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Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

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Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201, 20-77-107, and 25-10-129

Rule Title: 1915(i) Fee-for-service Adult Behavioral Health Services for Community Independence Manual; State Plan Amendment # 2018-16

Intended Effective Date
(Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 10 Days After Filing (ACA 25-15-204)
- ☑ Other March 1, 2019 (Must be more than 10 days after filing date.)

Date	
Legal Notice Published	10/14/2018
Final Date for Public Comment	11/12/2018
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Adopted by State Agency	03/01/2019

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

Becky Murphy (Contact Person) becky.murphy@dhs.arkansas.gov (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) 682-8330 (Phone Number) tami.harlan@dhs.arkansas.gov (E-mail Address)

Director (Title)

12/18/18 (Date)

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Adult Behavioral Health Services for Community Independence**

EFFECTIVE DATE: **March 1, 2019**

SUBJECT: **Provider Manual Update Transmittal ABHSCI-New-18**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
—	—	ALL	3-1-19

Explanation of Updates

A new Adult Behavioral Health Services for Community Independence policy manual is available for all Adult Behavioral Health Services for Community Independence providers.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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 Office of Policy Coordination and Promulgation 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: https://medicaid.mmis.arkansas.gov/.

Thank you for your participation in the Arkansas Medicaid Program.

Tami Harlan
Director

SECTION – ADULT BEHAVIORAL HEALTH SERVICES FOR COMMUNITY INDEPENDENCE

CONTENTS

200.000 ADULT BEHAVIORAL HEALTH SERVICES FOR COMMUNITY INDEPENDENCE GENERAL INFORMATION

201.000 Introduction 3-1-19

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Adult Behavioral Health Services for Community Independence are covered by Medicaid when provided to eligible Medicaid beneficiaries by enrolled providers.

Outpatient Behavioral Health Services may be provided to eligible Medicaid beneficiaries at provider certified/enrolled sites. Allowable places of service are found in the service definitions located in the Reimbursement section of this manual.

202.000 Arkansas Medicaid Participation Requirements for Adult Behavioral Health Services for Community Independence 3-1-19

All Behavioral Health Agencies that provide Adult Behavioral Health Services for Community Independence must meet specified qualifications for their services and for their staff. Providers with multiple service sites must enroll each site separately and reflect the actual service site on billing claims.

Behavioral Health Agencies that provide Adult Behavioral Health Services for Community Independence must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. Providers must be located within the State of Arkansas.

B. A provider must be certified by the Division of Provider Services and Quality Assurance (DPSQA). (See Section 202.100 for specific certification requirements.)

C. A copy of the current DPSQA certification as a Behavioral Health Agency must accompany the provider application and Medicaid contract.

D. The provider must give notification to the Office of the Medicaid Inspector General (OMIG) on or before the tenth day of each month of all covered health care practitioners who perform services on behalf of the provider. The notification must include the following information for each covered health care practitioner:

1. Name/Title
2. Enrolled site(s) where services are performed
3. Social Security Number
4. Date of Birth
5. Home Address
6. Start Date
7. End Date (if applicable)

Notification is not required when the list of covered health care practitioners remains unchanged from the previous notification.

DMS shall exclude providers for the reasons stated in 42 U.S.C. §1320a-7(a) and implementing regulations and may exclude providers for the reasons stated in 42 U.S.C. §1320a-7(b) and implementing regulations. The following factors shall be considered by DHS in determining whether sanction(s) should be imposed:

A. Seriousness of the offense(s)

B. Extent of violation(s)

C. History of prior violation(s)

D. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule.

202.100 Certification Requirements by the Division of Provider Services and Quality Assurance (DPSQA) 3-1-19

A Behavioral Health Agency must be certified by DPSQA in order to enroll into the Medicaid program as a Behavioral Health Agency participating in the Medicaid Adult Behavioral Health Services for Community Independence Program must be certified by the DPSQA. The DPSQA Certification Rules for Providers of Outpatient Behavioral Health Services is located at http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx.

Behavioral Health Agencies must have national accreditation that recognizes and includes all of the applicant's programs, services and service sites. Any Behavioral Health Agency service site associated with a hospital must have a free-standing behavioral health outpatient program national accreditation. Providers must meet all other DPSQA certification requirements in addition to accreditation.

210.000 PROGRAM COVERAGE

211.000 Coverage of Services 3-1-19

Adult Behavioral Health Services for Community Independence are limited to certified providers who offer Home and Community Based (HCBS) behavioral health services for the treatment of behavioral disorders. All Behavioral Health Agencies participating in the Adult Behavioral Health Services for Community Independence program must be certified by the Division Provider Services and Quality Assurance.

An Adult Behavioral Health Services for Community Independence provider must establish a site specific emergency response plan that complies with the DPSQA Certification Rules for Behavioral Health Agencies. Each agency site must have 24-hour emergency response capability to meet the emergency treatment needs of the beneficiaries served by the site. The provider must implement and maintain a written policy reflecting the specific coverage plan to meet this requirement. A machine recorded voice mail message to call 911 or report to the nearest emergency room in and of itself is not sufficient to meet the requirement.

All Adult Behavioral Health Services for Community Independence providers must demonstrate the capacity to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

211.100 Staff Requirements 3-1-19

In order to be certified to provide Adult Behavioral Health Services for Community Independence, each Behavioral Health Agency must ensure that they employ staff who are able and available to provide Adult Behavioral Health Services for Community Independence. In order to provide Adult Behavioral Health Services for Community Independence to be reimbursed on a fee-for-service basis by Arkansas Medicaid, the Behavioral Health Agency must meet all applicable staff requirements as required in the Behavioral Health Agency Certification manual.

Each Adult Behavioral Health Services for Community Independence service has specific provider types that are to be employed by the Behavioral Health Agency which can provide specific services. In order to provide and be reimbursed on a fee-for-services basis by Arkansas Medicaid, the Behavioral Health Agency must adhere to all service specific provider type requirements.

Registered Nursing (RNs) must provide services only within the scope of their individual licensure. The following chart lists the terminology used in this provider manual and explains the licensure, certification and supervision that are required for each performing provider type. Supervision for all Adult Behavioral Health Services for Community Independence service is required as outlined in the Behavioral Health Agency Certification manual.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Qualified Behavioral Health Provider – non-degreed	N/A	Yes, to provide services within a certified behavioral health agency	Required
Qualified Behavioral Health Provider – Bachelors	N/A	Yes, to provide services within a certified behavioral health agency	Required
Registered Nurse	Registered Nurse (RN)	No, must be a part of a certified agency	Required

When a Behavioral Health Agency which provides Adult Behavioral Health Services for Community Independence files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the rendering provider. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

211.200 Certification of Performing Providers 3-1-19

As illustrated in the chart in § 211.200, certain Outpatient Behavioral Health performing providers are required to be certified by the Division Provider Services and Quality Assurance. The certification requirements for performing providers are located on the DPSQA website at **http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx**.

211.300 Non-Refusal Requirement 3-1-19

A Behavioral Health Agency may not refuse to provide an Adult Behavioral Health Services for Community Independence service to a Medicaid-eligible beneficiary who meets the requirements for Adult Behavioral Health Services for Community Independence as outlined in this manual. If a provider does not possess the services or program to adequately treat the beneficiary's behavioral health needs, the provider must communicate this with the beneficiary so that appropriate provisions can be made.

212.000 Scope 3-1-19

Adult Behavioral Health Services for Community Independence are home and community-based treatment and services which are provided by a Certified Behavioral Health Agency to individuals eligible for Medicaid based upon the following criteria:

1. Beneficiaries receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis; and
2. Beneficiaries who are eligible for Arkansas Medicaid healthcare benefits under the 06, Medically Frail, Aid Category.

Adult Behavioral Health Services for Community Independence are provided to eligible beneficiaries that have a Behavioral Health diagnosis as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-5 and subsequent revisions).

Eligibility for services depends on the needs of the beneficiary. Beneficiaries will be deemed eligible for Adult Behavioral Health Services for Community Independence Rehabilitative Level

Services and Intensive Level Services based upon the results of an Independent Assessment performed by an independent entity. The goal of the Independent Assessment is to determine the care, treatment, or services that will best meet the needs of the beneficiary initially and over time. Please refer to the Independent Assessment Manual for the Independent Assessment Referral Process.

REHABILITATIVE LEVEL SERVICES

Home and community based behavioral health services for the purpose of treating mental health and substance abuse conditions. Services shall be rendered and coordinated through a team based approach. A standardized Independent Assessment to determine eligibility and a Treatment Plan is required. Rehabilitative Level Services home and community based settings shall include services rendered in a beneficiary's home, community, behavioral health clinic/ office, healthcare center, physician office, and/ or school.

INTENSIVE LEVEL SERVICES

The most intensive behavioral health services for the purpose of treating mental health and substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Eligibility for Intensive Level services will be determined by a standardized Independent Assessment. Intensive level Adult Behavioral Health Services for Community Independence treatment services are available—if deemed medically necessary and eligibility is determined by way of the standardized Independent Assessment.

213.000 Treatment Plan **3-1-19**

A Treatment Plan is required for eligible beneficiaries who are determined to be qualified for Adult Behavioral Health Services for Community Independence through the standardized Independent Assessment. The Treatment Plan should build upon the information from any Behavioral Health provider and information obtained during the standardized Independent Assessment.

The Treatment Plan must be included in the beneficiary's medical record and contain a written description of the treatment objectives for that beneficiary. It also must describe:

A. The treatment regimen—the specific medical and remedial services, therapies and activities that will be used to meet the treatment objectives.

B. A projected schedule for service delivery—this includes the expected frequency and duration of each type of planned therapeutic session or encounter.

C. The type of personnel that will be furnishing the services.

D. A projected schedule for completing reevaluations of the patient's condition and updating the Treatment Plan.

The Treatment Plan for a beneficiary that is eligible for Adult Behavioral Health Services for Community Independence must be completed by a mental health professional within 14 calendar days of the beneficiary entering care (first billable service) or within 14 days of an eligibility determination for beneficiaries receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis at a certified Behavioral Health Agency and must be signed and dated by a physician licensed in Arkansas. Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the mental health professional as well as signed and dated by a physician licensed in Arkansas. Revisions to the Treatment Plan for Adult Behavioral Health Services for Community Independence must occur at least annually, in conjunction with the results from the Independent Assessment. Reimbursement for Treatment Plan revisions more frequently than once per year is not allowed unless there is a documented clinical change in circumstance of the beneficiary or if a beneficiary is re-assessed by the Independent Assessment vendor which results in a change of Tier.

213.100 Beneficiary Participation in the Development of the Treatment Plan 3-1-19

The Treatment Plan should be based on the beneficiary's articulation of the problems or needs to be addressed in treatment and the areas of need identified in the standardized Independent Assessment. Each problem or need must have one or more clearly defined behavioral goals or objectives that will allow the beneficiary, provider and others to assess progress toward achievement of the goal or objective. For each goal or objective, the Treatment Plan must specify the treatment intervention(s) determined to be medically necessary to address the problem or need and to achieve the goal(s) or objective(s).

214.000 Covered Outpatient Services 3-1-19

Covered outpatient services include home and community-based services to Medicaid-eligible beneficiaries. Beneficiaries eligible for Adult Behavioral Health Services for Community Independence shall be served with an array of treatment services outlined on their Treatment Plan in an amount and duration designed to meet their medical needs.

215.000 Exclusions 3-1-19

Services not covered under the Adult Behavioral Health Services for Community Independence benefit include, but are not limited to:

A. Room and board residential costs;

B. Educational services;

C. Telephone contacts with patient;

D. Transportation services, including time spent transporting a beneficiary for services **(reimbursement Adult Behavioral Health Services for Community Independence is not allowed for the period of time the Medicaid beneficiary is in transport);**

E. Services to individuals with developmental disabilities which are non-psychiatric in nature;

F. Services which are found not to be medically necessary; and

G. Services provided to nursing home and ICF/IDD residents

216.000 Physician's Role 3-1-19

Certified Behavioral Health Agencies which provide Adult Behavioral Health Services for Community Independence are required to have relationships with a board certified or board eligible psychiatrist who provides appropriate supervision and oversight for all medical and treatment services for beneficiaries with behavioral health needs. A physician will supervise and coordinate all psychiatric and medical functions as indicated in the Treatment Plan that is required for beneficiaries receiving Adult Behavioral Health Services for Community Independence. Medical responsibility shall be vested in a physician licensed in Arkansas that signs the Treatment Plan of the beneficiary.

A. Beneficiaries receiving Adult Behavioral Health Services for Community Independence will receive those services through a Behavioral Health Agency, which is required to employ a Medical Director. A physician must review and sign the beneficiary's Treatment Plan, including any subsequent revisions. Medical responsibility will be vested in a physician licensed in Arkansas who signs the Treatment Plan of the beneficiary. If medical responsibility is not vested in a psychiatrist for a Behavioral Health Agency, then psychiatric consultation must be available, in accordance with DPSQA certification requirements.

B. Approval of all updated or revised Treatment Plans must be documented by the physician's dated signature on the revised document and should be completed in conjunction with the beneficiary's Independent Assessment.

217.000 Prescription for Adult Behavioral Health Services for Community Independence 3-1-19

Beneficiaries receiving Adult Behavioral Health Services for Community Independence must have a signed prescription for services by a psychiatrist or physician. Medicaid will not cover any Adult Behavioral Health Services for Community Independence without a current prescription signed by a psychiatrist or physician and eligibility determined by a standardized Independent Assessment. The signed Treatment Plan will serve as the prescription for beneficiaries that are eligible for Rehabilitative Level Services and Therapeutic Communities/Planned Respite in Intensive Level Services.

Prescriptions shall be based on consideration of an evaluation of the enrolled beneficiary. The prescription of the services and subsequent renewals must be documented in the beneficiary's medical record.

Beneficiaries determined through an Independent Assessment to be eligible to receive Rehabilitative Level Services (Tier 2) or Intensive Level Services (Tier 3) do not require a Primary Care Physician (PCP referral).

218.000 Authorization for Services 3-1-19

All Adult Behavioral Health Services for Community Independence receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis are retrospectively reviewed for medical necessity.

Procedure codes requiring retrospective review for authorization:

National Codes	Required Modifier	Service Title
H2023	U4	Supportive Employment
H0043	U4	Supportive Housing
H0035	U4	Partial Hospitalization
H2017	UB, U4	Adult Rehabilitative Day Service
H2017	UA, U4	Adult Rehabilitative Day Service
H2017	U3, U4	Adult Life Skills Development
H2017	U4, U5	Adult Life Skills Development
H0019	HQ, UC, U4	Therapeutic Communities – Level I
H0019	HQ, U4	Therapeutic Communities – Level 2

240.000 REIMBURSEMENT

240.100 Reimbursement 3-1-19

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The

provider is responsible for verifying that the beneficiary is eligible for Arkansas Medicaid prior to rendering services.

A. Outpatient Services

Fifteen-Minute Units, unless otherwise stated

Adult Behavioral Health Services for Community Independence must be billed on a per unit basis as indicated in the service definition, as reflected in a daily total, per beneficiary, per service.

Time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day. Providers may accumulatively bill for a single date of service, per beneficiary, per Adult Behavioral Health Services for Community Independence service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per Adult Behavioral Health Services for Community Independence service, based on the established procedure codes. No rounding is allowed.

The sum of the days' time, in minutes, per service will determine how many units are allowed to be billed. That number must not be exceeded. The total of minutes per service must be compared to the following grid, which determines the number of units allowed.

15 Minute Units	Timeframe
One (1) unit =	8-24 minutes
Two (2) units =	25-39 minutes
Three (3) units =	40-49 minutes
Four (4) units =	50-60 minutes

60 minute Units	Timeframe
One (1) unit =	50-60 minutes
Two (2) units =	110-120 minutes
Three (3) units =	170-180 minutes
Four (4) units =	230-240 minutes
Five (5) units =	290-300 minutes
Six (6) units =	350-360 minutes
Seven (7) units=	410-420 minutes
Eight (8) units=	470-480 minutes

30 Minute Units	Timeframe
One (1) unit =	25-49 minutes
Two (2) units =	50-60 minutes

In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary. There is no "carryover" of time from one day to another or from one beneficiary to another.

Documentation in the beneficiary's record must reflect exactly how the number of units is determined.

No more than four (4) units may be billed for a single hour per beneficiary or provider of the service.

NOTE: For services provided by a Qualified Behavioral Health Provider (QBHP), the accumulated time for the Adult Behavioral Health Services for Community Independence program service, per date of service, is one total, regardless of the number of QBHPs seeing the beneficiary on that day. For example, two (2) QBHPs see the same beneficiary on the same date of service and provides Adult Life Skills Development (HCPCS Code H2017, U3, U4). The first QBHP spends a total of 10 minutes with the beneficiary. Later in the day, another QBHP provides Adult Life Skills Development (HCPCS Code H2017, U3, U4) to the same beneficiary and spends a total of 15 minutes. A total of 25 minutes of Behavioral Assistance (CPT Code 2019) was provided, which equals (two) 2 allowable units of service. Only one QBHP may be shown on the claim as the performing provider.

241.000 Fee Schedule 3-1-19

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/Provider/Docs/fees.aspx** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

250.000 BILLING PROCEDURES

251.000 Introduction to Billing 3-1-19

Adult Behavioral Health Services for Community Independence providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary. **View a CMS-1500 sample form.**

Section III of this manual contains information about available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures

252.100 Procedure Codes for Types of Covered Services 3-1-19

Adult Behavioral Health Services for Community Independence are billed on a per unit or per encounter basis as listed. All services must be provided by at least the minimum staff within the licensed or certified scope of practice to provide the service.

Benefits are separated by Level of Service.

Prior to reimbursement for Rehabilitative Level Services or Intensive Level Services, a standardized Independent Assessment will determine eligibility and need for Rehabilitative Level

Services or Intensive Level Services. The standardized Independent Assessment will be performed by an independent entity as indicated in the Arkansas Medicaid Independent Assessment Manual.

253.000 Rehabilitative Level Services

253.001 Partial Hospitalization 3-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0035, U4	Mental health partial hospitalization treatment, less than 24 hours

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.	• Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to the treatment must include current progress or lack of progress toward symptom reduction and attainment of goals • Rationale for continued Partial Hospitalization Services, including necessary changes to diagnosis, master treatment plan or medication(s) and plans to transition to less restrictive services • All services provided must be clearly documented in the medical record • Staff signature/credentials

NOTES	UNIT	BENEFIT LIMITS
Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual. The medical record must indicate the services provided during Partial Hospitalization.	Per Diem	DAILY MAXIMUM THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF DAYS THAT MAY BE BILLED (extension of benefits can be requested): 40

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	A provider may not bill for any other services on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**

Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Partial Hospitalization must be provided in a facility that is certified by the Division of Behavioral Health Services as a Partial Hospitalization provider	11, 49, 52, 53
EXAMPLE ACTIVITIES	
Care provided to a client who is not ill enough to need admission to facility but who has need of more intensive care in the therapeutic setting than can be provided in the community. This service shall include at a minimum intake, individual and group therapy, and psychosocial education. Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual.	

253.002 Adult Rehabilitative Day Service 3-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2017, UB, U4 – QBHP Bachelors or RN H2017, UA, U4 – QBHP Non-Degreed	Psychosocial rehabilitation services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan.		
NOTES	**UNIT**	**BENEFIT LIMITS**
Staff to Client Ratio – 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs.	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 6 units QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 90 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adult – Ages 18 and Above	**The following codes cannot be billed on the Same Date of Service:** H2015 – Individual Recovery Support, Bachelors H2015 – Individual Recovery Support, Non-Degreed H2015 – Group Recovery Support, Bachelors H2015 – Group Recovery Support, Non-Degreed	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2019 with HK, HN modifiers)	04, 11, 12, 13, 14, 22, 23, 31, 32, 33, 49, 50, 52, 53, 57, 71, 72, 99

253.003 Supportive Employment 3-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H2023, U4	Supportive Employment	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Supportive Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017 code on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12 , 16, 49, 53, 57, 99

253.004 Supportive Housing 3-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0043, U4	Supportive Housing
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Supportive Housing is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits.

	A provider cannot bill any H2017 code on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12 , 16, 49, 53, 57, 99

253.005 Adult Life Skills Development 3-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2017, U3, U4 – QBHP Bachelors or RN H2017, U4, U5– QBHP Non-degreed	Comprehensive community support services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Life Skills Development services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness and nutrition). Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS

	15 Minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 8 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12 , 16, 49, 53, 57, 99	

253.006 Peer Support **3-1-19**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0038, UC, U4 H0038, U4 - Telephonic	Self-help/peer services, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual contact • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration

	• Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 120
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	Provider can only bill for 120 units (combined between H0038 and H0038, U8) per SFY	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Certified Peer Support Specialist • Certified Youth Support Specialist	03, 04, 11, 12, 13, 14, 15, 16, 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	
EXAMPLE ACTIVITIES		
Peer support may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.		

253.007 Treatment Plan **3-1-19**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
S0220, U4	S0220: Treatment Plan
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the	• Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis • Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • Projected schedule for service delivery,

beneficiary and demonstrate cultural competence.	including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed when the beneficiary is determined to be eligible for services. Revisions to the Treatment Plan for Adult Behavioral Health Services for Community Independence must occur at least annually, in conjunction with the results from the Independent Assessment. Reimbursement for Treatment Plan revisions more frequently than once per year is not allowed unless there is a documented clinical change in circumstance of the beneficiary or if a beneficiary is re-assessed by the Independent Assessment vendor which results in a change of Tier. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 4

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	Must be reviewed annually
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72

• Physician	

253.008 Aftercare Recovery Services 3-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H2017 – QBHP Bachelors or RN H2017 – QBHP Non-Degreed	Psychosocial rehabilitation services, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.	Date of Service Names and relationship to the beneficiary of all persons involved Start and stop times of actual encounter Place of Service (When 99 is used, specific location and rationale for location must be included) Client diagnosis necessitating service Document how treatment used address goals and objectives from the master treatment plan Information gained from contact and how it relates to master treatment plan objectives Impact of information received/given on the beneficiary's treatment Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration Plan for next contact, if any Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 Minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-	03, 04, 11, 12, 13, 14, 15, 16, 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	

Degreed	

254.000 Intensive Level Services 3-1-19

Eligibility for intensive level services is determined by the Intensive Level Services standardized Independent Assessment.

Prior to reimbursement for any intensive level service, a beneficiary must be deemed Tier III by the Behavioral Health Independent Assessment.

Eligibility for entry into a residential setting requires adherence to appropriate Medicaid rules regarding that residential setting. Eligibility for Therapeutic Communities requires that an Individualized Treatment Plan be developed for the beneficiary.

254.001 Therapeutic Communities 3-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0019, HQ, UC, U4 – Level 1 H0019, HQ, U4 – Level 2	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem.	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Place of Service • Document how interventions used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Therapeutic Communities Level will be determined by the following: • Functionality based upon the Independent Assessment Score • Outpatient Treatment History and Response • Medication • Compliance with Medication/Treatment	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be

Eligibility for this service is determined by the Intensive Level Services standardized Independent Assessment. Prior to reimbursement for Therapeutic Communities in Intensive Level Services, a beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Therapeutic Communities.		requested): H0019, HQ – 180 H0019, HQ, HK - 185
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider cannot bill any other services on the same date of service.	
	PROGRAM SERVICE CATEGORY	
	Intensive	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Therapeutic Communities must be provided in a facility that is certified by the Division of Behavioral Health Services as a Therapeutic Communities provider	14, 21, 51, 55	

255.000 Place of Service Codes 3-1-19

Electronic and paper claims now require the same national place of service codes.

Place of Service	POS Codes
Homeless Shelter	04
Office (Behavioral Health Agency Facility Service Site)	11
Patient's Home	12
Assisted Living Facility	13
Group Home	14
Mobile Unit	15
Temporary Lodging	16
Inpatient Hospital	21
Custodial Care Facility	33
Independent Clinic	49
Federally Qualified Health Center	50
Psychiatric Facility – Partial Hospitalization	52

Place of Service	POS Codes
Community Mental Health Center	53
Non-Residential Substance Abuse Treatment Facility	57
Public Health Clinic	71
Rural I lealth Clinic	72
Other	99

]

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *For elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Partial Hospitalization; Adult Rehabilitative Day Service; Supportive Employment; Supportive Housing; Adult Life Skills Development; Therapeutic Communities; Peer Support

2. **Concurrent Operation with Other Programs.** *(Indicate whether this benefit will operate concurrently with another Medicaid authority):*

***Select one*:**

	Not applicable
x	**Applicable**
Check the applicable authority or authorities:	
	Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
	Waiver(s) authorized under §1915(b) of the Act *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
Specify the §1915(b) authorities under which this program operates (*check each that applies*):	
	§1915(b)(1) (mandated enrollment to managed care)
	§1915(b)(2) (central broker)
	§1915(b)(3) (employ cost savings to furnish additional services)
	§1915(b)(4) (selective contracting/limit number of providers)
	A program operated under §1932(a) of the Act. *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
X	**A program authorized under §1115 of the Act.** *Specify the program*: Arkansas Works

3. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS. Benefit-***(Select one):*

X	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	X	The Medical Assistance Unit *(name of unit)*:	The Division of Medical Services (DMS)
		Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non- State Entity
1. Individual State plan HCBS enrollment	☑			
2. Eligibility evaluation	☑			
3. Review of participant service plans	☑		☑	
4. Prior authorization of State plan HCBS	☑		☑	
5. Utilization management	☑		☑	
6. Qualified provider enrollment	☑			
7. Execution of Medicaid provider agreement	☑			

8. Establishment of a consistent rate methodology for each State plan HCBS	☑		☑	
9. Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑			
10. Quality assurance and quality improvement activities	☑		☑	

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

A contracted vendor will perform reviews of service plans, authorizations for State plan HCBS, quality assurance and quality improvement activities, and utilization management for the services contained within this 1915(i) HCBS State Plan benefit.

The State contracted with an outside vendor to establish rates for the services contained within this this 1915(i) HCBS State Plan benefit.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	Jan. 1, 2019	Dec. 31, 2019	2,000
Year 2	Jan. 1, 2020	Dec. 31, 2020	
Year 3	Jan. 1, 2021	Dec. 31, 2021	
Year 4	Jan. 1, 2022	Dec. 31, 2022	
Year 5	Jan. 1, 2023	Dec. 31, 2023	

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. Medically Needy (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.

☑ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

	Directly by the Medicaid agency
X	By Other (*specify State agency or entity under contract with the State Medicaid agency*): The individual must have a behavioral health diagnosis and have received a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services conducted by DHS's third party vendor.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The assessor must have a Bachelor's Degree or be a registered nurse with one (1) year of experience with mental health populations.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Behavioral Health clients:
1) Must have a documented behavioral health diagnosis, made by a physician and contained in the individual's medical record; and
2) Must have been deemed a Tier 2 or Tier 3 by the independent assessment of functional need related to diagnosis.

Behavioral health clients must undergo the Independent Assessment and be deemed a Tier 2 or Tier 3 annually.

4. ☑ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The individual must have a behavioral health diagnosis and have received a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services conducted by DHS's third party vendor.

The functional assessment takes into account the individuals' ability to provide his or her own support, as well as other natural support systems, as well as the level of need to accomplish ADLs and IADLs.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
Behavioral Health: 1) Have a documented behavioral health diagnosis; and 2) Assessed as a Tier 2 or 3 on the independent assessment.	Must meet at least one of the following three criteria as determined by a licensed medical professional: 1. The individual is unable to perform either of the following: A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or, B. At least two (2) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without limited assistance from another person; or, 2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or, 3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening. 4. No individual who is	1) Diagnosis of developmental disability that originated prior to age of 22; 2) The disability has continued or is expected to continue indefinitely; and 3) The disability constitutes a substantial handicap to the person's ability to function without appropriate support services, including but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. Must also be in need of and able to benefit from active treatment and unable to access appropriate services in a less restrictive setting.	There must be a written certification of need (CON) that states that an individual is or was in need of inpatient psychiatric services. The certification must be made at the time of admission, or if an individual applies for Medicaid while in the facility, the certification must be made before Medicaid authorizes payment. Tests and evaluations used to certify need cannot be more than one (1) year old. All histories and information used to certify need must have been compiled within the year prior to the CON. In compliance with 42 CFR 441.152, the facility-based and independent CON teams must certify that: A. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary; B. Proper treatment of the beneficiary's psychiatric condition requires inpatient services under the direction of a physician and C. The services can be reasonably expected to prevent further regression or to improve the beneficiary's condition so that the

	otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.		services will no longer be needed.

*Long Term Care/Chronic Care Hospital **LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The State will target this 1915(i) State plan HCBS benefit to individuals in the following eligibility groups:

1.) Individuals who qualify for Medicaid through spenddown eligibility.

2.) Adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and covered under the Arkansas Section 1115 Demonstrative Waiver ("Arkansas Works") who are determined to be "Medically Frail".

The 1915(i) State plan HCBS benefit is targeted to individuals with a behavioral health diagnosis who have high needs as indicated on a functional assessment.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan):*

(By checking the following box the State assures that):

8. ☑**Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. ☑ **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One.
ii.	**Frequency of services.** The state requires (select one):
X	**The provision of 1915(i) services at least monthly**
	Monthly monitoring of the individual when services are furnished on a less than monthly basis If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The 1915(i) State plan HCBS benefit is subject to the HCBS Settings requirements and therefore must be included in the State Wide Transition Plan.

The Division of Medical Services (DMS) is the State Medicaid Agency (SMA) responsible for operating this 1915(i) State plan benefit impacted by the HCBS Settings Rule. The purpose of this waiver is to support individuals within specific eligibility categories who have a behavioral health diagnosis and who choose to receive services within their community. Each individual receiving a service within this 1915(i) State plan benefit are required to have a Treatment Plan which will offer an array of services that allow flexibility and choice for the participant.

Individuals served by the 1915(i) State plan benefit choose to reside in the community and receive HCBS services in their home. The home may be the person's home, the home of a family member or friend, a group home, a provider owned or controlled apartment, or the home of a staff person who is employed by the HCBS provider. It is assumed that people who live in their own home or the home of a family member or friend who is not paid staff receive services in a setting that complies with requirements found at 42 CFR 441.301(c)(4).

DMS and its agent (including DDS) will monitor the development of the Treatment Plan and the provision of services. Information on the HCBS Settings rule will be included in annual training opportunities for DMS's monitoring staff.

Assessment of Compliance with Residential and Non-Residential Settings Requirements

An inter-divisional HCBS Settings working group has met regularly since 2014 and will continue to meet during the implementation of the STP. The working group consists of representatives from DAAS, DDS, and Division of Medical Services (DMS) within the Arkansas Department of Human Services. The working group initially met to review the new regulations and develop the initial STP and corresponding timeline. DMS will convene this working group to set applicable standards for PASSE HCBS settings. It will be expected that PASSE organizations implement these standards, and the federal HCBS Settings Rule into their provider agreements and credentialing standards.

Agents of DMS will be assigned to review teams. The review teams will conduct reviews of randomly selected provider owned or controlled apartments and group homes.

Upon completion of the review, notes from the review team member will be summarized in a standard report and sent to the Provider and the PASSE. The report will summarize the visit, noted areas needing improvement that were observed and documented, requested clarification of provider policies and procedures and/or a corrective action plan. A deadline will be given to the provider and the PASSE to provide this information and technical assistance for DMS and the Settings working group will be provided.

Ongoing Training

DMS and the HCBS Settings working group will develop and conduct PASSE and provider trainings, as well as provided tailored technical assistance to partially compliant and non-compliant providers.

Heightened Scrutiny

DMS recognizes that certain settings are presumed non-compliant with the HCBS Settings requirements. Specifically, some home and community based settings have institutional qualities – those settings that are publicly or privately owned facilities that provide inpatient treatment, those settings that are located on the grounds of, or immediately adjacent to, a public institution, or those settings that have the effect of isolating individuals from the broader community. These settings include those that are located on or near the grounds of an institution and settings which may isolate individuals from the community. These settings include group homes located on the grounds of or adjacent to a public institution, numerous group homes co-located on a single site, a disability-specific farm-like service setting and apartments located in apartment complexes also occupied by persons who do not receive HCBS services. DMS will identify these settings and require the PASSE implement heightened scrutiny for those settings presumed not to be home and community based.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

For the behavioral health population, the assessor must have a Bachelor's Degree or be a registered nurse with one (1) year of experience with mental health populations.

5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The Treatment Plan must be completed by a licensed practitioner and signed by a Physician.

6. **Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

During the development of the Treatment Plan for the individual, everyone in attendance is responsible for supporting and encouraging the member to express their wants and desires and to incorporate them into the Treatment Plan when possible.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Each participant has the option of choosing their 1915(i) State plan service provider. If, at any point during the course of treatment, the current provider cannot meet the needs of the participant, they must inform the participant as well as their Primary Care Physician / Person Centered Medical Home

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

All 1915(i) FFS Behavioral Health Service providers must create a Treatment Plan for any beneficiary who is receiving 1915(i) FFS Behavioral Health Services. The Treatment Plan must be created within 14

calendar days of the beneficiary entering care (first billable service) or within 14 days of an eligibility determination for beneficiaries receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis at a certified Behavioral Health Agency and must be signed and dated by a physician licensed in Arkansas. The Treatment Plan is 100% retrospectively reviewed by the Division of Medical Services (or its' contractor).

9. **Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

	Medicaid Agency	X	Operating Agency		Case Manager

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Supportive Employment
Service Definition (Scope)*:*	
Supportive Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Must be listed in the treatment plan.	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	Quarterly Maximum of Units: 60
☑	Medically needy *(specify limits):*
	Quarterly Maximum of Units: 60

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) FFS Behavioral Health Services must Work under the direct supervision of a mental health professional. 1. Successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Adult Rehabilitation Day Treatment

Service Definition (Scope)*:*

A continuum of care provided to recovering members living in the community based on their level of need. This service includes educating and assisting the members with accessing supports and services needed. The service assists recovering members to direct their resources and support systems. Activities include training to assist the member to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular environment. Adult rehabilitation day treatment includes training and assistance to live in and maintain a household of their choosing in the community. In addition, activities can include transitional services to assist members after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

Adult rehabilitative day treatment is an array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified members that are aimed at long-term recovery and maximization of self-sufficiency. These rehabilitative day activities are person and family centered, recovery based, culturally competent, and provided needed accommodation for any disability. These activities must also have measurable outcomes directly related to the beneficiary's treatment plan. Day treatment activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his or her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement the member's behavioral health treatment plan.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be listed in the treatment plan.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Staff to member ratio: 1:15 maximum Daily Maximum of Units: 6 Quarterly Maximum of Units: 90
☑	Medically needy *(specify limits):*
	Staff to member ratio: 1:15 maximum Daily Maximum of Units: 6 Quarterly Maximum of Units: 90

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) FFS Behavioral Health Services must Work under the direct supervision of a mental health professional. Successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Adult Skills Development
Service Definition (Scope)*:*	
Life Skills Development services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness and nutrition). Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system. The Master Treatment Plan should address the recovery objective of each activity performed under Life Skills Development and Support.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Must be listed in the treatment plan.	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	Daily Maximum of Units: 8 Yearly Maximum of Units: 292
☑	Medically needy *(specify limits):*
	Daily Maximum of Units: 8 Yearly Maximum of Units: 292

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) FFS Behavioral Health Services must Work under the direct supervision of a mental health professional.

			1. Successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Partial Hospitalization

Service Definition (Scope)*:*

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation.

Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be listed in the treatment plan.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Yearly Maximum of Units: 40 A provider may not bill for any other services on the same date of service.
☑	Medically needy *(specify limits):*
	Yearly Maximum of Units: 40 A provider may not bill for any other services on the same date of service.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Certified by the Division of Provider Services and Quality Assurance as a Partial Hospitalization Provider. • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) FFS Behavioral Health Services must Work under the direct supervision of a mental health professional. Successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Therapeutic Communities

Service Definition (Scope)*:*

A non-facility based setting that emphasizes the integration of the member within his or her community; progress is measured within the context of that community's expectation. Therapeutic Communities are highly structured environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the member on their treatment plan. Therapeutic Communities employ community imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the community setting. Participants and staff members act as facilitators, emphasizing self-improvement.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be in the treatment plan and be determined to be Tier III by the functional independent assessment.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

None.

A provider may not bill for any other services on the same date of service.

☑ Medically needy *(specify limits):*

None.

A provider may not bill for any other services on the same date of service.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Certified by the Division of Provider Services and Quality Assurance as a Therapeutic Communities Provider. • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) FFS Behavioral Health Services must Work under the direct supervision of a mental health professional. • Successfully complete and document

			courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Supportive Housing

Service Definition (Scope)*:*

Supportive Housing is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey.

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Quarterly Maximum of Units: 60
☑	Medically needy *(specify limits):*
	Quarterly Maximum of Units: 60

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Certified by the Division of Provider Services and Quality Assurance as a Partial Hospitalization Provider. • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) FFS Behavioral Health Services must Work under the direct supervision of a mental health professional. Successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Peer Support

Service Definition (Scope)*:*

Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.

Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	Yearly Maximum of Units: 120
☑	Medically needy *(specify limits):*
	Yearly Maximum of Units: 120

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Certified by the Division of Provider Services and Quality Assurance as a Partial Hospitalization Provider. • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) FFS Behavioral Health Services must Work under the direct supervision of a mental health professional. Successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Aftercare Recovery Support

Service Definition (Scope):

A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

Yearly Maximum of Units: 292

☑ Medically needy *(specify limits):*

Yearly Maximum of Units: 292

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Certified by the Division of Provider Services and Quality Assurance as a Partial Hospitalization Provider. • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) FFS Behavioral Health Services must Work under the direct supervision of a mental health professional. Successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

2. ☑**Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

a) Medicaid Enrolled Behavioral Health Agencies are able to provide State Plan HCBS under authority of this 1915(i). Relatives of beneficiaries who are employed by a Behavioral Health Agency as a Qualified Behavioral Health Provider or Registered Nurse may be paid to provide HCBS services, provided they are not the parent, legally responsible individual, or legal guardian of the member.
b) The HCBS services that relatives may provide are: supportive housing, supportive employment, adult rehabilitative day treatment, therapeutic communities, partial hospitalization and life skills development.
c) All relatives who are paid to provide the services must meet the minimum qualifications set forth in this 1915(i) and may not be involved in the development of the master treatment plan.
d) All services are retrospectively reviewed for medical necessity. Each Behavioral Health Agency is subject to Inspections of Care (IOCs) as well as monitoring by the Office of Medicaid Inspector General.
e) Personal care is not an included benefit of this 1915(i) HCBS State Plan.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

Election of Participant-Direction. (Select one):

⊙	The state does not offer opportunity for participant-direction of State plan HCBS.

○

○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

2. **Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

3. **Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. Financial Management. (*Select one)* :

	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

5. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the

continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. **Participant–Employer Authority** *(individual can select, manage, and dismiss State plan HCBS providers). (Select one):*

	The state does not offer opportunity for participant-employer authority.	
	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. **Participant–Budget Authority** *(individual directs a budget that does not result in payment for medical assistance to the individual). (Select one):*

	The state does not offer opportunity for participants to direct a budget.
	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Treatment plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

3. Providers meet required qualifications.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

5. The SMA retains authority and responsibility for program operations and oversight.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Requirement 1: Service Plans Address Needs of Participants are reviewed annually and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	The percentage of treatment plans developed by Behavioral Health Agencies which provide 1915(i) State Plan HCBS that meet the requirements of 42 CFR §441.725. Numerator: Number of treatment plans that adequately and appropriately address the beneficiary's needs. Denominator: Total Number of treatment plans reviewed.
Discovery Activity *(Source of Data & sample size)*	All treatment plans are retrospectively reviewed as well as all HCBS services provided to eligible individuals by DMS (or its contractor). The data will be produced by the Behavioral Health Agencies and must remain in the medical record of the beneficiary.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents

Requirement	Requirement 1: Service Plans
Frequency	When services are approved for medical necessity retrospectively.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Behavioral Health Agency will be responsible for remediating deficiencies in treatment plan of their beneficiaries. If there is a pattern of deficiencies noticed, action may be taken against the Behavioral Health Agency, up to and including, instituting a corrective action plan or sanctions pursuant to the Medicaid Provider Manual.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and findings will be reported on a annual basis. If a pattern of deficiency is noted, this may be made public.

Requirement	Requirement 2: Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence One *(Performance Measure)*	All beneficiaries must be independently assessed in order to qualify for 1915(i) State plan HCBS eligibility. There are system edits in place that will not allow those who have not received an independent assessment to received 1915(i) State Plan HCBS. In order to maintain eligibility for 1915(i) State plan HCBS, the beneficiary must be re-assessed on an annual basis. Numerator: The number of beneficiaries who are evaluated and assessed for eligibility in a timely manner. Denominator: The total number of beneficiaries who are identified for the 1915(i) HCBS State Plan Services eligibility process.
Discovery Activity One *(Source of Data & sample size)*	A 100% sample of the application packets for beneficiaries who undergo the eligibility process will be reviewed for compliance with the timeliness standards. The data will be collected from the Independent Assessment Vendor.
Monitoring Responsibilities *(Agency or entity that conducts*	DMS or its agents

discovery activities)	
Discovery Evidence Two	The Percentage of beneficiaries for whom the appropriate eligibility process and instruments were used to determine initial eligibility for HCBS State Plan Services. Numerator: Number of beneficiaries' application packets that reflect appropriate processes and instruments were used. Denominator: Total Number of application packets reviewed.
Discovery Activity Two	A 100% sample of the application packets for beneficiaries who went through the eligibility determination process will be reviewed. The data will be collected from the Independent Assessment Vendor.
Monitoring Responsibility	DMS or its agents.
Discovery Evidence Three	The percentage of beneficiaries who are re-determined eligible for HCBS State Plan Services before their annual treatment plan expiration date. Numerator: The number of beneficiaries who are re-determined for eligibility timely (before expiration of treatment plan). Denominator: The total number of beneficiaries re-determined eligible for HCBS State Plan Services.
Discovery Activity Three	A 100% sample of the application packets for beneficiaries who went through the eligibility re-determination process will be reviewed. The data will be collected from the Independent Assessment Vendor.
Monitoring Responsibilities	DMS or its agents.

Requirement	Requirement 2: Eligibility Requirements
Frequency	Sample will be selected and reviewed quarterly.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for*	For Independent Functional Assessments: The Independent Assessment Vendor is responsible for developing and implementing a quality assurance process, which includes monitoring for accuracy, data consistency, integrity, and completeness of assessments, and the performance of staff. This must include a desk review of assessments with a statistically significant sample size. Of the reviewed assessments, 95% must be accurate. The Independent Assessment Vendor submits monthly reports to DHS's contract monitor. When deficiencies are noted, a corrective action plan will be implemented with the Vendor.

remediation)	
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.

Requirement	Requirement 3: Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	In order to enroll as a Medicaid provider, a Behavioral Health Agency must be certified by the Division of Provider Services and Quality Assurance. Numerator: Number of Behavioral Health Agencies that currently have Division of Provider Services and Quality Assurance certification. Denominator: Number of Behavioral Health Agencies enrolled in Arkansas Medicaid.
Discovery Activity *(Source of Data & sample size)*	100% of Behavioral Health Agencies will be reviewed to ensure certification by Division of Provider Services and Quality Assurance. Without this certification, the provider cannot enroll or continue to be enrolled in Arkansas Medicaid.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS, DPSQA, or its agents

Requirement	Requirement 4: Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of provider owned apartments or homes that meet the home and community-based settings requirements. Denominator: Number of provider owned apartments and homes that meet the HCBS Settings requirements in 42 CFR 441.710(a)(1) & (2). Numerator: Number of provider owned apartments and homes that are reviewed by the DMS Settings review teams.
Discovery Activity *(Source of Data & sample size)*	Review of the Settings Review Report sent to Behavioral Health Agencies. The reviewed apartments or homes will be randomly selected. A typical review will consist of at least 10% of each Behavioral Health Provider's apartments and homes (if they own any) each year.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents.

Requirement	Requirement 5: The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of policies developed must be promulgated in accordance with the DHS agency review process and the Arkansas Administrative Procedures Act (APA). Numerator: Number of policies and procedures appropriately promulgated in accordance with agency policy and the APA; Denominator: Number of policies and procedures promulgated.
Discovery Activity *(Source of Data & sample size)*	100% of policies developed must be reviewed for compliance with the agency policy and the APA.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents

Requirement	Requirement 5: The SMA retains authority and responsibility for program authority and oversight.
Frequency	Continuously, and as needed, as each policy is developed and promulgated.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHS's policy unit is responsible for compliance with Agency policy and with the APA. In cases where policy or procedures were not reviewed and approved according to DHS policy, remediation includes DHS review of the policy upon discovery, and approving or removing the policy.
Frequency *(of Analysis and Aggregation)*	Each policy will be reviewed for compliance with applicable DHS policy and the APA.

Requirement	Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Discovery	
Discovery Evidence One *(Performance Measure)*	The SMA will make payments to Behavioral Health Agencies providing 1915(i) State plan HCBS. In order for payment to occur, the provider must be enrolled as a Medicaid provider. There is not an option for a non-enrolled provider to receive payment for a service.
Discovery Activity One *(Source of Data & sample size)*	Review of claims payments via MMIS.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents

Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of Behavioral Health Agencies that meet criteria for abuse and neglect reporting training for staff. Numerator: Number of provider agencies investigated who complied with required Abuse and neglect training set out in the Behavioral Health Agency certification; Denominator: Total number of provider agencies reviewed or investigated.
Discovery Activity *(Source of Data & sample size)*	During certification or re-certification of Behavioral Health Agencies, DPSQA will ensure that appropriate training is in place regarding abuse, neglect, and exploitation for all Behavioral Health Agency personnel.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS, DPSQA or its agents

Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Frequency	Annually, and continuously, as needed, when a compliant is received.
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DQPSA will investigate all complaints regarding abuse, neglect, and exploitation.
Frequency *(of Analysis and Aggregation)*	As necessary

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The State will continuously monitor the utilization of 1915(i) FFS services for the eligible populations. The State will monitor treatment plans that are required for beneficiaries and will retrospectively approve services.

The State will investigate and monitor any complaints about Behavioral Health Agencies providing any 1915(i) FFS services.

2. Roles and Responsibilities

The State (including DMS, DPSQA, and its agents) will be responsible for oversight of Behavioral Health Agencies providing 1915(i) FFS services.

3. Frequency

On-going monitoring will occur.

4. Method for Evaluating Effectiveness of System Changes

The State will utilize multiple methods to evaluate the effectiveness of system changes. These may include site reviews, contract reviews, claims data, complaints, and any other information that may provide a method for evaluating the effectiveness of system changes.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

	HCBS Case Management
	HCBS Homemaker
	HCBS Home Health Aide
	HCBS Personal Care
	HCBS Adult Day Health
	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☑	HCBS Day Treatment or Other Partial Hospitalization Services
	Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.
	HCBS Psychosocial Rehabilitation
	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (Specify below):
	For all other services, the rate methodology is based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):*_____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26- 05, and Baltimore, Maryland 21244-1850.