

ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**



Secretary of State

Mark Martin

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Little Rock, Arkansas 72201-1094

(501) 682-5070

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For Office

Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Robert Nix E-mail robert.nix@dhs.arkansas.gov Phone 501-320-6177

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Outpatient Behavioral Health Services Update 1-17, Inpatient Psychiatric Services for Persons Under Age 21 Update 1-17, Residential Community Reintegration Program Certification and State Plan #2017-010

Intended Effective Date

(Check One)

Date

☐ Emergency (ACA 25-15-204)

Legal Notice Published 07/13/2017

☒ 10 Days After Filing (ACA 25-15-204)

Final Date for Public Comment 08/11/2017

☐ Other _____
(Must be more than 10 days after filing date.)

Reviewed by Legislative Council _____

Adopted by State Agency 10/01/2017

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy

becky.murphy@dhs.arkansas.gov

Contact Person

E-mail Address

Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

(501) 371-2165

rose.naff@dhs.arkansas.gov

Phone Number

E-mail Address

Director

Title

9-20-17

Date

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT _____

TELEPHONE _____ **FAX** _____ **EMAIL:** _____

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Outpatient Behavioral Health Services Update 1-17, Inpatient Psychiatric Services for Persons Under Age 21 Update 1-17, Residential Community Reintegration Program Certification and State Plan #2017-010

- | | | |
|---|---|--|
| 1. Does this proposed, amended, or repealed rule have a financial impact? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| 3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |

If an agency is proposing a more costly rule, please state the following:

(a) How the additional benefits of the more costly rule justify its additional cost;

(b) The reason for adoption of the more costly rule;

(c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

(d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

(a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____
 Total \$0 _____

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____
 Total \$0 _____

(b) What is the additional cost of the state rule?

Current Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____
 Total \$0 _____

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____
 Total \$0 _____

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year

\$ 0 _____

Next Fiscal Year

\$ 0 _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

\$ 0 _____

Next Fiscal Year

\$ 0 _____

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more _____ of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
 - (a) the rule is achieving the statutory objectives;
 - (b) the benefits of the rule continue to justify its costs; and
 - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

October 1, 2017

CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxxiii: Residential Community Reintegration Program*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: The Residential Community Reintegration Program is designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and Outpatient Behavioral Health Services. The program provides twenty-four hour per day intensive therapeutic care provided in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment. Services include all allowable Outpatient Behavioral Health Services (OBHS) based upon the age of the beneficiary as well as any additional interventions to address the beneficiary's behavioral health needs.

Example services include, but are not limited to, a combination of Individual Behavioral Health Counseling, Group Behavioral Health Counseling, Psychoeducation, Marital-Family Behavioral Health Counseling, Multi-Family Behavioral Health Counseling, Crisis Stabilization Intervention, Peer Support, Individual Pharmacologic Counseling, Group Pharmacologic Counseling, Adult Life Skills Development and Psychosocial Rehabilitative Services.

This service will not be paid for within and Institution for Mental Disease (IMD)

This service does not include payment for room and board of the beneficiary.

Residential Community Reintegration Programs shall be certified by the Department of Human Services as a Residential Community Reintegration Program .

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

*All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

October 1, 2017

MEDICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

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Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789



TO: Arkansas Medicaid Health Care Providers – Outpatient Behavioral Health Services

EFFECTIVE DATE: October 1, 2017

SUBJECT: Provider Manual Update Transmittal OBHS-1-17

REMOVE

Section

—

Effective Date

—

INSERT

Section

254.003

Effective Date

10-1-17

Explanation of Updates

Section 254.003 has been added to include information regarding the Residential Community Reintegration Program.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

TOC required

254.003

Residential Community Reintegration Program

10-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2020, U4	Therapeutic behavioral services, per diem
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
<p>The Residential Community Reintegration Program is designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and Outpatient Behavioral Health Services. The program provides twenty-four hour per day intensive therapeutic care provided in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment. Services include all allowable Outpatient Behavioral Health Services (OBHS) based upon the age of the beneficiary as well as any additional interventions to address the beneficiary's behavioral health needs.</p> <p>A Residential Community Reintegration Program shall be appropriately certified by the Department of Human Services to ensure quality of care and the safety of beneficiaries and staff.</p> <p>A Residential Community Reintegration Program shall have, at a minimum, 2 direct service staff available at all times. Direct service staff may include any allowable performing provider in the Outpatient Behavioral Health Services (OBHS) manual, teachers, or other ancillary educational staff.</p> <p>A Residential Community Reintegration Program shall ensure the provision of educational services to all beneficiaries in the program. This may include education occurring on campus of the Residential Community Reintegration Program or the option to attend a school off campus if deemed appropriate in</p>	<ul style="list-style-type: none"> • Date of Service • Place of Service • Diagnosis and pertinent interval history • Daily description of activities and interventions that coincide with master treatment plan and meet or exceed minimum service requirements • Mental Status and Observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Staff signature/credentials/date of signature

according with the Arkansas Department of Education.		
NOTES	EXAMPLE ACTIVITIES	
Eligibility for this service is determined by the standardized Independent Assessment. Prior to reimbursement for the Residential Community Reintegration Program in Intensive Level Services, a beneficiary must be eligible for Intensive Level Services as determined by the standardized Independent Assessment.		
APPLICABLE POPULATIONS	UNIT	BENEFIT LIMITS
Children and Youth	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 90
ALLOWED MODE(S) OF DELIVERY	TIER	
Face-to-face	Intensive	
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE	
The Residential Community Reintegration Program must be provided in a facility that is certified by the Department of Human Services as a Residential Community Reintegration Program provider.	14	



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TO: Arkansas Medicaid Health Care Providers – Inpatient Psychiatric Services for Under Age 21

EFFECTIVE DATE: October 1, 2017

SUBJECT: Provider Manual Update Transmittal INPPSYCH-1-17

<u>REMOVE</u>		<u>INSERT</u>	
Section	Effective Date	Section	Effective Date
203.100	7-1-17	—	—
212.100	7-1-17	212.100	10-1-17
221.802	7-1-17	221.802	10-1-17
221.803	7-1-17	221.803	10-1-17
221.804	7-1-17	221.804	10-1-17
250.500	7-1-17	—	—
251.000	7-1-17	251.000	10-1-17
262.100	7-1-17	262.100	10-1-17

Explanation of Updates

Sections 203.100, 212.100, 221.803, 221.804, 221.805, 250.500, 251.000 and 262.100 have been updated to remove all information regarding Facility Based Community Reintegration Programs.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

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Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

TOC required**212.100 Covered Locations 10-1-17**

Inpatient psychiatric services are covered by Arkansas Medicaid only when provided in:

- A. An inpatient psychiatric hospital
- B. A residential treatment unit within a psychiatric hospital
- C. A residential treatment center (freestanding)
- D. A Sexual Offender Program

221.802 Federal Provider Identification Numbers 10-1-17

A federal provider identification number is assigned to each provider who meets the attestation requirement. The identification numbers for PRTFs will have five digits and one letter. The first two digits identify the state in which the facility is located. This number is then followed by the letter L and then by three digits and is numbered according to the order in which a facility was identified.

- A. Federal provider numbers are assigned by the State Medicaid agency (SMA).
- B. A provider number is coded based on where the PRTF is physically located.

221.803 Roles and Responsibilities for the Reporting of Deaths, Serious Injuries and Attempted Suicides 10-1-17

The interim process for reporting deaths will follow a similar process as currently in place for the death reporting process for hospitals. The roles and responsibilities of the appropriate entities are outlined below.

- A. PRTFs
 1. Report to the SMA, no later than close of business the next business day, all deaths, serious injuries, and attempted suicides via fax at (501) 682-6171.
 2. Report to the CMS regional office (RO) all deaths no later than close of business the next business day after the resident's death. Death reporting information should be reported to CMS at (214) 767-4434.
 3. Document in the resident's record that the death was reported to the CMS regional office.
- B. CMS Regional Office (RO)
 1. The regional office should receive the report directly from the PRTF. Pursuant to 42 CFR 483.374(b)(1), the report must include the name of the resident, a description of the occurrence, and the name, street address and telephone number of the facility.
 2. The CMS regional office should make sure the survey agency (SA) has received the report. The SA is responsible for carrying out the investigation in conjunction with instructions from the State Medicaid agency.
 3. Since the PRTF is responsible for reporting to the agencies listed previously in addition to the CMS RO, the regional office should obtain the completed investigation from the SA.

4. The report should be received from the PRTF, according to 42 CFR 483.374(c)(1), no later than close of business the next business day after the resident's death.
 5. The CMS regional office will send the death report to the CMS central office (CMS CO).
- C. CMS Central Office (CO)
- The CMS CO is responsible for maintaining a central log of the death information reported from the CMS RO.

221.804 PRTF Staff Education and Training**10-1-17**

The facility must require staff to have ongoing education, training and demonstrated knowledge of:

- A. Techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situations;
- B. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and
- C. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.
 1. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.
 2. Individuals who are qualified by education, training and experience must provide staff training.
 3. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
 4. The staff must be trained and demonstrate competency before participating in an emergency safety intervention.
 5. The staff must demonstrate their competencies as specified in paragraph A of this section on a semiannual basis and their competencies as specified in paragraph B of this section on an annual basis.
 6. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.
 7. All training programs and materials used by the facility must be available for review by CMS, the SMA and the State SA.

251.000 Cost Report**10-1-17**

Inpatient psychiatric hospitals, residential treatment units and Sexual Offender Programs must submit an annual or partial period hospital cost report to the Arkansas Medicaid Program. Providers with less than a full 12-month reporting period are also required to submit a hospital cost report for the shorter period. Cost reports are due no later than five months following the close of the provider's fiscal year end. Extensions will not be allowed. Failure to file the cost report within the prescribed period may result in suspension of reimbursement until the cost report is filed.

Providers will submit all required hospital cost reports and budgets in accordance with Medicare Principles of Reasonable Cost Reimbursement identified in 42 CFR, Part 413. All cost settlements will be made using these principles.

262.100 Inpatient Psychiatric Revenue Codes

10-1-17

Revenue Code	Revenue Code Description
114	Inpatient Psychiatric Hospital only
124	Residential Treatment Center only
128	Sexual Offender Program only
129	Residential Treatment Unit only