

Summary

1915(i) State Plan Amendment for Home and Community-Based Services

NOTE: Bolded text within document denotes required health home language by the Centers for Medicare and Medicaid Services (CMS) with the additional language for context purposes only.

In an effort to better address individual needs of clients and families, Arkansas is developing a behavioral health system that will provide enhanced home and community based behavioral health services and care management services. The intent of this transformation is to meet the triple aim of:

- Improving the health of the population
- Improving the experience of care of individuals receiving services
- Improving quality of care while reducing the growth of health care costs

To facilitate and fund home and community based services, the Division of Medical Services (DMS) is planning to submit a 1915(i) State Plan Amendment. The proposed system will incorporate services and care coordination to meet the needs of low-needs (Tier 1), medium-needs (Tier 2), and high-needs (Tier 3) behavioral health populations. Designated levels of needs will be based on the findings from the InterRAI Assessment instrument that will be tailored specifically for children and adult populations of Arkansas. Tier definitions are detailed as follows:

Tier 1: Time-limited behavioral health services provided by qualified licensed practitioners in an outpatient based setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Tier 1 outpatient settings shall mean a behavioral health clinic/office, health care center, physician office, and/or school. Care management responsibilities will be coordinated by the designated primary care provider or Patient Centered Medical Home.

Tier 2: Intensive home and community based behavioral health services coordinated by a qualified behavioral health home agency for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Independent Assessment and Independent Assessment Report are required. Tier 2 home and community based settings shall include services rendered in a beneficiary's home, community, behavioral health clinic/office, healthcare center, physician office, and/or school. Care management responsibilities will be coordinated by the designated Behavioral Health Home.

Tier 3: Most intensive behavioral health services coordinated by a qualified behavioral health home agency for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Independent assessment and Independent Assessment Report are required. Tier 3 behavioral health services shall include services rendered in a

beneficiary’s home, community, behavioral health clinic/ office, healthcare center, physician office, and/ or school. Residential treatment services are available—if deemed medically necessary. Care management responsibilities will be coordinated by the designated Behavioral Health Home.

Proposed Services

The proposed 1915(i) services are:

- 1.) Home and Community Individual Psychotherapy
- 2.) Home and Community Family Psychoeducation
- 3.) Home and Community Marital/Family Psychotherapy with Patient Present
- 4.) Home and Community Martial/Family Psychotherapy without Patient Present
- 4.) Community Group Psychotherapy
- 5.) Partial Hospitalization
- 6.) Behavioral Assistance
- 7.) Aftercare Recovery Services
- 8.) Peer Support
- 9.) Family Support Partners
- 10.) Individual Life Skills Development
- 11.) Group Life Skills Development
- 12.) Child and Youth Support Services
- 13.) Individual Recovery Support
- 14.) Group Recovery Support
- 15.) Planned Respite
- 16.) Therapeutic Communities

Service definitions and benefit limits are available at <http://www.paymentinitiative.org/healthHome/Pages/Behavioral-Health.aspx>

Geographic Coverage

The State plans to implement the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.

Projected Number of Unduplicated Individuals To Be Served Annually

Annual Period	From	To	Projected Number of Participants
Year 1	7-15	12-15	20,000 - 25,000
Year 2	1-16	12-16	25,000
Year 3	1-17	12-17	25,000

Year 4	1-18	12-18	25,000
Year 5	1-19	12-19	25,000

The State proposes to implement the 1915(i) State plan HCBS benefit statewide and cannot limit the number of individuals served by this benefit.

Independent Assessment and Care Plan

The Center for Medicaid and Medicare (CMS) requires the implementation of a Needs Based Functional Evaluation/Re-evaluation by an independent party. Evaluations and re-evaluations will be conducted by an agency identified by a Request for Proposal (RFP). The qualifications for individuals performing the evaluation/reevaluation are:

- **A Bachelor’s-level education or higher in the mental health field and two years of experience working directly with persons with behavioral health diagnoses, or**
- **A Bachelor’s-level education or higher in any field and five years of experience working directly with persons with behavioral health diagnoses.**

The independent assessment is administered by an independent assessor to determine beneficiary eligibility, required level of care, and identify the need for 1915(i) services. **The assessment is a functional assessment utilizing instruments from InterRAI for both adults and youth to evaluate individuals across domains of safety, autonomy, health promotion, social, life, and economic issues**

An individual can be referred for an initial assessment by their current Behavioral Health or Health Care provider. The state will also examine historic utilization and identify individuals that may be better served by Home and Community-Based services. In order for the individual to get an independent assessment, the current Tier 1 Behavioral Health treating provider or Health Care provider must sign off on the referral form and send to the independent assessor to initiative the process to conduct an assessment to determine eligibility.

A re-assessment can be requested by the direct Behavioral Health service provider or Health Care provider if the direct service provider determines the individual’s needs are not being met at the current level. The individual (or caregiver/guardian/etc.) can request to be re-assessed, but a referral form must be signed by a service provider. Clients must

Eligibility for State plan HCBS (Tier 2 services and Tier 3 services) will be determined by the independent needs assessment. The results of the assessment will indicate if the client meets the needs-based criteria for State plan 1915(i) HCBS, as evidenced by the following:

- **Impairment in self-care evidenced by at least one of the following:**
 - **Lack of bathing and/or changing clothes in greater than one week**
 - **Lack of seeking care for a medical condition that is life-threatening or that may result in acute hospitalization without professional involvement (includes prenatal care)**

- Lack of seeking care for a dental condition that is life-threatening or that may result in acute hospitalization without professional involvement
- Lack of nutritional intake resulting in a BMI <17
- Impairment in behavior controls evidenced by at least one of the following:
 - History of violating state or federal laws that could result in justice system involvement
 - History of being found guilty of a crime in the Arkansas court system
- Inability to live in an independent or family setting without supervision as evidenced by:
 - Requirement of full-time supervision or support at home
 - Homelessness
 - Imminent risk of homelessness
- Inability to work or attend school full-time demonstrated by at least one of the following:
 - Lack of ability to keep a full-time job for more than 3 months
 - Lack of ability to stay enrolled in school for more than one semester or course length
 - Has been determined to be disabled due to mental illness by the social security administration
- Risk of deterioration evidenced by :
 - Presence of co-morbid substance abuse or dependence or developmental disability
 - Complex care that requires the attention of multiple providers to prevent hospitalization

Or

- Is a danger to self as evidenced by significant suicidal ideation or a suicide attempt
- Is a danger to others as evidenced by significant homicidal ideation, significant intention to harm others, or attempt at pursuing significant harm of others

Needs-based eligibility reevaluations must be conducted at least every twelve months.

The individualized, person-centered plan of care will be developed by the Behavioral Health Home that the individual chooses or is attributed to if the individual does not choose. This individualized plan of care will be developed in consultation with current Behavioral Health providers and current Health Care provider. The individual has the choice to allow anyone they deem necessary to be involved in the Plan of Care development.

The participant will be supported in Plan of Care development by the Behavioral Health Home and allowed the ability to choose who they want to participate in the Plan of Care development. If determined to meet the needs based criteria to receive Tier 2 services or Tier 3 services, the beneficiary will have the option to choose a Behavioral Health Home (BHH) provider. DMS will send notification to the beneficiary and the BHH that the beneficiary has been assigned to the BHH and will

include information on other BHH providers in the State and the process for how the beneficiary can change BHH providers.

The individual has the choice to allow anyone they deem necessary to be involved in the Plan of Care development. In the case of children (Under Age 18), the parents participation (or legal guardian, DCFS, DYS, caretaker) must be included in Plan of Care development.

Person-Centered Planning & Service Delivery

The client will be supported in Plan of Care development by the Behavioral Health Home and allowed the ability to choose who they want to participate in the Plan of Care development. If determined to meet the needs based criteria to receive Tier 2 services or Tier 3 services, the beneficiary will have the option to choose a Behavioral Health Home (BHH) provider. DMS will send notification to the beneficiary and the BHH that the beneficiary has been assigned to the BHH and will include information on other BHH providers in the State and the process for how the beneficiary can change BHH providers.

The individual has the choice to allow anyone they deem necessary to be involved in the Plan of Care development. In the case of children (Under Age 18), the parents participation (or legal guardian, DCFS, DYS, caretaker) must be included in Plan of Care development.

Clients have freedom of choice of providers. Once the range of services and needs are specified in the Independent Assessment report, the BHH will inform the participant of qualified providers of those services and will aid in making arrangements to obtain services from the provider(s) chosen by the participant.

Primary Care Physicians (PCPs) in Arkansas will also have information readily available to beneficiaries regarding providers of BHH services and State plan HCBS services.

Quality Improvement Strategy

The State has established a process to address the following Quality Improvement requirements by CMS:

- Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
- Providers meet required qualifications.
- The State Medicaid Authority (SMA) retains authority and responsibility for program operations and oversight.
- The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
- The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

The State has also established a process for systems improvement as a result of aggregated discovery and remediation activities. These include:

- **DBHS will coordinate and lead remediation efforts for Behavioral Health system complaints. DBHS staff will field calls, provide initial remediation, lead the caller to the correct contact within DHS and track the complaint and results of the call. If certain issues continue to come up (similar complaints about the same provider, similar complaints about a Behavioral Health system process, etc.), these issues will be discussed by the Behavioral Health internal Workgroup and efforts will be made to correct the problems.**
- **The DMS/DBHS Work Group (comprised of representatives from the Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General, the Division of Behavioral Health Services, the Office of Quality Assurance, the utilization review agency, as well as other units or divisions as required) will meet monthly to discuss Inspection of Care (IOC) reports. When warranted by IOC results, the DMS/DBHS Work Group shall recommend to the DHS Review Team allowable actions and that entity will be monitored by the DHS Review Team. If a deficiency related to safety or potential risk to the beneficiary or others is found, then the utilization review agency shall immediately report this to the DMS Director (or the Director's designee).**