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State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 18-0016

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved Page

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

January 9, 2019

Our Reference: SPA AR 18-0016

Ms. Dawn Stehle
State Medicaid Director
Arkansas Department of Health and Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, Arkansas 72203-1437

Dear Ms. Stehle:

Enclosed is a copy of approved Arkansas (AR) State Plan Amendment (SPA) 18-0016, with an effective date of March 1, 2019. This amendment was submitted to allow beneficiaries who are eligible for Arkansas Medicaid healthcare benefits on a medical spend down basis and who are medically frail to have access to Tier 2 and Tier 3 Behavioral Health Services.

This letter affirms that AR 18-0016 is approved effective March 1, 2019 as requested by the State.

We are enclosing the CMS-179 and the following amended plan pages.

- Attachment 2.2-A, Pages 31 – 32
- Attachment 3.1-i, Pages 51 – 85
- Attachment 4.19-B, Page 19

If you have any questions regarding this matter you may contact Stacey Shuman at 214-767-6479, or by email at stacey.shuman@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

CC: Billy Bob Farrell, DMCH Dallas
Stacey Shuman, DMCH Dallas
Daphne Hicks, CMS Baltimore
Tia Lyles, CMS Baltimore

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2018-016

2. STATE: ARKANSAS

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 $0
b. FFY 2020 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.2-A, pages 31-32
Attachment 3.1-i, pages 51-85
Attachment 4.19-B, page 19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

None, New Pages
None, New Pages
None, New Page

10. SUBJECT OF AMENDMENT: The Arkansas Title XIX State Plan has been amended to allow beneficiaries who are eligible for Arkansas Medicaid healthcare benefits on a medical spenddown basis and who are medically frail to have access to Tier 2 and Tier 3 Behavioral Health Services.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Tami Harlan

14. TITLE:
Director, Division of Medical Services

15. DATE SUBMITTED:
October 15, 2018

16. RETURN TO:

Division of Medical Services
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attention: Dave Mills

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: October 15, 2018

18. DATE APPROVED: January 9, 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Bill Brooks

22. TITLE: Associate Regional Administrator, Division of Medicaid and Children's Health (DMCH)

23. REMARKS:

FORM HCFA-179 (07-92)

FORM APPROVED
OMB NO. 0938-0193

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 Treatment; Supported Employment; Supportive Housing; Adult Life Skills Development; Therapeutic Communities; Peer Support; Aftercare Recovery Support

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

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***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)(3) (employ cost savings to furnish additional services)
	§1915(b)(2) (central broker)		§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.	State: Arkansas Date Received: 15 October, 2018 Date Approved: 9 January, 2019 Effective Date: 1 March, 2019 Transmittal Number: 18-0016
	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):

The State contracted vendor will assist with 3, 4, 5 and 10.

The contracted actuary will assist with 8.

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(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.

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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*): Evaluations and re-evaluations are conducted by DHS's third-party contractor who completes the independent assessment. Eligibility is determined by DMS using the results of the independent assessment and the individual's diagnoses.

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):*

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For the behavioral health population, the assessor must have:

a. Bachelor's Degree (in any subject) or be a registered nu
b. One (1) year of experience with mental health populatio

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 determined 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 determined a Tier 2 or Tier 3 annually.

Individuals are referred for the independent assessment based upon their current diagnosis and utilization of services. After completion of the independent assessment of functional need, DMS makes the eligibility determination for all clients based on the results of the independent assessment and the individual's diagnosis contained in his or her medical record. Eligibility is re-evaluated on an annual basis.

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):*

After medical eligibility has been determined through diagnosis, the following needs-based criteria is used:

For the behavioral health population: The individual must receive a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services. To receive at least a Tier 2, the individual must have difficulties with certain behaviors that require a full array of non-residential services to help with functioning in home and community-based settings and moving towards recovery. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.

Measurement is completed through an assessment of functional deficit through a face-to-face evaluation of the beneficiary, caregiver report and clinical record review. The assessment measures the beneficiary's behavior in psychosocial sub-domains and intervention domain that evaluates the level of intervention necessary to managed behaviors as well as required supports to maintain beneficiary in home and community settings.

The domains are: adaptive, personal/social, communication, motor, and cognitive. 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.

1915(i) services must be appropriate to address the individuals identified functional deficits due to their behavioral health diagnosis or developmental or intellectual disabilities.

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)
For the behavioral health population: The individual must receive a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services. To receive at least a Tier 2, the individual must have difficulties with certain behaviors that require a full array of non-residential services to help with functioning in home and community-based settings and moving towards recovery. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.	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,	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	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

The domains are: adaptive, personal/social, communication, motor, and cognitive. 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. 1915(i) services must be appropriate to address the individuals identified functional deficits due to their behavioral health diagnosis.	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 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.	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.	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 services will no longer be needed. Specifically, a physician must make a medical necessity determination that services must be provided in a hospital setting because the client cannot safely remain in the community setting.

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

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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.

The 1915(i) service settings are fully compliant with the home and community-based settings rule or are covered under the statewide transition plan under another authority where they have been in operation before March of 2014.

The state assures that this State Plan amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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 (in any subject) or be a registered nurse,
b. 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):*

Allowable practitioners that can develop the PCSP/Treatment Plan are:

- Independently Licensed Clinicians (Master's/Doctoral)
- Non-independently Licensed Clinicians (Master's/Doctoral)
- Advanced Practice Nurse (APN)
- Physician

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Individuals who complete the PCSP/Treatment Plan are not allowed to perform HCBS services allowed under this 1915(i) authority. Arkansas Medicaid requires that the performing provider (or individual who has clinical responsibility of the services provided) is indicated on claims when submitting billing.

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.

The Treatment Plan is a plan developed in cooperation with the beneficiary 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 beneficiary and demonstrate cultural competence.

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):*

The PCSP/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 PCSP/Treatment 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 beneficiary and demonstrate cultural competence. PCSP/Treatment plans will be signed by all individuals involved in the creation of the treatment plan, the beneficiary (or signature of parent/guardian/custodian if under age of 18), and the physician responsible for treating the mental health issue.

DMS or it's contracted vendor, on an ongoing basis, will provide for a retrospective/retroactive review process of PCSP/Treatment plans to ensure plans have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the member, and for financial and utilization components.

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

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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:	Supported Employment
Service Definition (Scope)*:*	
Supported 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. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Services may be provided in integrated community work settings in the general workforce. Services may be provided in the home when provided to establish home-based self-employment. Services may be provided in either a small group setting or on an individual basis. Transportation is not included in the rate for this service. Supported employment must be competitive, meaning that wages must be at or above the State's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work. 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):*	
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):*

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	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) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

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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 improve employability, 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. Meals and transportation are not included in the rate for Adult Rehabilitation Day Treatment.

Adult rehabilitation day treatment can occur in a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security Act.

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):*	
	Staff to member ratio: 1:15 maximum Daily Maximum of Units: 6	

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	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) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional. .

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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)*:*

Adult 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., 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.

Adult Skills Development can occur in following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

Transportation is not included in the rate for this service.

All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security Act.

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):*	
	Daily Maximum of Units: 8	

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	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) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional. 1.

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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.

Partial Hospitalization can occur in a variety of clinical settings for adults, similar to adult day cares or adult day clinics. All Partial Hospitalization sites must be certified by the Division of Provider Services and Quality Assurance as a Partial Hospitalization Provider.

All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security Act.

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):

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☑	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) Adult Behavioral Health Services for Community Independence Behavioral Health Services must be a mental health professional or work under the direct supervision of a mental health professional Allowable performing providers under the direct supervision of a mental health professional providing 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers under the direct supervision of a mental health professional must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

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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 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. These consequences and privileges are decided upon by the individual beneficiaries living in the community. 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.

Therapeutic Communities services may be provided in provider-owned apartment or home, or in a provider-owned facility with fewer than 16 beds.

All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security Act.

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

Must 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):

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☑ 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) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional. •

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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.

Supportive Housing includes assessing the participant's housing needs and presenting options, assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history), searching for housing, communicating with landlords, coordinating the move, providing training in how to be a good tenant, and establishing procedures and contacts to retain housing.

Supportive Housing can occur in following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

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 • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional.

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			Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have 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).

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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, supported 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 • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

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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. 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.

Meals and transportation are not included in the rate for Aftercare Recovery Support.

Aftercare Recovery Support can occur in following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security Act.

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	

State: Arkansas
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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) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

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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, supported 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/retroactively 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):*

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	☐	**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.*

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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 unexplained death, 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, A: 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/retroactively reviewed as well as all HCBS services provided to eligible individuals by DMS (or its contractor). Retrospective/retroactive reviews of services will occur at least annually for all services provided. 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

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Requirement	Requirement 1, B: Service Plans
Frequency	When services are approved for medical necessity retrospectively/retroactively.
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, A: 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.

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Requirement	Requirement 2, B: Eligibility Requirements
Frequency	Sample will be selected and reviewed quarterly.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	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.

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

Requirement	Requirement 3, A: 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

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Requirement	Requirement 4, A: 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, A: 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, B: 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.

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Requirement	Requirement 6, A: 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, A: The state identifies, addresses, and seeks to prevent incidents of unexplained death, 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 unexplained death, abuse, neglect, and exploitation for all Behavioral Health Agency personnel.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS, DPSQA or its agents

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Requirement	Requirement 7, B: The state identifies, addresses, and seeks to prevent incidents of unexplained death, 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 unexplained death, 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/retrospectively approve services. The State will review historical claims data as well as review the person-centered service plans of individuals to ensure that the services provided are effective and helping the beneficiary.

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. Yearly reports will be analyzed and reviewed by the State.

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.

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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. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2019 and is effective for services provided on or after that date. All rates are published https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.
	HCBS Psychosocial Rehabilitation
	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (Specify below):
	For all other services (State Plan 3.1-i attachment, pg.51, 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. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2019 and is effective for services provided on or after that date. All rates are published at https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.

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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):*_____%

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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.

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