

# DHS Responses to Public Comments Regarding ARChoices in Homecare Renewal

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Luke Mattingly – CEO/President

## On Behalf of CareLink

**Comment:** ARChoices Section 212.000(D) - Refers readers to the approved assessment manual. When reviewing this current on-line manual, there is no mention of ARChoices or how the tiers for LTSS are established and applied. Also, the eligibility rules have been red-lined and the rules only now reference the State Administrative Rule for level of care. This revision lacks transparency within the waiver for how the eligibility process is established, changed, and controlled.

**Response:** Thank you for your comment. The approved assessment tool manual is referenced to provide transparency in relation to the tool. Notwithstanding the final tier determination, the Level of Care eligibility is made by the Division of County Operation. The assessment of functional need is used as part of the process to determine medical eligibility and in the development of the PCSP. We have included reference to the State Administrative Rule to avoid possible incongruence should there be future rule change.

**Comment:** ARChoices Section 240.000 Prior Authorization - There is very little detail in this section. It needs to be changed to reflect the same language as the Personal Care Manual.

**Response:** Thank you for your comment. DHS will update this section to clarify that the authorization mechanism for the ARChoices program is the Person-Centered Service Plan. Additionally, sections 212.320 and 212.323 include language that the PCSP serves as the authorization for ARChoices waiver services.

**Comment:** ARChoices Section 262.300 Billing Instructions - The requirement for providers to supply the documentation proving that services were rendered at a time before or after the hospital discharge occurred has always been administratively burdensome. Medicaid has the information as a payor and has access to admission and discharge data. Unskilled home health providers do not have direct access to the information being requested. It requires significant administrative effort to obtain the required documentation.

With the implementation of state-wide requirement for Electronic Visit Verification systems, Medicaid has access to all information required to compare data and verify that services occurred before admission or after discharge without additional provider input.

This section needs to be revised to eliminate the provider requirement and to reflect that Medicaid will verify that services have been provided before admission or after discharge. All information to verify this is within state data systems available to Medicaid.

**Response:** Thank you for your comment. It is the providers responsibility to develop and maintain sufficient written documentation to support each service for which billing is made.

**Comment:** Methods for Remediation / Fixing Individual Problems – References an Intra-agency agreement between AADHS and DMS. What are the parameters of this agreement and where can this agreement be reviewed?

**Response:** Thank you for your comment. Providers may request a copy of this agreement through the Freedom of Information process.

**Comment:** Appendix J Cost Neutrality – It is interesting to note that the state projects a 2.5% annual inflationary factor for SNF's in factor D derivation. The state makes no such annual inflationary consideration for ARChoices providers. There are always several years between rate changes for ARChoices services. This 2.5% annual inflationary consideration is not applied to ARChoices waiver provider operational inflationary costs/expense, however the 2.5% increase for SNF's is directly applies to inflationary expenses related to operations. This is yet another inequity between SNF's and HCBS.

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

**Comment:** Rate for service - While the rate increase in the waiver is desperately needed, 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.

The state needs to engage in a more open conversation about this occupation and what skill sets would be preferable to deliver high quality customer care. This in turn would help ascertain what wage rate needs to be in place to support this high-quality care and in turn what rate would support the wage. Instead, the base assumption starting point for determining the rate is minimum wage, which here in Arkansas is \$ 11.00 per hour.

**Response:** Thank you for your comment. Under Executive Order 19-02 rates are reviewed on a regular cycle utilizing a standard rate review methodology.

**Comment:** Removal of Provisional Plans of Service - What is the plan to make ARChoices readily available to eligible participants? SNF's have the ability to begin services and then retro bill to first day of service after deemed eligible. No such provision is in place for ARChoices. With average processing of ARChoices initial applications exceeding 45 days or more it leaves many families with no choice but to select a facility placement over HCBS.

**Response:** In order to be determined eligible for the ARChoices waiver, individuals must meet both financial and medical eligibility requirements. Allowing for services to begin prior to determination of both financial and medical eligibility places both providers and individual at financial risk. Individuals with active full Medicaid benefit plans may receive services under state plan personal care until waiver services are approved.

**Comment:** Additional Requirements/Access to Services - In addition to topics already mentioned which fall into this category, the inability of DHS to issue a Prior Authorization at the same time as issuing the approved PCSP is detrimental to service providers and places participant services at risk. The prior authorization (PA) should be issued and coincide with the issuance of the PCSP. A prior authorization is required for a provider to be reimbursed for services. DHS issues the PCSP and expects providers to start services immediately upon receipt, but the Prior Authorization is not issued until a later date.

**Response:** Thank you for your public comment. DHS is reviewing internal processes to improve efficiency in systems. The authorization for services continues to be the Person-Centered Service Plan which is sent to the provider by the DHS PCSP/CC nurses.

**Comment:** Service Budget Caps -

Tier 1: \$ 34,000

Tier 2: \$ 23,000

Tier 3: \$ 6,000

All service caps are set to low to ensure that participants in that particular level of care has a reasonable opportunity to remain in their homes as long as possible. In Tier 1 allowing only \$34,000 annually to someone that is totally dependent and requires extensive assistance is not sufficient to ensure Home and Community Based care will assist the individual from being institutionalized. Likewise Tier 2 participants need additional supports than the budget cap allows. However, the \$ 6,000 cap for Tier 1 services is the most egregious. These individuals meet the functional needs requirements to be eligible for ARChoices. This service cap barely provides any services at all. The cap should be at least doubled to ensure a level of care that keeps participants in their home and delays progression into Tiers requiring more care or institutionalization. The service budget cap should at least be doubled to \$ 12,000.

**Response:** The Service Budget Limit (SBL) amounts were adjusted to incorporate rate increases to ensure clients continued to receive services authorized, notwithstanding subsequent rate increases. SBL's limit the maximum dollar amount of services that may be authorized based on medical determination by the Division of County Operation. Section 212.200 outlines the process for adjustments to the SBL based on change in condition.

**Jacque McDaniel, Executive Director**

**On Behalf of East Arkansas Area Agency on Aging**

**Comment:** Section 200.120-262.410 -The Personal Care policy changed “beneficiary” to “client”. The ARChoices policy changed “Beneficiaries” and “individuals” to “participants”. Why was different terminology utilized?

**Response:** Notwithstanding any difference in the terminology the individuals referenced are the same.

**Comment:** Section 213.540 E: There are three applicable rules listed—Section 215.350, 215.351 and 262.100. Is there a Section 262.100?

**Response:** Thank you for your comment. The reference to Section 262.100 has been removed.

**Comment:** Section 200.120-262.410 of the Personal Care policy changed “beneficiary” to “client”. The ARChoices policy changed “Beneficiaries” and “individuals” to “participants”. Why was different terminology utilized between Personal Care and ARChoices policies?

**Response:** Notwithstanding any difference in the terminology the individuals referenced are the same.

**Comment:** Section 212.000 Item B: The last sentence of this paragraph may have an error with the change from ‘individual’ to ‘participant’.

**Response:** Language has been reviewed to ensure consistency in the manual.

**Comment:** Section 212.000 Item I: The policy states the “program provides for the entrance of all eligible persons on a first-come, first-served basis, once participants meet all functional and financial eligibility requirements.” Should “functional” be changed to “medical”?

**Response:** Thank you for your comment. The language has been updated.

**Comment:** Section 212.000 Item I states eligible persons will be served on a first-come, first-served basis. With the elderly, behavioral health (BH) and development disabled (DD) populations being combined in one waiver, should the slots be segregated to the different populations to assure availability for the elderly population? The average length of program eligibility for elderly waiver clients is much shorter than the BH and DD populations.

**Response:** The ARChoices waiver is a distinct waiver and has not been combined with BH or and DD waivers. The slots available under the ARChoices waiver are available only to those beneficiaries who have been determined eligible for the ARChoices waiver.

**Comment:** Section 212.200 “Waiver Renewal Process:” Item C states “unless one of the following conditions applies:” then lists item 1, item 2, item 3 “or the participant disenrolls from the ARChoices Waiver program.” Should this last item actually be numerated as item 4?

**Response:** This item is listed as item 4.

**Comment:** Section 212.300 lists the acronym for person-centered service plan (PCSP) several times, but some of the listings were transposed as PCPS in Items A and C.

**Response:** Thank you for your comment. The manual has been updated.

**Comment:** Section 262.300 Billing Instructions: With the detailed requirements for caregivers to utilize electronic visit verification for documenting and billing services, the policy requiring a provider to gather documentation to prove what time the participant was admitted to a facility needs to be changed. The state should have the information to determine what time the participant was admitted to a facility instead of placing another burden on the lowest paid provider to gather this information.

**Response:** Thank you for your comment. It is the providers responsibility to develop and maintain sufficient written documentation to support each service for which billing is made.

**Comment:** Appendix 1-2: Rates, Billing and Claims— Rate Determination Methods: Even though various methodologies were used for rate determination, the rate is inadequate to support the services in our state when the minimum wage increase and other costs far exceeded the percentage increase in the rate. The added stress of low unemployment rates and shortage of workers with the ever-increasing older population has seriously threatened the viability of Home and Community-Based Services in our state.

**Response:** Thank you for your comment. Under Executive Order 19-02 rates are reviewed on a regular cycle.