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State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 23-0022

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

February 27, 2024

Janet Mann
State Medicaid Director
Arkansas Department of Human Services
P.O. Box 1437, Slot S401
Little Rock, AR 72203-1437

Re: Arkansas State Plan Renewal (SPA) 23-0022 §1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal

Dear Director Mann:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's 1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number 23-0022. The purpose of this amendment is to renew Arkansas' 1915(i) State Plan HCBS benefit with the following changes: 1) Remove the concurrent 1115 authority, 2) Authorize telehealth visits for 1915(i)-eligibility re-evaluations, and 3) Replace transition language with HCBS settings compliance language. The effective date for this renewal is March 1, 2024. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring 2/28/2029, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

It is important to note that CMS approval of this 1915(i) HCBS state plan benefit renewal solely addresses the state's compliance with the applicable Medicaid authorities. CMS approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Lynn Ward at lynn.ward@cms.hhs.gov or (214) 767-6327.

Sincerely,

[redacted] igitally signed by George . Failla Jr -S ate: 2024.02.27 17:40:53 -05'00'

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Elizabeth Pitman, AR DHS
Melissa Weatherton, AR DHS
Matthew Weaver, CMS DLTSS
Shawn Zimmerman, CMS DHCBSO
Robert Browning, CMS DRR
Cynthia Nanes, CMS DHCBSO
Wendy Hill Petras, CMS DHCBSO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0022

2. STATE: AR

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
§1915(i) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, Pages 47 through 86
Attachment 4.19 B; Pages 19-20

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, Pages 51 through 85
Attachment 4.19 B; Pages 19-20

9. SUBJECT OF AMENDMENT
Renewal of 1915(i) State Plan for Adult Behavioral Health Services for Community Independence (ABHSCI).

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Elizabeth Pitman

13. TITLE
Director, Division of Medical Services

14. DATE SUBMITTED
09/15/2023

15. RETURN TO
Office of Rules Promulgation
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attn: Mac Golden

FOR CMS USE ONLY

16. DATE RECEIVED
9/15/2023

17. DATE APPROVED
2/27/2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
3/1/2024

19. SIGNATURE OF APPROVI [redacted]
Digitally signed by George P. Failla Jr -S
Date: 2024.02.27 17:39:36 -05'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of Division of Home and Community Based Services Oversight and Operations

22. REMARKS

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

Administration and Operation

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

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

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

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

***Select one*:**

◉	**Not applicable**
○	**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:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

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

○	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)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
⊙	The State plan HCBS benefit is operated by *(name of agency)*	
	Division of Aging, Adult and Behavioral Health Services (DAABHS)	
	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's contracted vendor, Gainwell will assist with 1,6, and 7; Optum will assist with 2; Osource the state's contracted External Quality Review Organization (EQRO) will assist with 3 and 10; Kepro will assist with 4 and 5; and Milliman, the state's contracted actuary will assist with 8.

(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
Year 1	March 1, 2024	February 28, 2025	150
Year 2	March 1, 2025	February 28, 2026	
Year 3	March 1, 2026	February 28, 2027	
Year 4	March 1, 2027	February 29, 2028	
Year 5	March 1, 2028	February 28, 2029	

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

Financial Eligibility

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

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.
☑ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

○	Directly by the Medicaid agency
⊙	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	DHS's contracted vendor, Optum.

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):*

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.

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:

Eligibility is re-evaluated on an annual basis and all individuals who have an existing Tier 2 or above determination and meet Medicaid eligibility requirements are referred for annual evaluation. Reevaluations may be conducted in person or through the use of telehealth.

After the independent assessment of functional need is completed, DHS's contracted vendor, Optum determines whether an individual is eligible for 1915(i) through an evaluation of the client's functional deficit through an evaluation of the client and caregiver report.

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:
The beneficiary must receive a minimum of a Tier 2 on the Arkansas Independent Assessment (ARIA). To meet a Tier 2, the beneficiary must have the need for assistance because of certain behaviors that require non-residential services to help with functioning in home and community-based settings and moving towards recovering and is not a harm to his or herself or others.
The state utilizes the ARIA tool to determine needs-based eligibility based on the measurement of an individual's needs as assessed under the following domains:
Adaptive, personal/social, communication, motor, and cognitive. The ARIA tool 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. Needs assessed are due to manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.

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)**
The beneficiary must receive a minimum of a Tier 2 functional assessment for HCBS behavioral health services. To meet a Tier 2, the beneficiary must have difficulties with certain behaviors that require a full array of services to help with functioning in home and community-based settings and moving towards recovering and is not a harm to his or herself or others. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors. The state utilizes the Arkansas Independent Assessment (ARIA) tool to determine needs-based eligibility.	Must meet at least one of the following three criteria as determined by a licensedmedical professional: 1. The client is unable to perform either of the following: A. At least one (1) of the three (3) activitiesof daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from ortotal dependence upon another person; or, B. At least two (2) of the three (3) activities of dailyliving (ADLs) of transferring/locomotion, eating or toileting withoutlimited assistance from another person; or, 2. The client 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	1) Diagnosis of developmental disability that originated prior to ageof 22; 2) The disability has continued or is expected to continue indefinitely; and 3) The disability constitutes a substantial handicap tothe person's ability to function without appropriate support services, including butnot limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. Must also be in need of andable to benefit from active treatment and unable to access appropriate servicesin a less restrictive setting.	There must be a written certification of need (CON)that states that a client is or was in need of inpatient psychiatric services. The certification must be made at the time of admission, or if a client applies for Medicaid while in the facility, the certification must be made before Medicaid authorizes payment. Tests and evaluations usedto certify need cannot be more than one (1) year old. All histories and information used to certifyneed must have been compiled within the year prior to the CON. In compliance with 42 CFR441.152, 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 client; B.Proper treatment of

	engages in inappropriate behaviors which pose serious health orsafety hazards to himself or others; or, 3. The client has a diagnosed medical condition which requires monitoring or assessment atleast once a day by a licensed medical professional and the condition, if untreated, would be life-threatening. 4. No client 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 conditionwhich is temporary and expected to last no more than twenty-one (21) days. However, that client shall not receive waiver services or benefits when subject to a condition or change of condition which would render the client ineligible if expected to last more than twenty-one (21)days.		the client's psychiatric condition requires inpatient services under the direction of a physician and C. The services can bereasonably expected to prevent further regression or to improvethe client'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

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 clients in the following eligibilitygroups:

1.) Clients who qualify for Medicaid through spend-down eligibility.

☐ **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):	
	⊙	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

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

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

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

The 1915(i) service settings are fully compliant with the home and community-based settings.

The process that the state Medicaid agency used to assess and determine that the new service settings meet the HCB settings requirements and that the new services continue to meet the HCB settings requirements is overseen by the Division of Provider Services and Quality Assurance (DPSQA). DPSQA reviews all provision of services to ensure they are performed in home and community settings and integrated in order to support full access of individuals receiving Medicaid HCBS to the greater community and in compliance with 42 CFR §441.301(c)(4)(i) on an annual basis.

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 are:

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

Providers who complete the PCSP are not allowed to perform HCBS services allowed under this 1915(i) authority. Arkansas Medicaid requires that the performing provider (orindividual 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 Person-Centered Service Plan for the individual, everyone in attendance is responsiblefor supporting and encouraging the client to express their wants and desires and to incorporate them into the PCSP when possible.

The PCSP is a plan developed in cooperation with the client to deliver specific mental health services to restore, improve, or stabilize the client's mental health condition. The Plan must be based on individualized service needs as identified in the ARIA results and service provider documentation. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify, specific treatment modalities prescribed for the client, and time limitations for services. The plan must be congruent with the age and abilities of the client, person-centered and strength-based; with emphasis on needs as identified by the client 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 mustinform 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 is a plan developed in cooperation with the client (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the client's mental health condition. The PCSP must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. PCSP will be signed by all individuals involved in the creation of the treatment plan, the client (or signature of parent/guardian/custodian if under the age of 18), and the physician responsible for treating the mental health issue. Plans should be updated annually, when a significant change in circumstances or need occurs, and/or when the client requests, whichever is most frequent.

PCSP's will be completed by a vendor using a standard PCSP template. The Division of Medical Services (DMS) approves all contractual requirements and manages the contract to ensure compliance with federal regulations (including 42 CFR 441.725). Contract language for the process used to complete the PCSP, qualifications of the individual completing the PCSP as well as level of supervision of that staff member ensure that all beneficiaries receive the required individual attention that results in a PCSP prepared to meet their needs. DMS has ultimate authority and responsibility in the operation and oversight of the PCSP approval process. Either DMS or the EQRO communicates the finding from the review and the state requires vendor remediation.

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	☑	Operating agency	☐	Case manager
☐	Other (*specify):*				

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 beneficiary to be successful in integrating into the job setting.

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):*

☑ Medically needy *(specify limits):*

Service authorized based on client need

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurances	• 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

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 Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	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 Rehabilitative Day Service

Service Definition (Scope):

A continuum of care provided to recovering clients living in the community based on their level of need. This service includes educating and assisting the clients with accessing supports and services needed. The service assists recovering clients to direct their resources and support systems.

Activities include training to assist the clients to improve learn, retain or improve specific job skills and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In additional, transitional services to assist beneficiaries in stepping down after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

This service includes an array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified clients that are aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person and family centered, recovery based, culturally competent, and provide needed accommodation for any disability and must have measurable outcomes.These 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 client 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 client's behavioral health treatment plan.

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)*:

☑ Medically needy *(specify limits)*:

Staff to client ratio: 1:15

Daily Maximum of Units: 6

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Behavioral Health Agency Or Community Support System Provider (CSSP) (enhanced level)	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

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 Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	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 Life Skills Development

Service Definition (Scope)*:*

A service that provides support and training for adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the client into their community as they develop their recovery plan or habilitation plan. This service is designed to assist clients in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist clients in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented

decisions related to independent living. Services 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.

Other topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition.

The PCSP should address the recovery or habilitation objective of each activity performed under Supportive Life Skills Development.

In a group setting, the provider must maintain a beneficiary to staff ratio of 10:1

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):*

☑ Medically needy *(specify limits):*

Daily Maximum of Units: 8

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Servicesand 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

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 Or Community Support System Provider (CSSP)	Department of Human Services, Division Medical Services	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 delivered in a community-based clinic setting. 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- beneficiary ratio sufficient to ensure necessary therapeutic services. Partial Hospitalization may be appropriate as a time-limited response to stabilize acute symptoms, transition (an inpatient setting), or as a stand-alone service to stabilize a deteriorating

condition and avert hospitalization.

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)*:

☑ Medically needy *(specify limits)*:

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 Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Servicesand 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

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 Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	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 client 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 client on their PCSP. 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 clients 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 clients act as facilitators, emphasizing self-improvement. These activities must also have measurable outcomes directly related to the beneficiary's PCSP.

Therapeutic Communities services may be provided in a 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)*:

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):*

☑ 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 Or Community Support System Provider (CSSP)	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

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 Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	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 clients 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 clients 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 client's individual housing needs and presenting options, assistingin 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):*
☑	Medically needy *(specify limits):*
	Services authorized based on client need

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	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

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 Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

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

☐	Participant-directed	☑	Provider managed

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

Service Title: Peer Support

Service Definition (Scope):

A person-centered service where adult peers provide expertise not replicated by professional training. Peer support providers are trained peer specialists who work with clients to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach his or her fullest potential. Peer specialists may assist with navigation of multiple systems (housing, supported employment, supplemental benefits, building/rebuilding natural supports, etc.) which improve the client's functional ability. Services are provided on an individual or group basis and may be provided in the home or the community.

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)*:
☑	Medically needy *(specify limits)*: Service authorized based on client need

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:

Behavioral Health Agency Or Community Support System Provider (CSSP)	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

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 HealthAgency Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	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 (for Substance Abuse)

Service Definition (Scope):

A continuum of care provided to recovering clients living in the community based on their level of need. This service includes educating, face-to-face monitoring, and supporting the beneficiary with accessing supports and services needed. The service assists the recovering beneficiary to direct their resources and support systems and provide face-to-face supportive services including monitoring of symptoms, assessment of relapse factors and referral when appropriate. 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.

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 clients 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):*
☑	Medically needy *(specify limits):* Service authorized based on client need

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of	• 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

		Provider Services and Quality Assurance	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

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 Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	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 and Community Support System Providers are able to provide State Plan HCBS under authority of this 1915(i). Relatives of clients who are employed by a Behavioral Health Agency or Community Support System Providers 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 client.
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 this1915(i) and may not be involved in the development of the PCSP.
d) All services are retrospectively/retroactively reviewed for medical necessity. Each Behavioral Health Agency or Community Support System Provider is subject to Inspections of Care (IOCs) as well as monitoring by the Office of Medicaid Inspector General.

Participant-Direction of Services

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

1. 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):*

2. 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):

3. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness 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)*:

4. **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
	☐	☐
	☐	☐

5. **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.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

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

8. Opportunities for Participant-Direction

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

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

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

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

Quality Improvement Strategy

Quality Measures

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

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

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

3. **Providers meet required qualifications.**

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

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

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

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

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

Requirement	Requirement 1, A: Service Plans Address Needs of Participants are reviewed annually and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of PCSPs developed by the state's contracted vendor which provide 1915(i) State Plan HCBS that meet the requirements of 42 CFR §441.725. Numerator: Number of PCSPs that adequately and appropriately address the client's needs. Denominator: Total Number of PCSPs reviewed.
Discovery Activity *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of PCSPs are retrospectively/retroactively reviewed as well as all HCBSprovided to eligible clients. Retrospective/retroactive reviews of services will occur at least annually for all services provided. The data will be produced by the Behavioral Health Agencies or Community Support System Providers and must remain in the medical record of the client.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DAABHS and EQRO
Requirement	Requirement 1, B: Service Plans

	Frequency	Sample will be selected and reviewed annually.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The state's contracted vendor will be responsible for remediating deficiencies in the clients' PCSPs. If there is a pattern of deficiencies noticed, action may be taken against the vendor.
	Frequency *(of Analysis and Aggregation)*	Findings will be reported to the vendor on a quarterly basis. If a pattern of deficiency is noted, this may be made public.

Requirement	Requirement 2: Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i)benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence One *(Performance Measure)*	1. The number and percent of beneficiaries who are independently assessed and evaluated for eligibility within 14 days of successful contact with the beneficiary. Numerator: The number of beneficiaries who are evaluated and assessed for eligibility within 14 days after the date of successful contact. Denominator: The total number of beneficiaries who are referred for the 1915(i) HCBS State Plan Services and who are successfully contacted by the Independent Assessment vendor.
Discovery Activity One *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% 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	The Independent Assessment Vendor, EQRO, DAABHS, and DMS.

	(Agency or entity that conducts discovery activities)	
	Frequency	Quarterly
	Remediation	
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	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 submitsmonthly reports to DMS. When deficiencies are noted, a corrective action plan will be implemented with the Vendor.
	Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.
	Discovery Evidence Two	The number and percent 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 statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of the application packets for clients who went through the eligibility determination process will be reviewed. The data will be collected from the Independent Assessment Vendor.
	Monitoring Responsibility	The Independent Assessment Vendor, EQRO, DAABHS, and DMS
	Discovery Evidence Three	The number and percent of beneficiaries who are re-determined eligible for HCBS State Plan Services prior to the expiration of the current IA. Numerator: The number of beneficiaries who are re-determined eligible for HCBS State Plan Services prior to the expiration of the current IA. Denominator: The total number of beneficiaries whose IA is set to expire during the specific year.
	Discovery Activity Three	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of a 100% of the application packets for clients who went through the eligibility re-determination process will be reviewed. The data will be collected from the Independent Assessment Vendor.
	Monitoring Responsibilities	The Independent Assessment Vendor, EQRO, DAABHS, and DMS
	Frequency	Sample will be selected and reviewed quarterly.

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	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 submitsmonthly reports to DHS's Independent Assessment Contract Manager. When deficiencies are noted, a corrective action plan will be implemented with the vendor.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	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 Independent Assessment Contract Manager. When deficiencies are noted, a corrective action plan will be implemented with the vendor.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.

Requirement	Requirement 3: Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of Behavioral Health Agencies and Community Support System providers certified and credentialed by DPSQA. Numerator: Number of Behavioral Health Agencies and Community Support System providers that obtained annual certification in accordance with DPSQA's standards. Denominator: Number of Behavioral Health Agencies and Community Support System providers reviewed.
Discovery Activity *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of Behavioral Health Agencies and Community Support System Providers certified by DPSQA will be reviewed. Data will be collected from DMS's Provider Enrollment Unit and DPSQA.
Monitoring Responsibilities	DPSQA, DAABHS, DMS, and EQRO

	(Agency or entity that conducts discovery activities)	
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Remediation for the provider who does not meet the certification requirements is disenrollment from the Arkansas Medicaid Program. Remediation associated with provider certification that is not current would include an examination of the communication and processes between DPSQA and the provider enrollment contractor payments.
	Requirement	Requirement 3: Providers meet required qualifications.
	Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported annually.

Requirement		Requirement 4, A: Settings that meet the home and community-based setting requirements as specified in this SPA and in accordance with42 CFR 441.710(a)(1) and (2).
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of provider owned apartments/homes reviewed that meet the home and community-based setting requirements as specified 42 CF 441.710(a)(1) & (2). Numerator: Number of provider owned apartments/homes reviewed that meet the home and community-based setting requirements as specified in specified 42 CF 441.710(a)(1) & (2). Denominator: Total number of provider owned apartment/home settings reviewed.
	Discovery Activity *(Source of Data & sample size)*	Review of the Settings Review Report sent to DMS. The reviewed providers will be randomly selected. A typical review will consist of at least 10% of applicable providers each year.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DPSQA and DMS
	Frequency	Annually
Remediation		
	Remediation Responsibilities	The Behavioral Health Agencies or CSSP providers will be responsible for ensuring compliance with HCBS Settings requirements. If there is a pattern of deficiencies noticed by DPSQA DMS, action will be taken against the

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Behavioral Health Agency or CSSP provider, up to and including, instituting a corrective action plan or sanctions pursuant to the Provider Agreement.
Frequency *(of Analysis and Aggregation)*	Annually.

Requirement	Requirement 5: The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of rules developed by DAABHS must be reviewed and approved by DMS and promulgated in accordance with the DHS agency review process and the Arkansas Administrative Procedures Act (APA). Numerator: Number of rules appropriately promulgated in accordance with agency policy and the Arkansas Administrative Procedures Act (APA). Denominator: Number of rules promulgated.
Discovery Activity *(Source of Data & sample size)*	100% of rules developed must be reviewed for compliance with the agency policy and the APA.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS Waiver Compliance Unit or its agents
Requirement	Requirement 5: The SMA retains authority and responsibility for program authority and oversight
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DMS 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.

	remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Each policy will be reviewed for compliance with applicable DHS policy and the APA.

Requirement		Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized andfurnished to 1915(i) clients by qualified providers.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of claims reviewed that are coded and paid in accordance with the reimbursement methodology specified and only for services rendered. Numerator: Number of encounter claims reviewed that are coded and paid in accordance with the reimbursement methodology specified and only for services rendered. Denominator: Number of claims reviewed.
	Discovery Activity *(Source of Data & sample size)*	Utilization review of a statistically valid sample of claims to validate services were rendered by an enrolled Medicaid HCBS provider and paid in accordance with program requirements.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DAABHS, DMS or the EQRO
	Frequency	Annually
	Remediation	
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Action will be taken against the provider up to and including, instituting a corrective action plan or sanctions.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
Discovery Evidence One *(Performance Measure)*	Number and percent of Behavioral Health Agencies or Community Support System Provider who reported critical incidents to DMS or DAABHS within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Total number of critical incidents that occurred and were reviewed.
Discovery Activity One *(Source of Data & sample size)*	DPSQA and DAABHS will review all the critical incident reports they receive on a quarterly basis.
Discovery Evidence Two	Number and percent of Behavioral Health Agencies or Community Support System Provider Providers who adhered to Provider policies for the use of restrictive interventions. Numerator: Number of incident reports reviewed where the Provider adhered to policies for the use of restrictive interventions; Denominator: Number of individuals for whom the provider utilized restrictive intervention as documented on an incident report.
Discovery Activity Two	DMS will review the critical incident reports regarding the use of restrictive interventions and will ensure that Provider policies were properly implemented when restrictive intervention was used.
Discovery Evidence Three	Number and percent of Behavioral Health Agencies or Community Support System Providers who took corrective actions regarding critical incidents to protect the health and welfare of the client. Numerator: Number of critical incidents reported when Behavioral Health Agencies or Community Support System Provider took protective action in accordance with State Medicaid requirements and policies; Denominator: Number of critical incidents reported.
Discovery Activity Three	DPSQA and DAABHS will review the critical incident reports received to ensure that Provider policies were adequately followed and steps were taken to ensure that the health and welfare of the client was ensured.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DAABHS and DPSQA
Remediation	

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 work with a contracted vendor to develop PCSP with client and identified service provider will begin providing HCBS and mental health professional services. The service provider will use the PCSP and develop a treatment plan identifying all treatment services they are providing with goals and objectives.

Through Medicaid claims data the State will have the ability to measure the amount of services provided compared to what is described within the Person Centered Service Plan (PCSP) that is required for clients receiving HCBS State Plan services.

The State will work with an External Quality Review Organization (EQRO) to assist with comparison of service indicated on PCSP and claims submitted for those same services.

The State will investigate and monitor any complaints about agencies certified to provide 1915(i) services.

2. Roles and Responsibilities

The State (including DAABHS, DMS, DPSQA, and its agents) will be responsible for oversight of BehavioralHealth Agencies and Community Support System Providers providing 1915(i) FFS services.

3. Frequency

On-going monitoring will occur. Quarterly and annual reports will be analyzed and reviewed by the appropriate AR DHS divisions.

4. Method for Evaluating Effectiveness of System Changes

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

Any issues with the provision of 1915(i) services that are continually uncovered may lead to sanctions against providers or the Behavioral Health Agencies that are responsible for access to 1915(i) services.

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 **at the Fee Schedules website**.
	HCBS Psychosocial Rehabilitation
	HCBS Clinic Services (whether or not furnished in a facility for CMI)

Other Services (Specify below):

Therapeutic Communities

Effective November 1, 2022, the new rate for Therapeutic Communities is established with the highest intensity program set at 70% of the Arkansas State Hospital (ASH) inpatient rate, and the lowest intensity level of programming at 50% of the ASH inpatient rate. Because a rate comparison analysis of similar programs in other Region 6 states found no comparable programs, in- state facilities offering comparable levels of care were surveyed. Specifically, the rates for human development centers (HDCs) and the ASH were used for comparison because Therapeutic community provider actual costs for services were also considered in the rate setting process. A revised rate methodology was determined, focused on two levels of program intensity utilizing this method.

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 November 1, 2022, and is effective for services provided on or after that date. All rates are published at the **Fee Schedules** website.

For all other Adult Behavioral Health Services for Community Independence (ABHSCI) program 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.