available to participants. A solution would be to increase SBL limits and HCBS rates.

**Response:** Thank you for your comment.

The Waiver Renewal provides a “Process for Granting an Exception to the \$34,000 Maximum SBL” at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

DHS’ Division of Medical Services is currently considering service rates and adjustments thereto.

**Comment:** Rates for services Appendix J-2 6 through 14:

A waiver amendment is being submitted, which is an opportunity for the state to present to CMS adjustments to the rates to combat current unprecedented inflationary and labor cost increases along with labor shortages. Attendant care and Respite care rate setting methodology for In-home services results in low wages and minimal benefits for workers. The rate-setting process does not provide the opportunity to build a long career for in-home aides nor does it attract high quality applicants. The rate is such that providers can only offer a minimum wage or close to a minimum wage. This is not conducive to providing high-quality services and results in a high turnover rate for this occupation, which is detrimental to participant care. When our agency reviews ways to recruit, hire and retain caregivers, the root problem that we face is the reimbursement rate. Unfortunately, the HCBS participants are the ones who pay the ultimate price. We respectfully ask that DHS and the Arkansas Legislative body insist that the service budget limits and rates be adjusted during committee review before being submitted to CMS. We ask CMS to thoroughly review the waiver service limits and service rates in the spectrum of rebalancing institutional care and HCBS and require Arkansas DHS to stipulate how this waiver plan moves Arkansas closer to the CMS stated goal of a minimum 50/50 split between HCBS and institutional care. Without a HCBS increase-spending offset, the percentage spent on institutions will only continue to grow and move Arkansas even further away from the national rebalancing goal of a 50/50 spend.

**Response:** Thank you for your comment. Please be assured DHS continues to strive for improvement in all service delivery areas and to maximize results for clients, providers, and taxpayers, while responsibly managing budgetary allocations.

### **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 regarding the budgets of people on the program.

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 13 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. If these budget changes go into effect his hours will drop significantly when nothing has changed. The changes to the budget that is proposed would drop his budget from around \$45,000 down to around \$20,000 a year at the least. This would be because of the the changes to his budget when this is not currently an issue because his budget is grandfathered in because he has been on the program since 2009. 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 Budget and taking out the Grandfathering in clause you are proposing it would drastically affect the care I give my client as well as make ends meat because the budget will differ dramatically, talk about discrimination and a bullying tactic. You can not just group people into 3 categories and set a budget limit for their care because everyone's care is different and it takes some people more time 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 care a person receives by basically putting a value on the care they receive and 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 are putting the patients health at risk and takes more time away from the client being able to live their lives.

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 budgets/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 budget for tier 3 is \$34,000 a year and teir 2 is roughly \$20,000 a year which is totally a slap in the face to both the caregiver and 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 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 what amount of money someones health is worth. What if it was your family member? Putting budget limits on a persons care a d health is not just wrong, its wrong and aays hey your life has a price and thats all you a worth a year to us and causes unwanted stress on both the client and caregiver and causes them to rush and puts the client at risk of injury. If anything make the budgets 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 and

stop putting a price on people's lives. If you want the system to be fair do away with the budgets so that everyone is equal.

**QUESTIONS:**

Do you think these budgets 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 set a budget cap when every persons care is different? Is this because you are trying to save money to put in yalls pockets or you just don't care? Why are you not only discriminating against the people on the program but their caregivers as well? Since budgets are not currently in place why change it after 20 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 Budget changes? If his condition hasn't changed then why is his budget being threatened?

**Response:** Thank you for your comment. The ArChoices program was designed to address care and client benefits while still allowing for individual flexibility. The Waiver Renewal provides a “Process for Granting an Exception to the \$34,000 Maximum SBL” at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

**Trevor Hawkins, Attorney**

**Economic Justice Practice Group Leader, Legal Aid of Arkansas - Jonesboro**

**Comment:** Legal Aid of Arkansas offers these comments to the proposed rules issued on July 15, 2022, pertaining to the ARChoices and Independent Choices programs, including both the proposed waiver and the related provider manual. The proposed changes range from changing who may be eligible for the program to what level of services a given beneficiary may receive. Legal Aid of Arkansas offers these comments based on expertise gained over the last eight years representing hundreds of clients with a wide range of issues relating to the ARChoices program. Many of these problems relate to the program’s present form, as introduced in 2019. Legal Aid has four main concerns that center around how the program will function under the new rules.

DHS has removed the pathway for ARChoices eligibility for those who have a diagnosis of Alzheimer’s disease or dementia from the Provider Manual. Currently, applicants with a diagnosis of Alzheimer’s disease or dementia who do not otherwise meet the ARChoices physical eligibility criteria—assistance with eating, toileting, or mobility—can still be eligible for ARChoices if they have a medical diagnosis of dementia and exhibit behaviors that pose a serious health or safety concern. Specifically, Section 212.000 of the proposed Provider Manual, titled “eligibility for the ARChoices Program,” eliminates the provision that provides eligibility through a diagnosis of Alzheimer's disease or dementia. Furthermore, Section 212.050 removed the definition of Functional Eligibility, which provides that someone with a

diagnosis of Alzheimer's disease or dementia may be eligible. It is unclear whether this is intentional or an oversight because references to the eligibility pathway remain in the proposed Waiver (p. Appendix B-6: 16) and the proposed ARIA Manual (p. 57-58). This change is significant because many Arkansans with a diagnosis of Alzheimer's disease or dementia would otherwise be ineligible for Medicaid without the ARChoices program. This cognitive impairment provision acknowledges that Alzheimer's disease and dementia are unique conditions, and that the normal evaluation process may not accurately consider the kinds of assistance such a person may need. A recent study noted that those with a diagnosis of Alzheimer's disease or dementia have a unique utilization of services than others from programs like ARChoices. 1 Many of these individuals rely on services like medical equipment and transportation

rather than attendant care. 2 For many, these services allow them to remain at home longer than they otherwise would be able to. This change could profoundly affect those who are already on the program under this provision, as they would now need to re-establish eligibility under the remaining criteria. Because those with conditions such as Alzheimer's disease and dementia do not necessarily have the same needs for physical, hands-on assistance, many would experience terminations from the program. Notably, when asked, DHS was unable to provide numbers for how many are eligible under this pathway. As a result, it is difficult to ascertain how many would be affected and whether the agency considered the impact of such a change to the policy. Those who become ineligible as a result of the change will unexpectedly lose access to vital benefits that allow them to remain in the home and community as well as access to Medicaid altogether. Such changes would be life altering and would likely lead to a risk of institutionalization for most. For many of Legal Aid's clients with Alzheimer's disease or dementia, the attendant care and other services and supports make it possible for them remain in their home. If attendant care is lost, then those in the beneficiary's life, whether family or close friends, must choose between work and care for the beneficiary during those lost attendant care hours. Additionally, the loss in other benefits leads to an increased financial burden that requires those same unpaid caregivers to work more to afford the lost products and services. Such an outcome is directly counter to the ARChoices program goal of providing home and community based services as an alternative to nursing home placement. The proposal does not justify the deletion of this eligibility pathway, nor does it consider the impact that it will have on existing beneficiaries.

**Response:** Thank you for your comment. The comment misreads the legal effect of the changes proposed in the ARChoices Provider Manual. Eligibility for ARChoices has always been conditioned on the applicant requiring an intermediate level of care in a nursing facility. DHS is not proposing any substantive change to this requirement or to the criteria or definitions for determining whether an individual requires an intermediate level of care in a nursing facility. Nor is DHS proposing any substantive change to consideration of Alzheimer's Disease or related dementia in determining eligibility. Rather, DHS is proposing to remove duplicative language in the ARChoices Provider Manual. The criteria and definitions for determining intermediate level of care are set forth in the Procedures for Determination of Medical Need for Nursing Home Services, which is an existing rule promulgated by the DHS Office of Long-Term Care. These Procedures are referenced in the new language added at the end of Section 211.000 in the ARChoices Provider Manual.

**Comment:** The proposed Individual Service Budgets appear to arbitrarily limit services deemed medically necessary and incentivize institutional care.

The amount of attendant care, respite care, and personal care hours that a beneficiary receives each year will be determined by the Task and Hour Standards form as completed by the DHS registered nurse. Completing this form requires RN to look at the Needs Intensity Score, Frequency, and time that a beneficiary needs for all thirteen activities of daily living to figure the level of benefits the person should receive. 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 proposed budget levels are set at \$6,000, \$23,000, and \$34,000. DHS's methodology for setting the \$34,000 cap is not based on the actual overall cost of nursing home care. Other estimates show that the overall cost of nursing home care in Arkansas is significantly higher. In Appendix J of the proposed Waiver (p. Appendix J-1:1), DHS puts the average annual cost of nursing home care at \$69,191 (\$5,766 per month). This roughly accords with the 2021 estimate from a survey by Genworth Financial that put the annual cost at \$72,966 (\$6,083 per month).<sup>3</sup> Considering the cost of the long-term care equivalents, \$34,000 appears to be a gross underestimate. DHS originally derived the \$30,000 limit by including only the costs to the state's general revenue fund and the associated federal match rate. For the new proposal, DHS simply adds an additional 13% to arrive at the proposed \$34,000 figure. However, this figure accounts for only 49% of the average cost of nursing home care for an individual. The remainder 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. Thus, the additional cost will be borne not only by the federal government and providers but also by the beneficiary through the infringement of their preference for community-based living. The effect of the artificially low budget caps is that it places individuals at increased risk of

institutionalization. While the maximum budget is only \$34,000, very few beneficiaries may fall into this category because of the high bar that is set. To be eligible for the maximum budget limit, the individual must require extensive physical assistance with eating, toileting, and mobility. The issue Legal Aid's clients have commonly faced is that the definition of extensive assistance with eating is difficult to meet. If the beneficiary can arguably take a utensil from a prepared plate to her mouth—irrespective of the difficulty in doing so or their ability to get food on the utensil—then they would never meet the definition of needing extensive physical assistance with this task. As a result, such a person would be limited to the \$23,000 budget and an absolute maximum of 105 attendant care hours per month.

Another example is for those who have established eligibility for the program under the Alzheimer's disease or dementia diagnosis pathway. As discussed above, this pathway does not look at the person's needs regarding eating, toileting, and mobility in determining whether they are eligible for the program. Instead, it focuses on their diagnosis and behaviors that are exhibited as a result. The Individual Service Budget process ignores this difference in criteria, opting to only look at the eating, toileting, and mobility ADLs. Therefore, without the need for extensive, hands-on physical assistance with two of the three—eating, toileting, or mobility—a person with Alzheimer's disease or dementia will effectively be limited to a maximum of \$6,000 in program services. Legal Aid has many clients with serious medical conditions that are not adequately considered by the budget criteria, many of which would experience a cut of as much as 131 hours of attendant care per month if their grandfathered status was taken away. Put another way, some of Legal Aid's clients would go from having 7 or 8 hours of care each day to only 3.5 hours of care each day, with no one else to rely on for the lost time. Such an individual, without a waiver of the budget limits, would be required to enter a nursing facility.<sup>4</sup> Therefore, the low budget caps 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. The proposal fails to address the effects of these changes on those with the most acute needs or provide consideration of reasonable alternatives like matching the service budgets with the cost of nursing facility care.

**Response:** As noted above, the Waiver Renewal provides a "Process for Granting an Exception to the \$34,000 Maximum SBL" at Appendix C-4, Section I-4. Such an exception may be requested by a participant, physician, family member, Targeted Case Manager, or PSCSP/CC Nurse.

**Comment:** DHS's proposed budget exception request lack adequate protections for ARChoices Beneficiaries.

The proposed Waiver (Appendix C-4:6) and the proposed Provider Manual Section 212.200 include a new process for a beneficiary to request either a move to a higher budget Service Budget or an exception to the maximum Service Budget Limit of \$34,000, but this process may fall short of meeting the needs of the ARChoices program. First, the proposed policy omits any description of how beneficiaries should be provided notice of the budget exception process and where these requests should be made. Additionally, there does not appear to notification requirements once the panel has issued a decision. For many of Legal Aid's clients, this process will dictate whether they are able to live independently at home so clear notice of how to participate and when a decision is made is important.

Second, the new policy omits any procedural safeguards for the beneficiaries that make such requests. For example, the process only allows for an initial 60-day modification of the individual's service budget while several administrative processes play out to see if it should be granted. This includes, in most cases, a new ARIA assessment by an independent contractor and an undescribed amount of paperwork to be submitted for review by the DHS RN. Afterwards, the policy states that a panel of DHS RN's will review each case individually and determine whether the request should be granted. If the agency fails to complete these steps within the 60-day period, then the beneficiary will be required to revert to her previous Service Budget Limit and presumably start the process all over again. The proposed Waiver and Provider Manual does not appear to contemplate what procedures will be in place to ensure timely processing of these budget exception requests, the approval of which may very well decide whether a beneficiary must be institutionalized or not. Third, the proposal also eliminates a provision that has provided a "grandfathered" status to those that received more than \$30,000 in services prior to 2018. This provision has provided a great deal of stability for many of Legal Aid's clients that have been on the program the longest. As discussed above, without this provision, many of the grandfathered beneficiaries would receive a reduction in services of as much as 131 hours per month. This translates to going from having a caregiver with you for 7 hours per day to 3.5 hours per day on a seven day schedule. The grandfathering rule acknowledged that those on the program with the highest acuity was at risk of institutionalization under the new service budget limits and therefore exempted them from it. Now these "grandfathered" beneficiaries will be directed to the new proposed budget exception request to maintain the level of services that they have received for many years. Omitted from the new budget exception request is any consideration for these individuals and the profound effect such a reduction would have on them. Additionally, the proposal lacks any mention of whether these specific beneficiaries would be notified of the new process or whether their previous grandfathered budgets will be part of the consideration for the DHS RN panel that reviews

the request. Finally, the proposal does not address how a beneficiary's budget will be handled in the years following approval of a budget exception request. It would be very burdensome on both the beneficiary and the agency to have to participate in this multi-step, 60-plus day-long process each year to determine the level of care that a beneficiary should receive. Stability is a very important factor, and the risk of fluctuations that might occur year to year if treated as a one-year exception would be untenable. Legal Aid has regularly heard beneficiaries express concern about the yearly prospects of major changes in program services received and how that might impact their lives. Such a lack of consideration for these issues runs counter to the program's goals at providing independent living in the home and community rather than the alternative of nursing home placement

**Response:** Thank you for your comment. DHS will take your comments under advisement and consider your input as it relates to the processes mentioned.

**Comment:** The proposed ARChoices Waiver and related provider manuals remove definitions vital for program operations.

The ARChoices program requires an applicant or beneficiary to be both financially and functionally eligible for the program. In evaluating whether a beneficiary is functionally eligible for the program, the agency relies on a set of specific terms that are commonly not understood by the individual seeking to establish eligibility for the program. Section 212.050 of the proposed Provider Manual removes the following important definitions:

- EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.
- EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.
- LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.
- LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.
- SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.
- SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.

- **TOILETING** means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.
- **TOTAL DEPENDENCE** means the individual needs another person to completely and totally perform the task for the individual.
- **TRANSFERRING** means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.

Terms like “limited physical assistance,” “extensive physical assistance,” “total dependence,” “locomotion,” “eating,” and “transferring” are vital to the determination of both eligibility and the level of services received. Without a proper understanding of these terms, the beneficiary may not be able to convey her needs during the assessment process accurately and would then receive a denial of eligibility. Likewise, the failure to adequately describe her needs may still lead to eligibility for the program but could still severely limit the level of services that she may receive on the program.

The removal of these definitions is crucial for purposes of due process rights as well. Those that receive a denial of services have the right to a fair hearing to contest such agency decisions. The removal of these important definitions restricts a beneficiary’s ability to receive adequate notice of the agency’s decision and as well as her ability to present evidence to the impartial hearing officer that her understanding of these important terms is the same as the agency’s. Legal Aid has represented well over one hundred beneficiaries where eligibility or the level of services turned simply on the understanding of these definitions. The proposal lacks any reasoning for the deletion of these vital terms and therefore, it is unclear whether this was an oversight or a choice to create ambiguity in the program’s operation.

**Response:** Thank you for your comment. The comment misreads the legal effect of the changes proposed in the ARChoices Provider Manual. DHS is not proposing any substantive change to the criteria or definitions for determining whether an individual requires an intermediate level of care in a nursing facility. Rather, DHS is proposing to remove duplicative language in the ARChoices Provider Manual. The definitions referenced in the comment are set forth in the Procedures for Determination of Medical Need for Nursing Home Services, which is an existing rule promulgated by the DHS Office of Long-Term Care. The Procedures are referenced in the new language added at the end of Section 211.000 in the ARChoices Provider Manual.

**Comment:** Conclusion: Legal Aid’s clients rely on this program to maintain a safe and happy life in their homes and communities rather than in a nursing home facility. As such, it is important that the program provide adequate care to meet the needs of its beneficiaries in an understandable and consistent manner. The proposed removal of eligibility pathways, arbitrarily constrained services, and ambiguity in procedures and terms appears to run counter to the program’s goals and pose a risk of institutionalization for many that receive services through the program. DHS has options that would remedy each of these concerns at its discretion.

**Response:** Thank you for your comments. DHS will take your comments under advisement and consider your input further.