DHS Responses to Public Comments Regarding Rule 289 – Personal Care And Arkansas Independent Provider Manuals

Cathy Robertson – Owner

1SourceSeniorCare

Comment: Following are my comments regarding the proposed Personal Care Provider Manual.

1. Section 210.200 A 2 b – states that the client's Medicaid ID and date of birth be on the service log for caregivers. I think that is going to allow for a lot of fraud and identity theft. Anyone that has access to a caregiver's phone would have access to a client's name, address, phone, date of birth and Medicaid number. I have no issues with that information being on the log that is produced at the provider agency's office but putting that information on the in-home caregiver's phone app/service log is opening up a world of possibilities for illegal activities.
2. Section 220.300 E – refers to a "qualified supervisor" but there is no clarification on what a qualified supervisor is or what their qualifications must be. That needs to be specified.
3. Section 220.700 B 2 a – states the newly selected personal care provider must notify the current provider of the beneficiary's decision to switch personal care providers. Will DHS be providing contact information for all of the agencies? We do not have a central database showing the contact person or email address for every other agency. If we are required to keep proof that notification has been given, we need a way to get to the correct person in each agency. Not all agencies are willing to give out that information to other agencies – just like some agencies refuse to do a verification of employment for an employee.
4. Section 220.700 B 3 – says that services are to be performed by the current provider until the 1st day of the month. The example also says that the 1st day of the month is to be included in the service. Does that mean that all authorizations and requests should not be dated from the 2nd day of the month through the 1st day of the month or should the manual read that the services are rendered until the last day of the calendar month and the new provider starts services on the 1st day of a calendar month. That needs to be clarified because if our authorizations are from the 1st through the end of the month but the manual says the old provider is to provide services on the 1st, they will not be able to bill for the services because the manual dates do not match the authorization dates. That needs to be clarified.
5. Section 220.700 B 3 a – says the current provider must forward the service record but does not specify how. If that record is put in the mail 3 days prior to the start of services, the new agency will not receive that information in time to have it in their files by the 1st day of service delivery.
6. Section 230.300 – states that reviews will be completed by DHS within 15 working days. The current wait period is 60 days. Who do we contact to enforce that 15 day turnaround time?

Comment: Following are my comments for the Proposed Personal Care Provider Manual.

Section 215.300 B – can we see that form and is it open for public comment?

Section 215.500 C – can we see that form and is it open for public comment?

Section 230.200 A – can we see that form and is it open for public comment?

Section 215.400 B 1 and 2 - #1 says "under 20" and #2 says "21 and over". The wording for these 2 paragraphs does not include the age 20. Can you clarify which form to complete?

Section 220.200 A – refers to sections 222.100-224.000 and those sections do not exist in the new manual. We need clarification on that.

Section 220.200 B 2 – refers to section 202.00 and that section does not exist in the new manual. We need clarification on that.

Section 220.300 B 12 – refers to section 223.000 and that section does not exist in the new manual. We need clarification on that.

Section 220.300 D – refers to section 202.100 and that section does not exist in the new manual. We need clarification on that.

Section 220.700 A – refers to section 226.000 and that section does not exist in the new manual. We need clarification on that.

Comment: I am writing to express strong opposition to the change in the rounding rule found in Section 250.100 C. I formally oppose the proposed change for Personal Care billing and urge we keep the current method of rounding.

1. This is not the current practice. Currently rounding is used – see existing manual 262.312. Removing the rule will be a long-term issue involving clarity and consistency for agencies.
2. CMS and nationally accepted coding standards recognize and rely on rounding rules for time-based billing for personal care – the "8 minute rule".
3. State and Federal labor regulations require payment to employees for any actual time worked. Removing the rounding rule will cause an administrative and financial burden on home care providers which are already operating at a smaller margin for direct care than many states. As an example: If our caregiver works 14 minutes into a unit, by law, if our caregivers are employees and not contractors, we have to pay them for that time. Under the new rule, we would not be able to bill for that time. This will put an additional financial burden on the agency.
4. Removing the rounding gives an unfair advantage to agencies that use independent contractors because they have the ability to form a contract with the caregiver stating that they will only pay for services rendered that are actually billed and paid. Agencies using employees do not have that advantage. Agencies in compliance with Federal mandates using employees as home care aides, must pay for every minute worked, regardless of what is billed and/or paid by Medicaid.

5. The Federal Department of Labor does not recognize the job our caregivers do as being that of an independent contractor because of the amount of control agencies have over their workflow. Arkansas does recognize them as independent contractors. Each agency would then be forced to choose between a huge financial and administrative impact that may not be sustainable with the reimbursement rate and moving to an independent contractor model which is at odds with the Federal rule on using independent contractors as home care workers.

    a. If this rule goes into effect, I anticipate agencies switching to independent contractors because of the huge financial loss they will face to stay in compliance with payment rules for employees. That means all agencies will have to choose to be out of compliance with the Federal government in order to avoid the loss of revenue if they maintain their caregivers as employees. That is also going to be a financial impact with regard to State and Federal taxes – no State or Federal taxes will be withheld from employee paychecks, and no FICA will be paid by employers if all agencies in Arkansas convert to independent contractors.

    b. The quality of care for Medicaid clients would decrease significantly as independent contractors are not bound by the same standard of high level of care for Medicaid clients as employee caregivers are.

6. The current State mandated EVV system Authenticare calculates units based on the current rounding rule. Authenticare will need to update their system, and it will need to be tested prior to implementation.

While this rule makes sense in an environment like a facility, it does not make sense in a homecare environment where caregivers are paid from the time they get to the home, until the time they leave, and there is not a one-to-one ratio of the agency being able to bill for the time paid. There is no documented reason to remove a rule that has been in place and is working well. Policy and procedure changes should be made to correct problems that have been identified. Changing this rule would create a problem where none currently exists.

I hope that the current rule that is working will remain in place and the new rule will not be implemented when the manual is rewritten.

Response: Thank you for your feedback. We will take your comments under advisement.

While DHS-required forms are not part of the promulgation process and therefore not subject to public comment, DHS has sent drafted forms to the requestor for their review and understanding.

Regarding your comments on Section 210.200, this is a requirement of Medicaid State Plan services. All personal data and identifiers are required to be secured. The Personal Care providers are expected to protect and secure PHI per HIPAA requirements

Regarding your comments on Section 220.700, the new provider transfer process has been established to ensure a smooth transfer of continuous services between providers and to act in the best interest of the recipient. Each agency has the flexibility to determine the method of transferring the client's file securely and within the policy timelines.

For provider contact information, please refer to the most up to date list of publicly available agency-provided contact information via DHS' Freedom of Choice List of Providers website, here:

https://humanservices.arkansas.gov/divisions-shared-services/provider-services-quality-assurance/information-about-our-licensed-providers/freedom-of-choices

Regarding your comments on Section 230.300, DMS monitors compliance with contract regulations.

DHS is integrating back into the manual original language on rounding and unit calculation.

Jennifer Mieirs

Comment: I am reviewing the updated manual and had a few questions and concerns.

Regarding the functional assessment, will it require a subjective assessment component (similar to the FASI from CMS)? A subjective approach may better reflect client needs compared to an exclusively objective assessment (the current ARIA). It appears that the new manual intends to rely solely on the PCS provider RN and PCP agreement with the treatment plan, but what prevents documentation that may not be accurate because a client wants personal care?

Personal care appears to be poorly understood by many PCP's as to the scope of what is or is not medically necessary, or even what PCS is under CMS guidance and rules that were reflected in the previous manual, but are missing in this draft. If a PCP orders PCS only when IADLS are needed, or to comply with their appointments, I don't see anything that would prevent the PCS provider from completing an assessment saying someone needs assistance with an ADL to get approval, nor is this in the manual as a requirement, even though it is evident in the elder choices portion of the ARIA manual that is part of the qualifications.

While we have the medicaid fraud control unit, how would we have controls in place if the sole determination rests on documentation from the PCS provider being reimbursed for the service and a signed treatment plan? Most of the current convictions related to personal care are only at the aide level and billing for care not given and not directed towards actions taken by the RN or company that may have inflated the hours and needs. Arkansas spends many millions of taxpayer money on personal care annually, and while many need and deserve the service, the state needs to make sure it's appropriately being used. There seems to be more controls with the waiver programs, but not much for personal care alone.

Page 9 (section 220.200) references sections 222.1–224.000 as covered services, which do not appear in the current draft of the manual, with these sections repealed from the old manual. Will this be updated?

Also the new forms are not yet available. Will they provide further guidance on assessment and changes in what providers will provide or will the same 618 be used with minor changes? While I applaud the attempt of making things simpler, this manual is significantly condensed in material and clarity.

Previous guidance referenced the THS as evidence-based on approving units, but the current manual does not clarify how units will be approved. Will this information be forthcoming? If not, how is the state determining personal care hours?

In relation to the ARIA changes, I have no concerns with the changes, but rather with the lack of objective assessment within the process. Evidence-based assessment should be both objective and subjective, and the current process lends itself to risks of exaggerated responses in order to receive what maybe perceived as more services, and just as strongly lends itself to underreported symptoms that may inaccurately reflect needs.

Tiering really should be based on records or objective clinical assessment and what the client or their guardian report. While a referral maybe required to get the ARIA, it alone should not be the sole clinical component. Even though the assessment is done by a clinician, no clinical judgment is used in the process.

Response: Thank you for your feedback. We will take your comments under advisement.

DHS has sent drafted forms to the requestor for their review and understanding of how personal care units and hours are determined.

Jennifier Jorgensen Vannoy, RN, BSHM

Medicaid In The Schools RN

Comment: Thank you for sending the proposed PCS Manual for review prior to making final changes. I'd like to ask some clarifying questions on behalf of my school district.

1. In the Notice of Rulemaking, the proposed effective date is listed as April 1, 2026. This proposed timeline may be problematic for schools to switch processes and forms, as well as training.

* Will current PAs carry through until the expiration before the new process would take effect for those students?

* Would it be a possible consideration to wait until August for the next school year for School Districts that enroll students in MITS?

2. Will the DMS-618 ER be required for students already receiving personal care?

3. Currently, personal care in the schools is done the same for all students, regardless of the Medicaid plan that they are enrolled in. We know private insurance does not pay for personal care provided in the school. We bill the same for all plans.

* Is it necessary to separate out the individual plans and have more than one process for the students at school? I foresee parents complaining that they still have to complete Optum assessments when the neighbors do not.

* Can it be considered to have all school aged students receiving personal care in the school setting go to the new State Plan requirements? (Section II-5215.300.B & C)

* Will a parent/guardian signature still be required on the functional needs assessment? (Provided we have a Medicaid consent form already signed by the parent.)

4. Our District utilizes EdPlan for our documentation and billing services. Currently, the billing is submitted on a monthly basis. It is separated by service type, however ambulation/transfers are lumped together, as are cleaning/laundry/and shopping. Do these need to be further separated out for logging purposes?

* Service types such as personal hygiene at school may not be a daily need, and will not likely use a full unit of service in one day.

* We have recently been instructed to request units of service based on a full month when submitting for a PA. Is it necessary to submit each service type separately on <u>each day</u> for schools?

* Can schools be allowed to submit time rolled up on a monthly basis as some service types are provided daily and some are prn? The Changes needed for programming development for the vendor will take time.

5. Section II-3; 210.200 A.2.c.ii. *It is not necessary to itemize the time spent on each ADL..., provided these tasks were performed by the same personal care aide on the same visit on the same day and at the same location.*

* How does this apply to school-based care? For our logging purposes, we currently log each service type separately with a start and stop time. How does this work if we have to separate each service type, or is this not necessary?

6. Section II-3; 210.200A.2.c.iv. *If a personal care aide does not perform a scheduled treatment plan task, the personal care aide must document and justify why the task was not performed as scheduled.*

* For school-based services that are not needed everyday such as personal hygiene, laundry, and dressing for instance, is this a daily requirement?

* Gastric tube feeding has been excluded for reimbursement. As a student is obviously not able to do this for themselves and the service is delegatable in the schools per the Nurse Practice Act, can this be reconsidered? Eating is a large part of a student's medically required ADL's.

* Per Section II.220.300.D. *All personal care services must be performed by a certified personal care aide.* Just to clarify - this means for it to be billable, correct?

7. Section II.220.300.E. Supervision:

* We currently have a two-fold supervision set up in our large District. The paras are initially trained by the District Medicaid Nurse to reach their MITS certification qualifications. For individual care skills training, they are trained at their school buildings by the nurse at that school responsible for the care of those particular students.

* To clarify, the "supervisor" referred to in E1.a-d is the <u>*school nurse responsible for each particular school*</u> - correct? I'm specifically asking - referencing the documentation log reviews.

* Our second line of supervision is the District Medicaid RN making yearly (or more) on-site visits and documenting a Supervisory visit separate from the monthly visits done by the school nurse.

8. Can you please clarify who will submit the Personal Care Functional Assessment and Treatment Plan from the physician? Will this be the school requesting services, or the physician's office once they receive the Personal Care Functional Assessment from the school's RN?

9. Clarification please: We were recently instructed by Acentra that Reconsiderations will no longer be accepted only if submitted within 30 days, but we will now have 65 days. The manual states in Section II,230.300.B. - 30 calendar days.

10. Clarification please: Section II-250.100C.6. We have been previously instructed that documentation of a service can be included in the service time. I want to make clear that what this statement means is that we should not document a separate entry for documentation time as a separate service. Correct?

Thank you for your time and consideration,

Response: Thank you for your feedback. We will take your comments under advisement.

Trainings will be provided to all providers prior to the April 1, 2026 effective date to cover specific topics and questions related to implementation. The following responses address comments submitted about the manual:

1. The DMS 618-ER Form is only required for students seeking school-based personal care services for the first time.
2. The documentation requirements listed in the manual apply to all providers. This manual does not address individual practices or internal processes used in school-based billing or service documentation.
3. If services are not delivered on the intended day and/or frequency according to the student's Treatment Plan, the service log should reflect why the services were not delivered.
4. Skilled care is not part of personal care services, per state and CMS guidelines. Skilled care cannot be billed as personal care.
5. The RN at the school is responsible for performing documentation log reviews.
6. The manual discusses the reconsideration process, which is a request for more or revised supporting documentation within 30 days in order to gain prior authorization for an Assessment & Treatment Plan.
7. Time spent on documentation is not a reimbursable service in Personal Care. It should not be entered as a separate service entry.

Katie Raines Chief Executive Officer

Comment: Please see information below from Kathy Weatherl regarding the changes to the Independent assessment regulations. Can you confirm how IDD assessments are going to occur? Are they now in the same category as BH? If so then this change is more prescriptive and certainly will not save the money that was listed in these proposed regs. I look forward to hearing from you.

KATHY'S REVIEW

1. Under section 210.100 it states reassessments will occur annually unless a change in circumstances requires a new assessment. - Aren't we currently on a 3-year reassessment schedule? Makes no sense to go back to yearly assessment for IDD and I didn't see an exception listed for IDD. Behavioral Health and/or aging more frequent assessment might make sense but for true IDD with no other issues, yearly is too much. Conditions are static, rarely improve or change.
2. They updated from the last manual dated 1/1/24 - but there is stuff in that manual that is not in this manual, and this notice of rulemaking doesn't show those changes for the ARIA.

Old manual had a section 220.00 that was labeled Developmental/Intellectual disability services, but this proposed one doesn't have that at all. (Below pic is what I am talking about in the old manual). In this proposed one, I do not even see where it talks about how a referral is made for IDD, only for Behavioral and Aging, unless I am overlooking it somewhere. We serve folks with IDD who have no behavioral health needs.

In proposed manual there is mention under 220.300 Tiering Logic B that simply states DDS tier logic is organized by categories of needs as follows:

Safety: Your ability to remain safe and out of harm's way

b. Behavior: Behaviors that could place you or others in harm's way

c. Self-Care: Your ability to take care of yourself, such as bathing yourself, getting

dressed, preparing your meals, shopping, or going to the bathroom

And then the chart starts for Tier 2 and 3

220.100 Independent Assessment Referral Process 1-1-24

A. Independent assessment referrals are initiated by the DHS Division of Developmental Disabilities (DDS) when a beneficiary has been determined, at one time, to meet the institutional level of care. DDS will send the referral for a Developmental Disabilities (DD) assessment to the current ARIA vendor. DDS will make referrals for the following populations:

1. Beneficiaries receiving services under the Community and Employment Supports (CES) 1915(c) Home and Community-Based Services Waiver.

2. Beneficiaries on the CES Waiver waitlist.

3. Beneficiaries applying for or currently living in a private Intermediate Care Facility (ICF) for individuals with intellectual or developmental disabilities.

4. Beneficiaries who are applying for placement at a state-run Human Development Center (HDC).

To continue to receive services within these populations, all individuals referred must undergo an independent assessment annually. A reassessment will be completed by staff employed by the independent assessment contractor utilizing the current approved assessment instrument (ARIA), which was approved prior to April 1, 2021, to assess functional need. An interview will be conducted in person for initial assessments, with the option of using telemedicine to complete reassessments for members with

intellectual or developmental disabilities. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

B. All populations, except for those served at an HDC, will be reassessed every three (3) years.

1. An individual can be reassessed at any time if there is a change of circumstances that requires a new assessment.

2. Individuals in an HDC only will be assessed or reassessed if they are seeking transition into the community.

Response: Thank you for your feedback. We will take your comments under advisement.

These updates to the ARIA manual do not have any impact on DD Independent Assessments at this time. Only sections of the ARIA manual that were updated were included in the public comment posting, not the entire manual. No deletions or changes were made to the sections the commenter references.

Discussion of cost-savings in the Rule is related to changes to the Personal Care manual, not the ARIA manual.

Jonathan Fry, Owner

J & S Fry Enterprises, Inc., Home Instead, Not Home Alone, Inc.

Comment: I am writing to voice significant concern regarding the proposal to eliminate the long-standing rounding rule from the Medicaid Provider Manual for Personal Care services. After reviewing the practical, financial, and compliance implications, it is clear that removing this rule does not resolve an existing issue—rather, it creates multiple new challenges for DHS, providers, and Medicaid recipients.

1. The Current Rounding Rule Provides Needed Consistency — Eliminating It Reduces Accuracy

The rounding approach currently in place has been relied upon for many years because it promotes clarity, uniformity, and predictability when billing time-based services. The proposed removal offers no replacement guidance, which would mean:

- Each provider must independently determine how to convert minutes to units.
- Billing teams will inevitably apply different standards.
- DHS will see more disputed claims, audit discrepancies, and processing slowdowns.

Instead of one clear expectation, DHS would be left with countless individual interpretations—inviting confusion rather than improving efficiency.

2. The Proposal Conflicts With Established CMS Expectations

CMS has long supported the use of standardized rounding practices for time-based billing across multiple service categories. The most widely recognized example—the 8-minute rule—serves as a national benchmark across Medicare, Medicaid, and private insurance.

Removing the rounding rule would place Arkansas Medicaid outside of alignment with:

- CMS billing conventions
- National coding and documentation requirements
- Federal compliance and actuarial assumptions

In effect, DHS would be asking providers to bill in a manner that contradicts the very standards their claims could later be measured against. This creates operational and regulatory conflict.

3. The Change Adds Administrative Burden Rather Than Reducing It

If the rounding rule is removed, providers will be required to:

- Redesign billing and software systems
- Retrain staff statewide
- Manually verify thousands of daily clock-in and clock-out entries
- Respond to an inevitable rise in denied or questioned claims

This is not a minor revision. It is a substantial administrative overhaul that increases costs for providers and generates new complexities for DHS—without producing a clear benefit.

At a time when direct care providers are already stretched thin, removing a rule that streamlines workflow actively undermines the goals of rate-review reform.

4. The Change Increases the Risk of Accidental Non-Compliance

Without a clear rounding policy, even a one-minute variance below a unit threshold could lead to:

- consistent underbilling
- varying interpretations across agencies
- unintentional overbilling
- increased audit exposure
- inconsistent claim decisions on the DHS side

Eliminating the rule essentially forces providers to guess how DHS wants time converted—an unsafe and unnecessary position for any regulated entity.

5. There Is No Identified Problem That This Change Solves

The proposal does not present evidence of:

- compliance concerns linked to the rounding rule

- fraud, waste, or abuse facilitated by its use
- cost savings for DHS
- measurable improvements for beneficiaries

Policy changes should address documented issues. In this case, the change introduces risk and ambiguity into a process that currently works as intended.

6. The Result Is Fewer Resources Directed Toward Patient Care

Every new administrative requirement pulls time, staffing, and financial resources away from serving Medicaid members. Eliminating the rounding rule is not a harmless adjustment—it adds operational strain at a moment when the long-term-care industry is already facing workforce shortages and cost pressures.

Conclusion

The rounding rule is not the source of a problem. Removing it would destabilize a functioning billing framework, conflict with federal norms, and add significant administrative burden for both DHS and providers.

For program stability, regulatory alignment, and continued quality of care, I respectfully urge DHS to retain the current rounding rule.

Thank you for considering these concerns. I strongly encourage DHS to withdraw the proposed change and maintain the existing, clear rounding standards that providers have relied on for years.

Response: Thank you for your feedback. We will take your comments under advisement. DHS is integrating back into the manual original language on rounding and unit calculation.

Noel Morris, Franchise Owner, Three Rivers Senior Services, Inc.

Home Instead, Inc.

Comment: I am submitting this comment in strong opposition to the proposed elimination of the longstanding rounding methodology for billing Personal Care services in the Medicaid Provider Manual.

After carefully reviewing the proposal, I am convinced that removing this rule does not resolve any existing issue; instead, it will create significant new operational, financial, and compliance problems for DHS, providers, and the Medicaid beneficiaries we all serve.

1. The Current Rounding Rule Provides Clarity and Consistency – Eliminating It Will Create Chaos

For years, the established rounding standard has given providers and DHS a predictable, uniform way to convert service minutes into billable units. The proposal offers no replacement guidance. The predictable result will be:

- Hundreds of providers developing their own ad-hoc conversion methods

- Widespread inconsistency in claims submission

- A sharp increase in claim denials, payment delays, disputes, and audits

Replacing one clear, statewide standard with thousands of individual interpretations is the opposite of simplification.

2. The Change Puts Arkansas Out of Step with Federal CMS Expectations

The Centers for Medicare & Medicaid Services (CMS) expressly permits and relies on rounding methodologies (most notably the widely adopted 8-minute rule) for time-based services in Medicare, Medicaid, and private insurance nationwide.

By deleting its rounding rule without a replacement, Arkansas would be forcing providers to bill in a manner that conflicts with the very federal standards CMS auditors use. This creates unnecessary legal and compliance risk for both providers and the state.

3. Far from Reducing Burden, This Change Dramatically Increases It

Providers across Arkansas will be required to:

- Overhaul billing software and internal processes

- Conduct statewide retraining of billing and scheduling staff

- Manually review tens of thousands of daily clock-in/clock-out records

- Defend a surge in claim rejections and payment disputes

These are not minor adjustments—they represent a costly, system-wide disruption at a time when the home- and community-based services workforce is already stretched thin.

4. Removing the Rule Invites Inadvertent Errors and Audit Exposure

When a caregiver's shift ends just one or two minutes short of the next unit threshold, the absence of a rounding rule will lead to inconsistent decisions—some providers will round down (underbilling), others may inadvertently round up (risking overbilling allegations). Without explicit guidance, honest mistakes become almost inevitable, exposing everyone to greater audit liability.

5. No Problem Has Been Identified That Justifies This Change

The notice provides no evidence that the current rounding rule has caused compliance violations, enabled fraud, generated overpayments, or harmed beneficiaries. In the absence of a documented problem, introducing widespread uncertainty and new costs is unjustified.

6. Resources Will Be Diverted from Care to Paperwork

Every hour spent rewriting policies, retraining staff, and fighting claim denials is an hour not spent delivering care to Arkansas's most vulnerable citizens. At a time of severe direct-care workforce shortages and tight margins, this proposal moves resources in exactly the wrong direction.

Conclusion

The existing rounding rule is a proven, efficient, and federally aligned standard that supports accurate billing and program integrity. Eliminating it without a replacement will inject confusion, increase costs, heighten compliance risk, and ultimately harm the beneficiaries the Medicaid program exists to serve.

I respectfully urge the Arkansas DHS to withdraw this proposed change and retain the clear, consistent rounding methodology that has served the state well for many years.

Thank you for considering my comments during this public comment period.

Response: Thank you for your feedback. We will take your comments under advisement. DHS is integrating back into the manual original language on rounding and unit calculation.

Matt McClure, Ed.D.

Arkansas Home and Community Based Services- Board Chairman

Comment: I am writing to express strong opposition to the proposed removal of the long-standing rounding rule from the Medicaid Provider Manual for Personal Care services. After reviewing the operational, financial, and regulatory consequences, it is clear that this change does **not** solve a problem—but instead creates several new ones for DHS, providers, and beneficiaries alike.

1. The Current Rounding Rule Works — Removing It Damages Accuracy

The existing rounding methodology has been used for years because it ensures clarity, consistency, and predictability in billing time-based services. The proposed removal provides no alternative standard, which means:

- Each provider will be forced to interpret how to convert minutes into units.
- Billing staff will inevitably apply different methods, creating inconsistent claims.
- DHS will face increased claim disputes, audits, and administrative delays.

This change replaces one clear rule with *thousands of individual interpretations*—a recipe for confusion, not efficiency.

2. The Proposal Conflicts with Federal CMS Standards

CMS explicitly recognizes rounding methodologies for time-based billing across many benefit categories. The most well-known example—the 8-minute rule—is foundational for Medicare, Medicaid, and commercial payers nationwide.

Removing the rounding rule would put Arkansas Medicaid out of alignment with:

- CMS billing practices
- National coding and documentation standards
- Actuarial expectations used for federal compliance

In essence, DHS would be asking providers to bill in a way that directly contradicts the standards against which their claims may later be audited. That makes no operational or legal sense.

3. The Change Increases Administrative Burden, Not Reduces It

The proposed change will force providers to:

- Rebuild internal billing systems
- Retrain staff statewide
- Review thousands of daily clock-in/clock-out entries manually
- Address increases in denied or questioned claims

This is not a small adjustment. It is a massive administrative undertaking, introducing new costs for providers and new oversight headaches for DHS—without any identified benefit.

At a time when direct care providers are already overburdened, removing a rule that *improves efficiency* runs counter to the goals of the system and the intent of the rate review reforms.

4. It Opens the Door to Unintentional Non-Compliance

Without a rounding rule, something as simple as a clock stopping one minute short of a billing unit could lead to:

- systematic underbilling
- inconsistent interpretations
- accidental overbilling
- audit risk for providers
- adjudication inconsistencies for DHS

A lack of guidance forces providers to "guess" DHS's intent—something no stakeholder wants.

5. There Is No Documented Reason to Remove the Rule

The proposal does not identify:

- a compliance issue the rule creates
- any fraud, waste, or abuse the rule enables
- a measurable financial benefit to DHS
- any operational improvement for beneficiaries

Policy changes should fix identifiable problems; this one simply introduces risk and confusion in an area that was functioning as designed.

6. It Ultimately Diverts Resources Away From Patient Care

Every additional administrative burden takes time, money, and attention away from serving Medicaid beneficiaries. Eliminating the rounding rule is not a neutral change—it directly raises operational costs at a time when the industry is already strained by workforce shortages and reimbursement pressures.

Conclusion

The rounding rule is not the problem. Removing it would destabilize a billing structure that providers and DHS rely on, contradict federal norms, and increase administrative burden for everyone involved.

For the sake of program integrity, regulatory alignment, and continuity of care, I strongly urge DHS to preserve the existing rounding rule.

Thank you for the opportunity to share these concerns. I respectfully request that DHS withdraw this proposed change and maintain the clear and consistent rounding standards currently in place.

Response: Thank you for your feedback. We will take your comments under advisement. DHS is integrating back into the manual original language on rounding and unit calculation.

Cody Garrison, Vice President, MHA, MSN, RN
Co-Owner/Operator – Genesis Partners, LLC dBa Arkansas Home Helpers

Comment: I am writing to formally oppose the proposed change to the Department of Human Services Medicaid Provider Manual for Personal Care that would eliminate the established rounding rule used for billing time-based services. This change has significant implications for administrative accuracy, provider compliance, and alignment with federal standards governing Medicaid claims.

The current rounding rule provides clarity, consistency, and administrative efficiency for both providers and the Department. Removing this rule introduces ambiguity regarding how units of service should be calculated, increasing the likelihood of billing errors, inconsistencies in claims adjudication, and unintentional non-compliance. Time-based codes—particularly those aligned with CPT and HCPCS standards—require clear and uniform guidance to ensure that billing practices remain accurate and auditable.

Furthermore, the Centers for Medicare & Medicaid Services (CMS) continues to recognize and rely on rounding rules for time-based billing across multiple service categories, including evaluation and management codes, therapy services, and other time-dependent procedures. CMS guidance and nationally accepted coding standards commonly reference the use of rounding—for example, the “8-minute rule” and other established methodologies—to determine appropriate billing units. Maintaining a rounding mechanism within the state Medicaid manual is therefore essential to preserve consistency

with federal expectations and industry norms. Removing the rounding rule would place Medicaid providers at odds with the very standards that CMS uses to evaluate claims and could lead to unnecessary confusion, administrative burden, and potential claim denials.

Additionally, the proposed change risks impacting federal and state labor regulations. The loss of a clear rounding standard will introduce avoidable operational costs and increase the administrative burden on staff, diverting time and resources away from direct patient care.

For these reasons, I strongly urge the Department to retain the existing rounding rule. Maintaining alignment with federal billing guidelines protects the integrity of the Medicaid program, supports provider compliance, and ensures the continued availability of high-quality services for Medicaid beneficiaries.

Thank you for the opportunity to comment on this proposed change. I respectfully request that the Department reconsider this modification and preserve a clear and consistent rounding rule within the provider manual.

Response: Thank you for your feedback. We will take your comments under advisement. DHS is integrating back into the manual original language on rounding and unit calculation.

Catherine Burks, RN

Chief Compliance Officer

Comment: Public Comment Opposing Proposed Changes to Section 220.700: Transitioning Personal Care Providers

I respectfully submit the following comments in opposition to the proposed rule changes regarding the transition process between personal care providers. While the intent of ensuring continuity of care is understandable, these specific procedures introduce significant risks and challenges for beneficiaries, caregivers, and care-coordinating professionals. For the reasons outlined below, I urge that these changes not be implemented as written.

1. The proposed process creates unnecessary friction and communication barriers between competing providers.
Requiring new providers to notify and communicate directly with the incumbent provider places two competing agencies in a position where cooperation may be strained or even hostile. In practice, agencies are often reluctant to share client information or coordinate in good faith when competition for staffing and client retention is involved. This rule presumes a level of willingness and transparency that does not always exist, and it sets the stage for conflict rather than smooth transitions.

2. The plan forces beneficiaries into the middle of provider-to-provider conflict.
Because agencies have a natural desire not to lose clients, any required direct communication between old and new providers creates an incentive for the current provider to delay or discourage the transition.

This places the beneficiary—who may already be vulnerable—in the uncomfortable and potentially stressful position of being caught between two agencies trying to retain or acquire their case. Beneficiaries should never be subject to this pressure.

3. Inter-agency transfer of service records is not always feasible or reliable.
The expectation that one provider will seamlessly supply another with the beneficiary's complete service record (including assessments, treatment plans, and required forms) is unrealistic. Providers use different systems, documentation standards, and internal workflows. Delays, omissions, or incomplete records are common when transferring documentation between agencies, and the beneficiary ultimately bears the consequences. Missing or delayed paperwork could directly interrupt care.

4. Lack of a new assessment when a new provider take over poses clinical and safety concerns.
Each provider employs its own clinical staff, with its own RN supervisors, caregivers, and quality standards. A beneficiary's needs may appear consistent on paper, but in reality, a safe and effective care plan requires each RN to assess the client directly. Not requiring a new assessment bypasses a critical clinical safeguard: allowing the newly responsible RN to independently verify functional needs and ensure the treatment plan is appropriate, accurate, and safe. A plan written by one agency's nurse should not automatically be adopted by a different agency's team without confirmation.

5. Care transitions should be coordinated by the authorizing party—not by competing providers.
The responsibility for initiating, approving, and coordinating a change in providers should rest with the authorizing entity, such as the client's primary care provider (PCP) or DHS. These parties have no competitive stake in the outcome and can ensure that transitions protect the beneficiary's rights, medical needs, and continuity of care. Direct inter-provider communication places the process in the hands of parties with conflicting business interests.

6. The delayed transition timeline unnecessarily prolongs care under an unwanted provider.
Requiring clients to remain with their current provider until the first day of the second month after notification prolongs a relationship that the beneficiary has already elected to end. Clients typically seek a new provider due to unmet needs, dissatisfaction, or changes in circumstances. Extending their time under the old agency may compromise their well-being and undermines their stated freedom of choice.

Conclusion
While continuity of care is essential, the proposed rule changes introduce problematic inter-agency communication requirements, place clients in the middle of provider disputes, risk incomplete documentation transfer, and eliminate essential clinical assessments. Most importantly, they shift control of the transition process away from neutral authorizing entities and into the hands of competing providers.

For these reasons, I respectfully urge reconsideration of these proposed changes and recommend that any transition process preserve beneficiary choice, maintain clinical safety, and ensure that coordination is handled by impartial authorizing parties, not by competing agencies.

Thank you,

Response: Thank you for your feedback. We will take your comments under advisement.

The provider transfer process has been established to ensure a smooth transfer of continuous services between providers and to act in the best interest of the recipient. This policy allows, but does not require, the new provider to utilize the unexpired Assessment & Treatment Plan and 618-TP from the outgoing provider. Freedom of Choice mandates that the beneficiary is at the center of decision-making for choice in providers and care delivery. This DHS policy does in fact mandate more coordination of transitions, as per the authority of DHS.

Luke Mattingly, CEO/President

CareLink

Comment: Public Comment

Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals CareLink response
December 4, 2025
Section II 250.100 C. 1. 2. 3. The following standard reimbursement rules apply to all services.

This change in billing procedure deviates from decades of precedence and the In-Home Services industry standard of following the CMS 8-minute (or rule of 8) rounding rule.
This change is unnecessary and arbitrary. It will require the retraining of thousands of in-home aides (for which there is no ability to bill or reimbursement for providers), the reprogramming of numerous software systems used by various providers (again for with there is no reimbursement mechanism), and the shifting of some costs, that were previously billable, to providers of the service in a time when reimbursement rates for these services are inadequate and already threaten the viability and sustainability of Medicaid in-home services.
Strike the proposed change and return the language in this section to reflect procedures in the current manual, which correlates with the CMS 8-minute rounding rule.
Section II 250.100 C. 5**.** Rest, toileting, or other break times between service delivery is not billable.

Not providing reimbursement for break times is totally understandable. However, specifically including toileting is antiquated and harkens back to being on the manufacturing production lines in the 1930's, 40's and 50's. Expecting an in-home Aide to clock-out and then clock-in again with an EVV system to take a 2-minute bathroom break is ridiculous. I question whether the heavily Medicaid funded nursing home industry requires staff to clock out to go and urinate or for that matter the publicly funded facilities operated by the State of Arkansas, the answer of course is no.
This language further demonstrates policy makers lack of understanding of operational concerns for Home and Community based services and in this case common sense.
While we are updating the manual, the word toileting should be eliminated from Section 250.200 Fee

Schedules
There is no problem with the fee schedules per se, the problem is with the fee reimbursement rate. The reimbursement rate for Personal Care, Attendant Care, and Respite is woeful and in desperate need of revision. The current rate endangers the sustainability of these home and community-based services. Inflationary pressures affecting labor, insurance, benefits, software and a plethora of other factors impacting businesses are not being addressed in the reimbursement rate. A cyclical rate review by DHS has been cancelled or indefinitely postponed creating a critical situation where these services and providers are effectively on life support, to use a healthcare analogy. The variation in spending between facility-based care and home and community-based care in Arkansas continues to widen in favor of facilities. This is partially because of concessions made to facility-based care during COVID that remained in affect even after the pandemic was in control and partially because nursing home facilities have a regulatory mechanism to annually address cost increases.
The Great State of Arkansas needs to commit to healthy thriving Home and Community Based services. Other than the Hutchinson administration, which initiated a three-year rate review cycle, rates have only been adjusted when a crisis arises. Crisis management as a policy does not build a system of sustainable high-quality services.
Providers of these services will tell you; “we are in a crisis now”.
INCREASE THE RATE FOR PERSONAL CARE, ATTENDANT CARE, and RESPITE CARE IMMEDIATELY.

Response: Thank you for your feedback. We will take your comments under advisement.

Reimbursement rates are outside of the scope of the Personal Care manual.

Regarding your comments on 250.100, this policy is to prevent billing for personal time spent away from the beneficiary.

DHS is integrating back into the manual original language on rounding and unit calculation.

Shanna Maguffee Deputy Director

White River Area Agency on Aging

Comment Section 200.100, B. 2 and 3
While we completely understand and agree the importance of background checks for client safety, we do question the reduction of Child and Adult Maltreatment from five to two years.

Section 210.200 A. 3

This asks for “weekly or more frequent progress notes” but does not take into consideration the EVV system of documentation. There is very limited ability to have free type. Please, when completing this manual, explain exactly what types of “beneficiary conditions" are expected and allow for less condition comments for those who are stable and are not dealing with changes in condition or issues.

Section 215.400 Section B
Starting at this section, it appears there is an assessment (DMS618) and then later in manual, it appears duplicative information is required two additional times.

ADLs and IADLs documented in Section V
Summary of level of need again in narrative in Section VII
Describe ADL and IADL need in the Treatment Plan Section in Section X

RN assessment is vital, but the time and repetitive nature that appears to be required here should be reviewed.

Section 215.400 E. 1 and Section 220.700 3.
The expectation that all information, assessments, service planning will be shared with another provider, in the event that a beneficiary chooses to change providers, seems to be asking for proprietary information and processes. Additionally, some providers likely will not willingly share the information to assure a smooth transition for the beneficiary. The outcome will likely be that beneficiaries who need care will have a lapse in service.
Section Section 220.300 E. 1 and 2
Staff changes have occurred since the manual changes that allowed for a "qualified supervisor" that did not have to be a registered nurse. In this section, there is language that appears to intermingle the two roles (RN and QS). We respectfully request maintaining the qualified supervisor duties and not increasing RN duties. It is important to point out that there is no reimbursement for any RN duties (other than we are aware that it is stated that the RN costs are built into the rate, but the rate is so desperately low that it no longer can be mathematically stated that it is.)

Section 215.400 F.
Confusion exists in the verbiage of section F. Please clarify.
Section 250.100 C. 1, 2, 3
It appears that this section deviates from CMS 8-minute ruling and it also does not take into consideration the business type of home and community based services. This creates a monumental burden of retraining of staff and restructuring of software services that have been created under a long-standing accepted rule.

Section 250.100 C. 5
This section appears to be asking a caregiver to clock out for a brief break and using the restroom. If we are reading this incorrectly, please re-word for clarification. If we are reading this correctly, this seems to be a ridiculous request. What industry or work place expects such a requirement? As difficult as it is to hire good caregivers at this time, and as low as the reimbursement rate is that restricts what caregivers can be paid, it seems like a final knock-out blow to tell them they must now clock out for the five minute trip to the restroom.

Section 250.200 Fee Schedule
This seems to be the most appropriate place to note this comment. We respectfully request an increase in the rate for home and community based services. The rate has not come close to keeping up with salary costs, additional unfunded mandates, and general inflation and cost of living increases.

Response: Thank you for your feedback. We will take your comments under advisement.

While forms are not part of the promulgation process and therefore not subject to public comment, DHS has sent drafted forms to the requestor for their review and understanding.

Regarding your comments on Section 200.100, Act 853 was enacted in the last legislative session. It removed the certification process by the Division of Provider Services & Quality Assurance at DHS for private care agencies. As a result, personal care providers are now deemed high-risk providers by Arkansas Medicaid. The change in frequency of checks is in line with this change.

Regarding your comments on Section 215.400, included in the Transition Request Form is the option to request an "Emergency Transfer," which would include changing providers due to a loss of services. Please see Section 220.700 of the manual. DHS and its contractors will work to ensure clients do not have a gap in services.

Regarding your comments on Section 250.100, this policy is to prevent billing for personal time spent away from the beneficiary.

Reimbursement rates are outside of the scope of the Personal Care manual.

Brad Bailey

Area Agency on Aging of Northwest Arkansas

Comment: Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals

Area Agency on Aging of Northwest Arkansas Response

Change of Providers seems punitive to Medicaid recipients. Clients will have to wait until the first of the second month after they switch providers. Eg. Client decides they want to change providerson may 15th. They will not be able to start with a new provider until July 1. This is too long and the client suffers. Generally if they are wanting to switch its because there is not a PCA available. They will be going month and a half without services.

If there is a switch of providers I do not agree with having the current provider to hand over their care plan to the new provider. We don't want to give our care plans to other providers

And do not feel comfortable with using some other providers care plans. Providers should do their own care plan upon referral of new clients. There could be changes that have occurred since the last provider has seen the client and the enforcement of this proposal will be difficult if not impossible. I would think that professional liability insurance providers would require a new care plan if they are assuming the liability. Claims could possibly be denied if errors were made by a prior provider and new providers uses the old care plan.

Section II 250.100 C. 1. 2. 3. The following standard reimbursement rules apply to all services.

This change in billing procedure deviates from decades of precedence and the In-Home Services industry standard of following the CMS 8-minute (or rule of 8) rounding rule. I feel the change is unnecessary.

Section II 250.100 C. 5. Rest, toileting, or other break times between service delivery is not billable.

Not providing reimbursement for break times is totally understandable. Requiring employees to clock out to clock in and out to take a short bathroom break is unreasonable. Plus how would this ever be policed. Recipients complain about PCAs that are not doing their job and wasting time and can be addressed through that means.

Section 250.200 Fee Schedules

There is no problem with the fee schedules per se, the problem is with the fee reimbursement rate. The reimbursement rate for Personal Care, Attendant Care, and Respite is woeful and in desperate need of revision. The current rate endangers the sustainability of these home and community-based services. Inflationary pressures affecting labor, insurance, benefits, software and a plethora of other factors impacting businesses are not being addressed in the reimbursement rate. A cyclical rate review by DHS has been cancelled or indefinitely postponed creating a critical situation where these services and providers are effectively on life support, to use a healthcare analogy. The variation in spending between facility-based care and home and community-based care in Arkansas continues to widen in favor of facilities. This is partially because of concessions made to facility-based care during COVID that remained in affect even after the pandemic was in control and partially because nursing home facilities have a regulatory mechanism to annually address cost increases.

Response: Thank you for your feedback. We will take your comments under advisement.

Regarding your comments on Section 215.400, included in the Transition Request Form is the option to request an "Emergency Transfer," which would include changing providers due to a loss of services. Please see Section 220.700 of the manual. DHS and its contractors will work to ensure clients do not have a gap in services.

Reimbursement rates are outside of the scope of the Personal Care manual.

Regarding your comments on 250.100, this policy is to prevent billing for personal time spent away from the beneficiary.

Alycia Stroud RN, CEO

1st Choice Home Care, Inc

Comment: Impact of Arkansas Medicaid Personal Care New Rules on 1st Choice Home Care Costs

Overview of New Arkansas Medicaid Rules

The state of Arkansas has introduced new rules for its Medicaid program, which are anticipated to have a significant effect on home health care providers, including 1st Choice Home Care. While the specifics of the new regulations are still being analyzed, the primary areas of impact are related to reimbursement structures, administrative requirements, and patient eligibility criteria.

The effective date for these changes is Apr 1, 2026. A detailed summary of the new regulations is available in the appendix, https://humanservices.arkansas.gov/wp-content/uploads/Personal-Care-and-Arkansas-Independent-Assessment-Provider-Manuals.pdf.
Projected Additional Costs for 1st Choice Home Care

The implementation of these new rules will introduce several additional costs for 1st Choice Home Care. These costs can be categorized into administrative overhead, direct patient care expenses, and compliance and training.

1. Administrative and Compliance Costs

New regulations will necessitate updates to our internal processes and increased administrative oversight.

Area of Cost	Description	Estimated Impact
Staff Training and new hires (approx. 11 new RNs)	Mandatory training for all staff on new documentation and compliance standards. Hire new RNs to replace LPN's/other medical professionals	Increased expenditure on training sessions and materials. Due to the new staff replacing all current LPN's/Health professionals that are qualified to do assessments and supervisory forms. (Must hire all

Area of Cost	Description	Estimated Impact
	(**The average RN salary in Arkansas is approximately $61,530 to $74,474 annually, with hourly rates ranging from about $35.16 to $39.83.)*	RN's) ***LPN's, Medical professionals and RN's that we pay now, annually $1,070,014.40 compared to if we had all RN's doing patient assessments, supervisory visits and VA. (* RN pay is based on $40hr) $$1,664,000.00** That is a difference of +**$593,985.60** more annually that will have to be paid in wages.
Layoffs for all LPN's/Medical professionals that were allowed to assess patients/supervisory visits	Any staff that is NOT a RN due to the new rules. Only an RN is able to Assess for DMS-618	Significant cost in unemployment insurance will have to be paid to staff that will be laid off due to new rules. (Est. Cost layoffs of 11 employees if we figured that at the maximum benefit amount of $451 for the 12 weeks that would be a total of $59,532.00)
Auditing and Reports	Increased frequency and complexity of internal and external audits required by the new rules. (Running state background checks every 5 yrs, Adult and child maltreatment every 2 yrs (used to be 5 yrs) All caregivers and staff must also have a sexual offender registry every 2 yrs.	Additional staff hours dedicated to compliance and reporting. (**Difference of $180,000 more in a 10-year span. Extra cost of $18,000 a year.)** $22.50 Arkansas Background, $10 each maltreatment check Adult and Child = $42.50 each Sexual Predator background is free so that is not an extra cost.
Fee Schedules in Personal Care, AR Choice Waivers, (attendant care, respite) Targeted case management= TCM	Last updated fee schedule for personal care, attendant care and respite is 1/1/2021 at $5.12 unit. (Unit=15 minutes) Which is $20.48/hr. Last fees update 4/27/16 TCM $7.50 unit/ $30.00 hr. *Criteria for TCM employment:* Licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Certified Social Worker),	Vet Assist pays $26.00/hr. for personal care VA or Veteran services pay $37.00/hr. for personal care, respite, homemaker/attendant care. *Personal Care Fee Schedules in Neighboring States.* Missouri Reimbursement Fee Schedule (Unit=15min) $8.16 unit=$32.64hr

Area of Cost	Description	Estimated Impact
	a registered nurse or a licensed practical nurse. Have a bachelor's degree from an accredited institution in a health and human services or related field; or Have two years' experience in the delivery of human services, including without limitation having performed satisfactorily as a case manager for a period of two (2) years (experience must be within the past three (3) years).	Tennessee Reimbursement Fee Schedule (Unit=15min) $6.49 unit=$25.96hr Oklahoma Reimbursement Fee Schedule (Unit=15min) $6.58 unit=$26.32hr ***RN assessments and supervisory visits are not reimbursed through Arkansas Medicaid.***

2. Direct Patient Care Costs

Changes to patient eligibility and service definitions may lead to changes in service delivery.

- Increased Documentation Approval Time: The new rules require a PCP/Physician signature before it is turned in with Atrezzo Registration to apply for a preapproval number for services. (Services cannot start until we have obtained the number for approval)

  The New Documentation and Process:

Client/Patient Eligibility, Process of Admission and Supervision

Initial DMS-618ER "Evaluation Referral"
  - Required initially when entering the personal care program but not annually
  - Only required again if the client is not serviced for 120 days
  - Must be signed by a PCP
- Functional Needs Assessment & Treatment Plan
  - Will replace our current DMS-618
  - Youth - under 20 years of age - "Youth Personal Care Functional Assessment & Treatment Plan"
  - Adult - above 21 years of age - "Adult Personal Care Functional Assessment & Treatment Plan"
  - Must be completed, signed, dated by RN
  - Only done annually, not needed when switching providers
- DMS-618TP "Treatment Prescription"
  - Must be signed by PCP
  - Valid for 1 year, renew annually
  - New DMS-618TP is not required if client switches PCP or companies
- Supervisory Visits
  - Must be performed by an RN
  - Must be done 1x annually but no limit on frequency if more completed

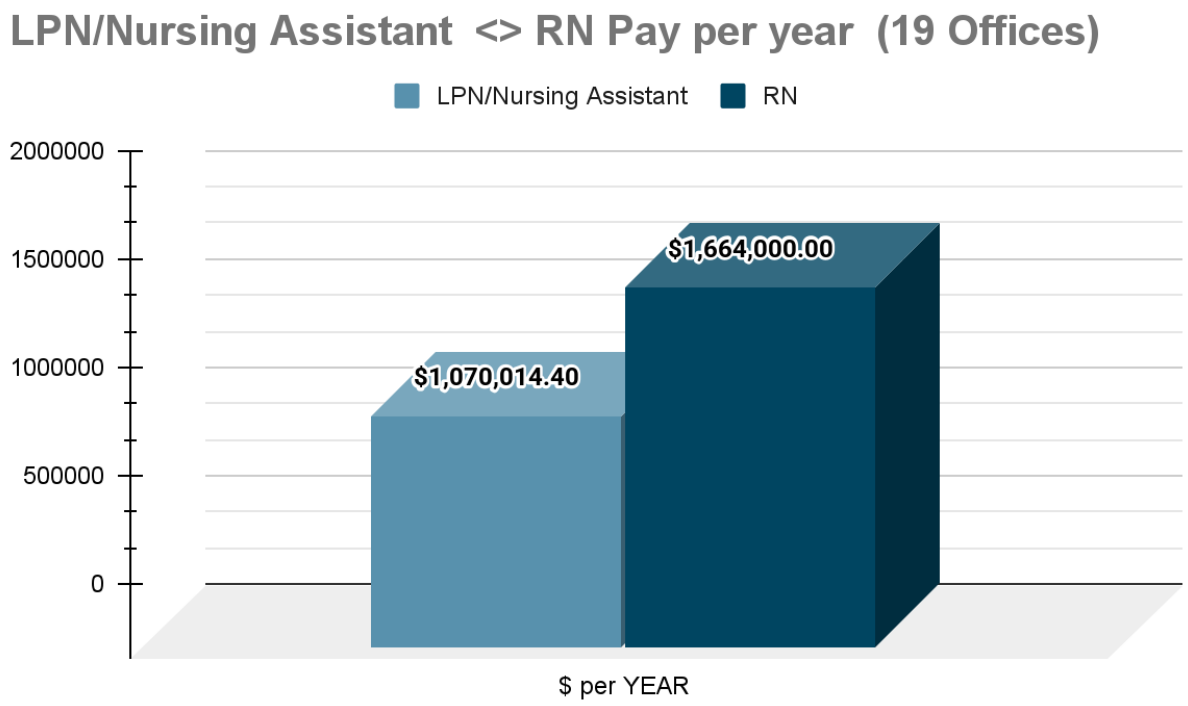
Transitioning Personal Care Providers

- Beneficiary Requirements
- Must complete a “Personal Care Provider Transition Request Form”
- New Provider Requirements
    - Must notify current provider of transition
    - Must provide current provider with the client’s Transition Form
    - Must keep proof that transition notification was sent, date and time, in client file
- Current Provider Requirements
    - Must continue servicing clients/patients until the 1st day of the second month after notification was sent to them
        - If notification is sent May 11, the current provider will continue services until July 1st
    - Must provide the new provider with a complete “Service Record”
        - Service records include:
            - DMS-618ER - “Evaluation Referral”
            - Current Assessment & Treatment Plan
            - Active signed DMS-618TP - “Treatment Prescription”
- Revised RN-Staff: If new rules mandate staffing all Registered Nurses, certain levels of care, additional hiring will be required, impacting on overall payroll costs. A meeting to discuss these changes has been set in place to discuss all changes.
- Enhanced Service Requirements/reports: New mandates for specific types of requirements for background checks more frequently or specialized training for care staff will lead to higher operational costs per patient. The multistep process to approve a client/patient for services can severely impede the care of the client/patient. As of now, it is taking months to get a PA (preapproval) due to the steps with OPTUM and Atrezzo. As of 4/1/26, OPTUM will no longer be a step in the process, but several steps are added to the providers to get the approval for services.

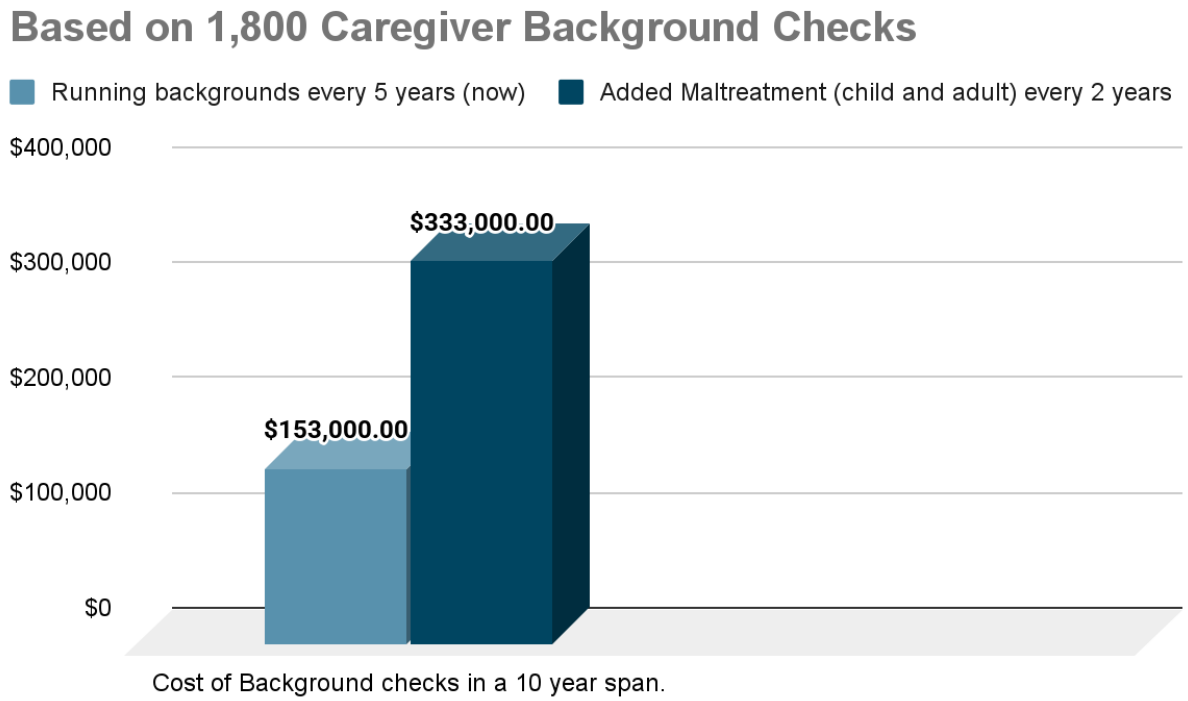
3. Financial Implications

Based on preliminary analysis, the overall financial burden is projected to increase.

[A detailed financial projection table showing increased operating expenses due to the new Medicaid rules]



LPN's, Medical Professionals and RN's that we pay now, compared to if we had all RN's doing clients assessments, supervisory visits and VA. RN pay is based on $40 ph.



Difference of $180,000 more in a 10-year span. Extra cost of $18,000 a year. $22.50 Arkansas Background, $10 each maltreatment check Adult and Child = $42.50each

Sexual Predator background is free so that is not an extra cost.

3. Direct Client/Patient Care Impact

- Longer waiting time for approval
- Change in continuity of care, due to the impact of changing staff (LPN/Medical Professionals to all RNs)
- Lack of care due to the time of waiting for approvals. Many clients/patients will go without care due to the wait and several steps that need to be approved for services.
- Changing providers can be a hindrance to client/patient if the old provider does not comply with the new rules. This is a strain on the client/patient, which can be a window for harassment or lack of care.

3. Arkansas Medicaid Personal Care Proposal from 1st Choice Home Care, Inc.

- Fee schedule increase to adjust to the increase of cost to provider
- Grandfather in LPN's/Medical professionals to do assessments/supervisory visits but it must be supervised and signed off by an RN.
- Instead of the PCP/Physician signing off on all assessments, making it mandatory to have documentation from hospitals/physicians' clinics, or therapists (physical or mental health) to reflect services rendered or requesting and patient condition and diagnosis.
- Atrezzo should have a time limit to approve clients/patients, it should not take 2-3 months for approvals. Better communication from Atrezzo, when a client/patient changes provider or any change needs to be communicated better to the provider.

Next Steps

To mitigate the financial impact, 1st Choice Home Care is taking the following actions:

- Staff Briefing: A mandatory meeting for all supervisory staff will be held at our administration office, 120 N 2nd Street Paragould AR 72450, to review the changes.
- System Review**:** An internal team is assessing the necessary updates to background checks, new assessments, and new regulations for approvals and change in providers.
- Advocacy: We will be reaching out to state representatives across the state to discuss collective action regarding reimbursement rates/fee schedules and the impact on providers and Arkansas Medicaid personal care recipients.

I hope you took the time to look over our proposal and information that was collected to help with the impact on Arkansas Medicaid Personal Care and providers and the Medicaid recipients across the state of Arkansas.

Response: Thank you for your feedback. We will take your comments under advisement.

DHS acknowledges the concerns raised regarding administrative burden, staffing requirements, financial impact, and delays in prior authorization. These rules are intended to strengthen patient safety, ensure clinical appropriateness, and align with federal compliance standards.

***MegAnne Townsend* Corporate Operations Manager**

Townsend Healthcare *and* Townsend Healthcare of Eastern Arkansas

Comment: This memo presents public comments from a Provider of Care regarding the proposed changes to the State Plan Personal Care Program.

Before the specific comments are made, we would like to make some general comments to set the framework for the many revisions to the current plan. These general comments are summarized below:

- The overall goal of the revisions by the State should be to streamline and reduce, if possible, the regulations to allow the Providers to comply with the intent of the Personal Care Program (i.e. take care of the Clients ADL's to allow them to remain at home and not in institutions) but not become more burdensome and increase the cost of compliance to the Providers with unnecessary regulations which are, in effect, unfunded mandates.

- The proposed revisions consistently are written using phrases such as "treatment prescription", "treatment plan", "progress notes" and other medical terms and requirements that lend themselves to higher levels of care than Personal Care Companies are licensed to provide. Personal Care Companies can only provide unskilled services (ADLs) with primarily unskilled workers (i.e. CNA's, PCA's, etc.) These workers are not trained to assess or write progress notes, etc. No medical services can be provided under our license.

- The Federal Guidelines for Personal Care are more permissive than the Proposed State Plan regarding Personal Care Supervision and Transportation.

  Section II-STATE PLAN PERSONAL CARE CONTENTS

  200.000 GENERAL INFORMATION

  200.100 Participation Requirements for State Plan Personal Care Providers 1-1-26

  B. Each employee must successfully pass the following:

  1. A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann.§ 20-38-103;

  2. An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;

  3. An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years.

  4. An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and

Comment Summery Response:

- Background and Registry Checks cost $22.00 State / $13.00 FBI for federal checks.

- Medicaid Provider Enrollment is provided by Gainwell Technologies who also completes background checks to determine whether a Provider Identification Number (PIN) number is issued to a Practitioner.
- This process should be streamlined since Gainwell Technologies already does background checks. There is no need for the Personal Care Providers to duplicate this process.
- The above also includes the Arkansas Sex Offender Central Registry which should be done for both Aides as well as Clients.

Request: Gainwell Technologies should be the one stop for all background checks to assure compliance with the regulations.

210.000 DOCUMENTATION REQUIREMENTS

210.200 State Plan Personal Care Provider Documentation Requirements 1-1-26

A. State Plan Personal Care providers must maintain in each beneficiary's service record:

d. The initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP) (see section 212.200);

e. All treatment prescriptions (see section 212.300);

g. All treatment plans;

Comment Summery Response:

- *Use of "Treatment" and "Prescription" would assume Personal Care is a Skilled Medical Service by a Credentialed Provider.*
- *Treatment Prescription is a Referral for Non-Medical Unskilled Services by an Uncredentialed Provider (Personal Care Aide)*

Request: To Utilize Non-Medical language in place of Skilled Medical Language in the Rules for Personal Care.

210.000 DOCUMENTATION REQUIREMENTS

210.200 State Plan Personal Care Provider Documentation Requirements 1-1-26

2. Treatment plan service log documentation, which must be completed at the time-of service delivery and at a minimum include:

b. Beneficiary's Medicaid ID number and date of birth;

i. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.

iii. If the personal care aide discontinues or interrupts the beneficiary's service-plan-required activities at one location to begin service-plan required activities at another location, the aide must record the beginning and ending times of service at each location.

Iv. If a personal care aide does not perform a scheduled treatment plan task, the personal care aide must document and justify why the task was not performed as scheduled;

e. Any service performance difficulties;

f. Notes on the beneficiary's condition or other data or criteria required by the treatment plan;

g. When an emergency or special circumstances requires a personal care aide to perform a task not included on the personal care treatment plan, documentation describing:

i. The nature of the emergency or special situation;

ii. The action or task required to resolve the emergency or special situation;

iii. The date, start time, end time, location, nature and scope of the unscheduled task performed;

Iv. When supervisor approval for the unscheduled task was obtained; and

v. If supervisor approval was not obtained prior to performing the unscheduled task, justification for why pre-approval was not possible

h. Name(s), credential(s), and signature(s) of the personal care aide who performed the service; and

3. Weekly or more frequent progress notes outlining the condition of the beneficiary;

4. If service delivery involves delivering services to multiple beneficiaries, the following additional service log documentation requirements apply:

a. When service delivery involves two (2) beneficiaries concurrently (i.e. cleaning a bathroom shared by two beneficiaries), then the personal care aid must also document in each beneficiary's service delivery log the name of the other individual who received the concurrent personal care service;

b. When service delivery is in a congregate setting (i.e. involves more than two (2) beneficiaries), then the personal care aide must:

i. Record the date and time the congregate service began and ended; and

ii. The name of each individual who received congregate services;

c. The provider must equally split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took twenty (20) minutes, the personal care aide would document ten (10) minutes to each beneficiary for the service).

Comment Summery Response:

- To implement these changes according to Arkansas State Plan will be a financial burden to Personal Care Agencies.
- The current EVV system is on phones and not tablets. This will not allow for the extensive additional documentation necessary for implementation of the proposed changes.
- Authenticare 2.0 will not adequately provide the capabilities to implement these changes.
- Authenticare 2.0 does not include the beneficiary's DOB in the Aide Service log or Worker Activity Report
- Providing both Medicaid ID and DOB to the Personal Care Aide could impact HIPAA.
- Providing both Medicaid ID and DOB of another patient's service log could impact HIPAA.

- The extensive time for an aide to enter the requested documentation on a smart phone after clocking out is an unfunded mandate to a PCA.

- Authenticare cannot cumulatively add a day's clock in and out times. Each clock in and out is identified as an individual claim. MMIS will reject the duplication of more than 1 claim per day. To process this claim would take additional work and expense to process by splitting and manually adjusting the split shift.

- The above system needs to reflect the rules and regulations not adding to these unrealistic additions (i.e. having to clock in and out for bathroom breaks).

- Any service performance difficulties the aide would be documenting would be related to the tasks that they themselves performed: Cooking, Housekeeping, Shopping, etc.

- Notes on the beneficiary's condition or treatment plan for are beyond the scope of practice of the uncredentialed PCA whose tasks are for nonmedical tasks only.

- Name, credential (s) and signature of the personal care aide who performed the service is not a feature of the State's Authenticare 2.0 EVV system as the aide is non credentialed.

- Weekly or more frequent progress notes outlining the condition of the beneficiary are beyond the scope of practice for a PCA. They are to assist with unskilled, non-medical tasks and are unqualified to determine treatment progress of a Beneficiary.

- The listed ADL on both the Authenticare 2.0 App and the care plan is either completed or not completed by the checked box on the app. i.e.: Personal Grooming, Bathing, Meal Preparation, Toileting, Housekeeping, Ambulation, Medication, Shopping, Dressing/Undressing and Laundry. Any service delivery difficulty the aide would be documenting would be how well they completed the task of i.e. cooking and cleaning.

Request: Personal Care Aides should not make progress notes on a Beneficiary.

215.100 PROGRAM ELIGIBILITY

215.400 Functional Needs Assessment

C. All Personal Care Functional Assessment & Treatment Plan functional needs assessments must be completed, signed, and dated by a licensed Registered Nurse.

Comment Summery Response:

- *Per the Office of the Inspector General: "Personal care services (PCS) is a Medicaid benefit for the elderly, people with disabilities, and people with chronic or temporary conditions. It assists them with activities of daily living and helps them remain in their homes and communities. Examples of PCS include bathing, dressing, light housework, money management, meal preparation, and transportation. "*

- *As can be seen from the above list, all these activities are unskilled and do not require any medical intervention of any kind. The plan of care does not include any skilled or medical intervention by the caregiver. An LPN is fully qualified to determine the needs of a Beneficiary.*

Request: LPNs should be allowed to do Assessments and Service Plans

215.500 Treatment Prescription

A. Personal care services require a treatment prescription signed by the beneficiary's primary care provider (PCP). The frequency, intensity, and duration of the prescribed personal care services must be medically necessary based on the results of the assessment and realistic for the age of the beneficiary.

B. A treatment prescription for personal care services is valid for one (1) year unless a short period is specified on the treatment prescription.

C. A treatment prescription for personal care services must be on form DMS-618 TP "State Plan Personal Care Services Treatment Prescription."

Comment Summery Response:

- Use of "Treatment" and "Prescription" would assume Personal Care is a Skilled Medical Service by a Credentialed Provider.
- Treatment Prescription is a Referral for Non-Medical Unskilled Services by an Uncredentialed Provider (Personal Care Aide)

Request: Referrals and not Prescriptions will be required from the PCP.

220.300 Personal Care Services

B.

12. Transportation to and from employment (or seeking employment) meets the requirements of section 223.000 of this Medicaid manual (no mileage cost associated with the transportation would be covered).

Comment Summery Response:

- Medical Appointments are not included in the Treatment Plan but is imperative in keeping the elderly in their homes and out of institutions.
- According to a study by ACHI, more than one-third of Arkansans live in Health Professional Shortage areas.
- Medical Appointments are necessary to maintain the health of this aging population. Verida, Inc. transports Beneficiaries with a 48 hour notice which is not always possible with this fragile population. Allowing personal care aide to transport a client to their physician rather than the expense of an emergency room visit would be a cost savings to Medicaid.

Request: Transportation should be allowed in the Personal Care Service Plan.

220.300 Personal Care Services

E. The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered:

1. The qualified supervisor must complete the following at least monthly:

2. A supervising registered nurse must conduct an on-site evaluation of a day's service delivery to a beneficiary as required in the treatment plan, but no less often than annually. On each on-site evaluation, the supervising registered nurse must:

a. Observe and document.

iii. The interaction and relationship between the beneficiary and the personal care aide; and

Comment Summery Response:

- The definition of a Qualified Supervisor is not defined by the Arkansas State Plan.
- Referencing the CMS document "Preventing Medicaid Improper Payments for Personal Care Services: "Approved supervising entities may include nurses (both Registered Nurses and Licensed Practical Nurses), PCS agency staff, case managers, other agency staff deemed qualified, and in some cases the beneficiary."
- A Registered Nurse to complete an on-site evaluation of a day's service delivery to a beneficiary of non-skilled activities such as meal preparation, housekeeping and laundry for 3-5 hours is an unfunded mandate. It is not defined as a Supervisory Visit.
- Registered Nurse must complete an updated Personal Care Function Assessment & Treatment Plan which is an unfunded mandatory requirement. Both Home Health and the Veterans Administration allow this to be a billable expense.
- The State of Arkansas should not create a more regulatory burden than the Federal Government. As can be seen from the above CMS document, the CMS language is clearly permissive language by saying "may" not "shall". It also refers to "other Personal Care Provider staff who are deemed qualified." We believe that we should allow and define "other approved supervising entities" so that this person, versus a Registered Nurse, could perform these services. This would reduce costs to the Personal Care Provider while ensuring compliance with the regulation. The State of Arkansas already has a Registered Nurse Shortage; this would add to that problem without any measurable benefit.

Request: Define a Qualified Supervisory Entity other than a Registered Nurse.

220.700 Transitioning Personal Care Providers

Comment Summery Response:

- *The Vender, Atrezzo manages the Authorization Process through its database. Atrezzo has implemented a process of transitioning Clients by submitting the 9511 for Discharge with Total Billed Units for the Month which the current Personal Care Provider must provide.*

Request: Not allowing Atrezzo to implement processes before they have been approved.

250.000 REIMBURSEMENT

A. Reimbursement for personal care services is the lesser of the billed amount per unit of service or Medicaid's maximum allowable fee (herein also referred to as "rate" or "the rate") per unit.

B. Reimbursement for Arkansas Medicaid state plan Personal Care services are based on a fifteen (15-) minute unit of service.

C. The following standard reimbursement rules apply to all services:

1. A full unit of service must be rendered to bill a unit of timed service.

2. Partial units of a timed service may not be rounded up and are not reimbursable. State Plan Personal Care Section II

3. Non-consecutive periods of service delivery over the course of a single day may be aggregated when computing a unit of a timed service.

4. Concurrent billing is not allowed unless specifically permitted herein. It is considered concurrent billing when multiple practitioners bill Medicaid for services provided to the same beneficiary during the same time increment.

5. Rest, toileting, or other break times between delivery service is not billable.

6. Time spent on documentation alone is not billable as a treatment service.

Comment Summery Response:

- Partial units of a timed service are currently rounded up or down to the nearest 15-minute unit.
- AuthentiCare applies rounding rules to actual hours by rounding the total hours worked to the next quarter hours, which is shown as the number of units on an EVV Visit. Within each quarter-hour increment, the EVV system rounds up to the next quarter-hour when the total actual time is eight minutes or more and rounds down to the previous quarter hour when the total actual time worked is seven minutes or less.
- Examples of rounding rules are:
- If worker works 2 hours and 53 minutes, the adjusted pay hours will round up to 3 hours.
- If worker works 2 hours and 52 minutes, the adjusted pay hours will round down to 2.75 hours.
- If worker works 4 hours and 10 minutes, the adjusted pay hours will round up to 4.25 hours.
- Not rounding up or down to the nearest unit will result in unpaid work time for the PCA who has worked.
- Partial Units of the timed service are currently being calculated following DHS guidelines. All the Approved EVV systems (Authenticare 2.0, HHAexchange and Carebridge) are configured with rounding to the nearest 15-minute unit.
- The functionality of the Electronic Devices makes it extremely difficult if not impossible to clock out at a precise unit of time.
- Nonconsecutive periods of service delivery in a single day are not billable as a single claim and would be denied.
- Rest and toileting breaks would require clocking in and out in a single day, the Authenticare 2.0 system cannot determine that this is not a duplicate claim and there will deny the claims.
- The proposed evaluation and progress notes completed on the mobile phone will be a very slow process.
- The Interactive Voice Response (IVR) method will not allow the required documentation proposed, therefore it will have to be manually written which would be an unpaid mandate for the PCA.

- Time spent on documentation should be allowed if it is considered part of the service.

Request: No change to the current "Rounding Rules" should be made.

Response: Thank you for your feedback. We will take your comments under advisement.

Regarding your comments on Section 200.100, Act 853 was enacted in the last legislative session. It removed the certification process by the Division of Provider Services & Quality Assurance at DHS for private care agencies. As a result, personal care providers are now deemed high-risk providers by Arkansas Medicaid. The change in frequency of checks is in line with this change.

Regarding your comments on Section 215.400, the Arkansas Nursing Board has advised that specific domains and required criteria within the Functional Assessment & Treatment Plan fall under the professional scope of a Registered Nurse (RN).

Regarding your comments on Section 220.300, there is no change from the original policy regarding personal care assistance going to/from medical appointments. Transportation to medical appointments is a separate service provided to eligible Medicaid recipients. More training will be provided prior to April 1, 2026 effective date on this topic.

DHS is integrating back into the manual original language on rounding and unit calculation.

Quincy Hurst

Superior Senior Care

Comment: We appreciate the opportunity to provide comments to the recent proposed regulation changes. We welcome changes that better the system and create a more sustainable future; however, we feel some of the proposed changes would negatively impact the programs and its recipients. Our comments on the proposal are as follows:

200.100 Participation Requirements for State Plan Personal Care Providers 4-1-26

1. *Federal fingerprint-based checks in accordance with 42 CFR 455.434 and 42 CFR 455.50(c). All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq.*

SSC Response: We want to ensure fingerprinting is only required for those who have lived outside Arkansas within the last 5 years. Fingerprinting is a lengthy process that could impact the timeliness in which beneficiaries receive care.

ii. Each employee must successfully pass the following:

- *A criminal background check, upon hiring and prior to any contact with clients, and at least once every five (5) years in accordance with Ark. Code Ann.§ 20-38-103;*
- *An Arkansas Child Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;*
- *An Arkansas Adult Maltreatment Central Registry check, upon hiring and prior to any contact with clients, and at least every two (2) years;*
- *An Arkansas Sex Offender Central Registry search upon hiring and prior to any contact with clients, and at least every two (2) years; and*
- *At least a five (5) panel drug screen upon hiring and prior to any contact with clients, and as required thereafter by Ark. Code Ann. §20-77-128(b).*

SSC Response:

A. Many staff members have no direct or physical contact with clients. We request that the word "direct" or "physical" be inserted before the word "contact" throughout this section to avoid unintended inclusion of administrative staff.

B. We recommend maintaining the current five-year schedule for all screening checks. This reduces administrative burden, aligns with existing processes, and ensures consistency. Requiring certain screenings every two years adds unnecessary cost and delays without evidence of increased safety.

C. Maltreatment registry results can take up to four weeks. During a national caregiver shortage, requiring providers to wait for results before a caregiver may begin work could significantly delay care. We oppose the proposed requirement and request that caregivers be allowed to work contingent upon results, as is the current practice.

205.200 Personal Care Aide 4-1-26

An individual must meet the following requirements to serve as a personal care aide for a personal care services provider:

A. Have one of the following active certifications in good standing:

1. Certified Nursing Assistant (CNA);

2. Home Health Aide; or

3. Certified Personal Care Aide;

SSC Response: We request clarification on the use of the phrase *"active certifications in good standing"* as it relates to Certified Nursing Assistants (CNAs). Many CNAs have extensive industry experience but may choose not to renew their license. Their prior CNA certification is verifiable in the Employment Clearance Registry and confirms that they received the required training under Private Care Agency Regulations. We request that these individuals qualify as a personal care aide.

215.300 Evaluation Referral 4-1-26

- *Personal Care services require an initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP).*

- *An initial evaluation referral for personal care services is required to be on a DMS-618 ER "State Plan Personal Care Services Initial Evaluation Referral." **View or print the form DMS-618 ER.***
- *A DMS-618 ER evaluation referral is only required to perform a beneficiary initial evaluation for state plan personal care services.*
- *No DMS-618 ER is required for a provider to perform the annual functional needs assessment necessary to demonstrate a beneficiary's continued eligibility for state plan personal services, unless there is a significant break in services. A significant break in service is defined as not receiving state plan personal care within the prior one hundred twenty (120) days.*

SSC Response: We believe the requirement for a DMS-618 ER form is redundant. If a physician does not support personal care services, they would simply decline to sign the DMS-618. It is unclear what additional value this new form provides.

Additionally, we request confirmation that providers will have access to all newly created forms prior to implementation.

220.300 Personal Care Services 4-1-26

B. A personal care provider may be reimbursed for performing the following medically necessary personal care services in accordance with the beneficiary's treatment plan:

1. Bathing;

2. Dressing;

3. Feeding/eating;

4. Grooming;

5. Toileting;

6. Transferring;

7. Walking;

8. Cleaning;

9. Laundry;

10. Preparing meals;

11. Shopping; and

12. Transportation to and from employment (or seeking employment) that meets the requirements of section 223.000 of this Medicaid manual (no mileage costs associated with the transportation would be covered).

SSC Response: Current regulations allow assistance to and from medical appointments and community activities. These supports are essential to beneficiary well-being and community integration. We strongly request that these activities remain reimbursable under the updated regulations.

- *The personal care service delivery of each beneficiary must be supervised by a qualified supervisor who is responsible for the quality of services rendered:*
    - *The qualified supervisor must complete the following at least monthly:*
        - *Review the beneficiary's service delivery logs and documentation;*
        - *Document the time and date of their service documentation review;*
        - *Actively train or assist assigned personal care aide with personal care service delivery when necessary;*
        - *Document any training or assistance provided to an assigned personal care aide.*

SSC Response: We request a definition of *"qualified supervisor"* for clarity and consistency across providers.

220.700 Transitioning Personal Care Providers 4-1-26

The new provider should maintain verifiable proof of the date and method of its required notification and transition request form delivery.

B. *The current personal care service provider will continue to provide services to the beneficiary in accordance with this Medicaid manual until the first day of the 2nd month after the month the new provider completed the notification and delivery requirements in subpart (2.) directly above (i.e. if notified on May 11th, then current provider would continue providing personal care services until July 1st).*

- *The current provider is responsible for forwarding the beneficiary's complete service record to the newly selected personal care provider before the current provider's last day of service, as described in subpart (3.) directly above.*
- *The beneficiary's complete service record includes, at minimum: The beneficiary's signed 618-ER; the beneficiary's active current Assessment and Treatment Plan; the beneficiary's active, signed 618-TP.*

  Switching from one personal care provider to another personal care provider does not automatically require a new:

- *Treatment prescription;*
- *Functional needs Assessment and Treatment Plan.*

SSC Response: Beneficiaries typically change providers due to staffing challenges. Under the proposed transition timeline, beneficiaries could wait up to two months before services begin with their new provider. This could significantly disrupt care.

Currently, beneficiaries sign a new Freedom of Choice form, providers upload it to the Ascentra portal, and Ascentra issues notifications with start and end dates. Because providers will still upload 618s into the Ascentra portal, we believe a more efficient transition process is to allow new providers access to the 618 through the portal. This mirrors current processes and eliminates delays caused by providers not releasing documentation.

Regarding section (3)(a), requiring the transfer of records only by the day before the transition does not provide sufficient time for providers to staff cases effectively. Ensuring earlier access to documentation—

or allowing retrieval directly from the portal—mitigates this risk. We also request clarification on corrective actions for providers who fail to submit documentation in a timely manner

250.100 Reimbursement Methods 4-1-26

A. Reimbursement for personal care services is the lesser of the billed amount per unit of service or Medicaid's maximum allowable fee (herein also referred to as "rate" or "the rate") per unit.

B. Reimbursement for Arkansas Medicaid state plan personal care services is based on a fifteen (15-) minute unit of service.

C. The following standard reimbursement rules apply to all services:

2. *A full unit of service must be rendered to bill a unit of a timed service.*

3. *Partial units of a timed service may not be rounded up and are not reimbursable.*

SSC Response: We strongly oppose eliminating current rounding rules. The existing methodology aligns with FLSA guidance, which requires compensating employees for time worked beyond seven minutes. The proposed rule would result in up to fourteen minutes of unreimbursed services per shift, which could violate federal labor requirements and create financial hardship for providers.

Additionally, revising rounding rules would require costly changes to timekeeping systems and would deviate from standard business and industry practices. We respectfully urge DHS to retain the current rounding standards.

Thank you again for the opportunity to provide feedback. As a statewide HCBS provider serving Arkansas for more than 40 years, we understand both the importance of these programs and the real-world implications of regulatory changes on the vulnerable populations we serve. We are committed to working collaboratively to ensure sustainable, effective, and accessible care for all Arkansans.

Response: Thank you for your feedback. We will take your comments under advisement.

While forms are not part of the promulgation process and therefore not subject to public comment, DHS has sent drafted forms to the requestor for their review and understanding.

Regarding your comments on Section 200.100, Act 853 was enacted in the last legislative session. It removed the certification process by the Division of Provider Services & Quality Assurance at DHS for private care agencies. As a result, personal care providers are now deemed high-risk providers by Arkansas Medicaid. The change in frequency of checks is in line with this change.

Regarding your comments on Section 205.200, a personal care aide must have "one" of the active certifications in good standing. If not the CNA license, then the aide must have either a currently active certification as a Home Health Aide or Certified Personal Care Aide and that certification must be in good standing.

Regarding your comments on Section 220.300, there is no change from the original policy regarding personal care assistance going to/from medical appointments. Transportation to medical appointments is a separate service provided to eligible Medicaid recipients. More training will be provided prior to April 1, 2026 effective date on this topic.

Regarding your comments on Section 220.700, under the proposed provider transition timeline, the current provider agency remains responsible for delivering Personal Care Services until the transition date, when the new receiving agency assumes services. This timeline is designed to ensure sufficient time for documentation and prior authorizations to be completed and in place for the receiving agency.

DHS is integrating back into the manual original language on rounding and unit calculation.

Barbara Flowers | Executive Director

Area Agency on Aging of West Central Arkansas, Inc.

Comment: Updates to the Personal Care and Arkansas Independent Assessment Provider Manuals

Section II 250.100 C. 1. 2. 3. The following standard reimbursement rules apply to all services:

I don't see the advantage of changing the standard reimbursement rules. This will be confusing to our aides and a nightmare to record. I would like to see this language remain as it is in the current manual.

Section II 250. 100 C. 5. Rest, toileting, or other break times between service delivery is not billable:

I don't think there would be any disagreement with aides clocking out for breaks, however, clocking in and out for bathroom (toileting) breaks is not even reasonable. I know I wouldn't want to tell our aides, "sorry, but you're not allowed to use the bathroom, unless you're clocked out."

The immediate need is an increase in reimbursement rates. The expenses to provide services and to conduct the required background checks, and other required checks are not addressed in the reimbursement rate. Benefits, insurance and most operating cost have increased, but rates have not. Now, I understand that the rate reviews are on hold. Please help us and don't make it more difficult for us to provide for our most vulnerable population, since that is our mission and the reason the Older Americans Act was established.

Thank you,

Response: Thank you for your feedback. We will take your comments under advisement.

Regarding your comments on 250.100, this policy is to prevent billing for personal time spent away from the beneficiary.

DHS is integrating back into the manual original language on rounding and unit calculation.

Marshall and Rebecca Brashear | RCF Owner

Comment: Hello,

We own and operate an RCF in Dardanelle, Arkansas, and upon reviewing the proposed updates to the Medicaid personal care provider manual by DHS we have a couple of questions. Since the proposed update removes the entirety of the previous Section II of the manual, the section that listed RCF as a personal care provider type no longer exists, and the new language has three options for licensing as a personal care provider. The new Section II 200.100 C. 2. States that in order to be a licensed personal care provider we have to "Obtain a private care agency or home health class A or B license". I see no language stating RCF's have any other options, as these are the only licenses listed in the proposed manual update. Is this the case or has the RCF medicaid personal care provider language been moved to somewhere else? Are RCF's no longer allowed to participate in Arkansas Medicaid and in order to do so we have to license as one of these 3 entities?

There is another section that raises a major question for our future operation, 220.700 C. 3. States: "The current personal care service provider will continue to provide services to the beneficiary in accordance with this Medicaid manual until the first day of the 2nd month after the month the new provider completed the notification and delivery requirements in subpart (2.) directly above (i.e. if notified on May 11th, then current provider would continue providing personal care services until July 1st."

I have no idea how an RCF could comply with this section if a beneficiary decided to change providers, and move to a new facility, as we don't have the ability or staffing capability to provide services across the state for up to 2 months. Does this section apply to RCF's? I see no exceptions or exclusions anywhere in this proposal that would imply that we are exempt from this regulation.

Thanks, Marshall

Response: Thank you for your feedback. We will take your comments under advisement.