

EXHIBIT K

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

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

DESCRIPTION: This manual and State Plan Amendment creates the Adult Behavioral Health Services for Community Independence program, which are Tier II and Tier III home and community-based treatment and services provided by a Certified Behavioral Health Agency to individuals eligible for Medicaid based upon the following criteria:

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

If an individual falls into one of the above two categories, that individual will not be enrolled into a Provider-Led Arkansas Shared Savings Entity (PASSE) and, if determined by the Independent Assessment to be eligible for Tier II or Tier III services, will be provided access to those services through traditional Fee-for-Service Medicaid.

PUBLIC COMMENT: The Department of Human Services (DHS) held two public hearings, one in Springdale on October 26, 2018, and one in Little Rock on November 5, 2018. The public comment period ended on November 12, 2018. DHS received the following comments and provided its responses:

Bonnie Bryant, LPC

Comment: I am a mental health therapist who primarily works with people with serious mental illness and who are suicidal. When we have these clients who are Medicaid recipients, they are assessed by a clinician, determined to meet Tier 2 or 3 category of services, then they must wait for their Independent Assessments before they can start their services. This wait period is essentially a denial of services for the client, and unethical, as well as dangerous to the client. Also, the fact that Medicaid will not retro-actively cover the service, should the Independent Assessor agree with the licensed mental health clinician, places the providers in an ethical bind. You see, clinicians' ethical duties are to never abandon a client, and to provide the appropriate service for the person's need. So providers are placed in the position of choosing to provide mental health services for FREE, or to deny the client necessary services, because they have no funding source. I am not alone in the firm belief that a licensed clinician is qualified to assess a client's level of care need and to have to be "double checked" by anyone, much less a non-licensed, non-clinical assessor, is an arbitrary, useless barrier to care. I don't know of other medical services where a lesser qualified personnel can trump the clinical recommendation of someone with further training and licensure. I don't know of any sensible reason a person must wait to start a service that is essential to preventing decompensation that is a covered service. We are seeing clients become hospitalized, incarcerated, disappear even, because of barriers to access to care for what is now classified as Tier 2 or Tier 3 services, simply because of the wait time on a redundant, and less useful in my opinion, Independent Assessment.

I realize this is a complicated subject and I can't possibly know all the contingencies with Medicaid. I am not sure this message should go to you, or someone else, but I am starting here. Please help in whatever capacity you can, to help us providers find ways to serve our community members with the necessary care for which they are entitled.

Response: The independent assessment required to obtain services contained in the 1915(i) is a functional assessment and is being used to determine need for home and community based services. Clinical services provided by licensed professionals can and should be provided through the Outpatient Behavioral Health program. These services were designed to be easily accessed and do not require an independent assessment or prior authorization. In addition, services for crisis include hospitalization and acute crisis units that can be accessed prior to an independent assessment. The HCBS services contained in the (i) services are intended for individuals that have chronic functional deficits related to their mental health condition.

Brad Holloway, Chief Operations Officer – Birch Tree Communities

Comment: ISSUE#1: Following thorough review of the above mentioned proposed manual it appears that several key services were excluded for Tier I (Counseling level) and Tier 2 (Rehabilitative level) beneficiaries.

The covered services outlined in the manual include (Section 218.00):

- Supportive Employment
- Supportive Housing
- Partial Hospitalization
- Adult Rehabilitative Day Service
- Adult Life Skills Development
- Treatment Plan
- Therapeutic Communities - Level I
- Therapeutic Communities - Level 2

While these services are clinically indicated and needed for the majority of our Spend Down beneficiaries, there are at least five medically necessary and key services that appear to have been omitted:

- Diagnostic Assessment
- Psychiatric Evaluation
- Pharmacological Management
- Individual Psychotherapy
- Group Psychotherapy

These services are clearly outlined in the Current OBH manual as medically necessary and Psychiatric Evaluation is required. It is assumed that these services would be covered by reverting back to the current OBH manual. If this is the case, then all of these Tier 2 (Rehab level) beneficiaries would only be allowed the services limited to Tier I (Counseling level) beneficiaries.

According to the current OBH manual, beneficiaries who have been assessed at the Tier 2 level are approved at a higher level of care for additional services above and beyond what is allowed for Tier 1 beneficiaries, and these services have already clearly been determined to be medically necessary by virtue of the Independent Assessment.

Tier 1 Services are limited to:

- Twelve (12) Individual Behavioral health Counseling Encounters per year

- Twelve (12) Group Behavioral Health Counseling Encounters per year
 - Twelve (12) Pharmacologic management Encounters per year
- Tier 2 Services are limited to:
- Twelve (26) Individual Behavioral health Counseling Encounters per year
 - One hundred four (104) Group Behavioral Health Counseling Encounters per year
 - Twelve (12) Pharmacologic management Encounters per year

By virtue of the Tier 2 assessment, it has been determined that the amount of services for these beneficiaries are warranted and medically necessary. It is contradictory to only allow these beneficiaries the Tier I limits. This will require an Extension of Benefits request to be filed on an ongoing basis with the uncertainty of whether or not the extensions will be granted?

The question also arises as to whether or not a PCP referral will be required, as is the case for Tier I (Counseling level) beneficiaries after the 3rd visit? If the answer is that they will not require a PCP referral, it would need to be documented somewhere in one of the manuals?

Response: The public comment period is for the (i), this comment is for a manual that has already been promulgated. The Adult Behavioral Health Community Independence manual will be updated to reflect a PCP referral is not required.

Comment: ISSUE #2:

There appears to be a contradiction in the manual regarding treatment planning.

Section 213 states that:

.... "Revisions to the Treatment Plan for Adult Behavioral Health Services for Community Independence must occur at least annually, in conjunction with the results of the Independent Assessment."

Section 253.00 I (in the NOTES column) states that:

.... "This service may be billed when the beneficiary enters care and must be reviewed every ninety (90) calendar days or more frequently if there is documentation of significant acuity changes"

THEN.... Directly across from those notes in the column titled SPECIAL BILLING INSTRUCTIONS, it states: "Must be reviewed every 180 calendar days."

Response: DHS agrees and this will be updated.

Tom Masseau with Disability Rights of Arkansas, INC, David Deere with Partners for Inclusive Communities, Sha Anderson with Arkansas State Independent Living Council

Comment: Thank you for allowing our agencies this opportunity to provide comments regarding the Department of Human Services (OHS) proposed rulemaking regarding the above-referenced manuals and services.

Arkansas State Independent Living Council

The Arkansas State Independent Living Council is a non-profit organization promoting independent living for people with disabilities. The Arkansas State Independent Living Council has a Board of Directors comprised of Governor appointed Arkansans, the majority with disabilities.

The mission of the Arkansas State Independent Living Council is to promote independence, including freedom of choice and full inclusion into the mainstream of society, for all Arkansans with disabilities.

Partners for Inclusive Communities

Partners for Inclusive Communities (Partners) is Arkansas' University Center on Disabilities. Administratively located within the University of Arkansas College of Education and Health Professions. Partners is a member of the nationwide Association of University Centers on Disabilities - AUCD.

Partners' Mission is inclusion of people with disabilities in community life.

Disability Rights Arkansas, Inc.

Disability Rights Arkansas (ORA) is a private nonprofit organization designated by the Governor to implement the federally authorized Protection and Advocacy systems. Our mission is to vigorously advocate for and enforce the legal rights of people with disabilities in Arkansas. We assist people with disabilities through education, empowerment and protection of their legal rights. We serve all Arkansans with disabilities of all ages. We provide services through information and referral, direct advocacy and legal representation. DRA also provides training and outreach throughout the State.

Every year, the ORA Board of Directors solicits input into the development of the agency priorities. This solicitation is accomplished through public surveys and analyzing and reviewing prior year's request for assistance. In Fiscal Year 2019, the priorities established are as follows:

- Abuse, Neglect and Exploitation
- Community Integration
- Education
- Employment
- Access
- Self-Advocacy/Training

The priority that is most relevant to this issue is Community Integration. This priority focuses on the idea that individuals should receive quality support services, rights protection and be empowered to make choices in their lives.

Background

In 1999, the Supreme Court ruled in *Olmstead v L.C.* that public entities are required to provide community-based services to individuals with disabilities when, a) such services are appropriate; (b) the affected persons do not oppose community-based treatment and, (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability

services. Essentially state and local governments need to provide more integrated community alternatives to individuals in or at risk of segregation in institutions or other segregated settings. (US Department of Justice, Civil Rights Division, "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v L.C.*") Further, the *Olmstead* decision required each state to develop a plan that would place individuals with disabilities in less restrictive settings.

Following the *Olmstead* decision, former Governor Mike Huckabee formed the Governor's Integrated Services Taskforce. This taskforce was charged with assisting the state OHS in writing an *Olmstead* Plan. In 2003, the Taskforce completed its charge and developed The *Olmstead* Plan in Arkansas. The plan contained over one hundred recommendations for the state OHS and members of the Legislature to consider. The report highlighted the intent of the state's movement towards providing services in less restrictive settings. Waiver services reduce the need for emergency care, increase quality of life for people with disabilities and their families and allow families to remain together in their communities.

Supportive Employment

The 1915(i) waiver offers supportive employment to individuals with behavioral health needs; however, they have limited this service to a maximum of 60 hours per quarter. OHS states that an extension of this benefit may be requested, but there is not a standard dictating under what circumstances an extension would be approved. Individuals who receive this behavioral health service and their providers need predictability in the services they expect to receive or provide. That said, the rules would benefit from a standard or description of circumstances an extension would be granted.

Sixty (60) hours of supported employment per quarter is equivalent to approximately 4.6 hours per week, or less than one hour per business day. We are concerned that this level of service is too low. We would like to know whether OHS is utilizing data to support this maximum level of service, and, if so, from where that data was obtained and if it can be published for review by the public. Additionally, if there is data, does it indicate whether this level of service provides any indicia of success for individuals who receive this level of service? Included in this request, are individuals who have received this level of service currently engaged in competitive integrated employment?

Arkansas Rehabilitation Services can provide this service to individuals who are eligible; however, they are a provider of last resort under their own regulations. Medicaid services are also typically a payer of last resort as well. Is supported employment offered under this program going to precede services offered by Arkansas Rehabilitation Services, and, if an individual requires more than the maximum amount offered by this program, will OHS coordinate with Arkansas Rehabilitation Services to ensure that this service is seamlessly provided to an individual, even though there will be a transition of payer?

Further, this rule indicates that an individual cannot receive Adult Rehabilitative Day Service or Adult Life Skills Development on the same date that the individual receives

Supportive Employment. For what reason is OHS placing this restriction on individuals with behavioral health needs? Is this an area that is alleged to have been used inappropriately by providers or beneficiaries? If so, please indicate how this limitation will prevent that. If OHS accumulated data to conclude that the effectiveness of the service is lessened by permitting them to occur on the same date, please indicate how that data was collected, from whom it was collected, and whether that data will be published to allow for public inspection.

Response: The criteria for treatment services is based on Medicaid medical necessity criteria. Supportive employment is one of the services in a full array of services to beneficiaries in tier 2 or tier 3. The service limit has not changed under this new program and remains the same as developed for the OBH manual. At this time there is no data to support a change, but DHS will continue to monitor. In addition, as with all services contained in the manual these services are individualized. If plans require an extension of benefits prior to benefits being extended for a specific individual, that can be accomplished through plan submission to the prior authorization vendor. Medicaid is the payor of last resort and it would be the responsibility of the provider to coordinate services and payors. It is unclear to DHS as to how a beneficiary would receive both Supportive Employment and Rehab Day Services or Adult Life Skills development on the same date of service. Due to lack of provision of this service during this transition period, DHS has been unable to analyze service provision patterns.

Adult Rehab Day Treatment

The 1915(i) waiver continues allowing adult Rehabilitative Day Service to individuals with behavioral health needs; however, they have limited this service to a maximum of 90 hours per quarter. OHS states that an extension of this benefit may be requested, but there is not a standard dictating under what circumstances an extension would be approved.

Individuals who receive this behavioral health service and their providers need predictability in the services they expect to receive or provide. That said, the rules would benefit from a standard or description of circumstances an extension would be granted.

Ninety (90) hours of Rehabilitative Day Service per quarter is equivalent to approximately 6.9 hours per week, or less than one hour per calendar day. We are concerned that this maximum level of service is too low. We would like to know whether OHS is utilizing data to support this maximum level of service, and, if so, from where that data was obtained and if it can be published for review by the public. Additionally, if there is data, does it indicate whether this level of service provides any indicia of success for individuals who receive this level of service? For example, is there data that indicates whether individuals who receive this maximum level of service have voluntarily reduced this service after a period of time on average?

Further, this rule indicates that an individual cannot receive Adult Rehabilitative Day Service on the same date that the individual receives Individual Recovery Support or Group Recovery Support. For what reason is OHS placing this restriction on individuals with behavioral health needs? Again, is this an area that is alleged to have been used inappropriately by providers or beneficiaries? If so, please indicate how this limitation will prevent that. If OHS accumulated data to conclude that the effectiveness of the

service is lessened by permitting them to occur on the same date, please indicate how that data was collected, from whom it was collected, and whether that data will be published to allow for public inspection.

Response: The criteria for treatment services is based on Medicaid medical necessity criteria. Adult Rehab Day Treatment is one of the services in a full array of services to beneficiaries in tier 2 or tier 3. The service limit has not changed under this new program and remains the same as developed for the OBH manual. At this time there is no data to support a change, but DHS will continue to monitor. In addition, as with all services contained in the manual these services are individualized. If plans require an extension of benefits prior to benefits being extended for a specific individual, that can be accomplished through plan submission to the prior authorization vendor. Due to lack of provision of this service during this transition period, DHS has been unable to analyze service provision patterns.

Supportive Housing

The 1915(i) waiver provides Supportive Housing to individuals with behavioral health needs; however, they have limited this service to a maximum of 60 hours per quarter. OHS states that an extension of this benefit may be requested, but there is not a standard dictating under what circumstances an extension would be approved. Individuals who receive this behavioral health service and their providers need predictability in the services they expect to receive or provide. That said, the rules would benefit from a standard or description of circumstances an extension would be granted.

Sixty (60) hours of Supported Housing per quarter is equivalent to approximately 4.6 hours per week, or less than one hour per business day. We are concerned that this maximum level of service is too low. We would like to know whether OHS is utilizing data to support this maximum level of service, and, if so, from where that data was obtained and if it can be published for review by the public. Additionally, if there is data, does it indicate whether this level of service provides any indicia of success for individuals who receive this level of service? For example, is there data that indicates whether individuals who receive this maximum level of service have voluntarily reduced this service after a period of time on average?

Further, this rule indicates that an individual cannot receive Adult Rehabilitative Day Service or Adult Life Skills Development on the same date that the individual receives Supportive Housing. For what reason is DHS placing this restriction on individuals with behavioral health needs? Is this an area that is alleged to have been used inappropriately by providers or beneficiaries? If so, please indicate how this limitation fby permitting them to occur on the same date, please indicate how that data was collected, from whom it was collected, and whether that data will be published to allow for public inspection.

Response: The criteria for treatment services is based on Medicaid medical necessity criteria. Supportive Housing is one of the services in a full array of services to beneficiaries in tier 2 or tier 3. The service limit has not changed under this new program and remains the same as developed for the OBH manual. At this time there is no data to support a change, but DHS will continue to monitor. In addition, as with all services contained in the manual these services are individualized. If plans require an extension of

benefits prior to benefits being extended for a specific individual, that can be accomplished through plan submission to the prior authorization vendor. Due to lack of provision of this service during this transition period, DHS has been unable to analyze service provision patterns.

Community Integration

Services such as Supported Housing and Supportive Employment are absolutely vital to ensuring individuals with behavioral health needs are able to live and work in integrated community settings. We fear that DHS is not providing the level of support necessary to ensure that individuals with behavioral health needs are provided a meaningful opportunity to receive the supports and services necessary to regain or maintain their independence. Accordingly, if there is no data or limited data to show that the preceding levels of care authorized under this program are successful in providing sustained independence and integration, we would ask that DHS reconsider the limits applied, or ensure that extensions of these benefits are freely provided if requested.

Response: As this is not a service listed in the (i) services or Adult Behavioral Health Community Independence Manual, we are unable to respond to this comment.

Therapeutic Communities

The 1915(i) waiver provides a service called Therapeutic Communities to individuals with behavioral health needs. This service provides a structured, residential environment to individuals in the “Intensive” tier of services. This program is intended to provide daily services to individuals. That said, we have received concerns from providers that they will not be reimbursed for an entire week if an individual misses a single day. We do not see such a punitive approach to reimbursement in the proposed rule, but would greatly appreciate DHS’s response to this concern.

Response: Therapeutic Communities is reimbursed on a per diem basis. DHS will follow the rules set forth in the manual.

Timing for Public Comment

The proposed rules represent more changes the programs whose implementation is uniformly described by stakeholders as “hurried.” The proposed changes encompass several hundred pages of rules, regulations and technical applications to CMS.

The Arkansas Administrative Procedure Act requires that DHS allow at least thirty days for public comment. Ark. Code Ann. § 25-15-204. Given the volume of information individuals are required to review, analyze, and consider, we believe that OHS and the public would both be better served by enlarging the period for public comment.

Response: The Waivers ran for public comment from October 14, 2018 to November 12, 2018. Two public hearings were held during this time, one in Springdale on October 26, 2018, and one in Little Rock on November 5, 2018. Additionally, the Waivers were posted on the Arkansas PASSE webpage for review and comment around August 31, 2018. And, letters were sent out at that time soliciting comments on the Waivers.

DHS has sought approval from CMS for the State Plan Amendment, and formal approval is pending.

The proposed effective date of the rule is January 1, 2019.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, DHS shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See Ark. Code Ann. § 20-76-201(1)*. DHS shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See Ark. Code Ann. § 20-76-201(12)*. DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See Ark. Code Ann. § 25-10-129(b)*. Arkansas Code Annotated § 20-77-107(a)(1) specifically authorizes DHS to “establish and maintain an indigent medical care program.”

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS
WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Tami Harlan
CONTACT PERSON Isaac Linam
ADDRESS PO Box 1437, Slot S295, Little Rock, AR 72203-1437
PHONE NO. 501-320-6570 **FAX NO.** 501-404-4619 **E-MAIL** Isaac.Linam@dhs.arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Paula Stone
PRESENTER E-MAIL Paula.stone@dhs.arkansas.gov

INSTRUCTIONS

- A. Please make copies of this form for future use.**
- B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
- C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
- D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:**

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

1. What is the short title of this rule? 1915(i) Fee-for-service Adult Behavioral Health Services for Community Independence Manual; State Plan Amendment # 2018-16

2. What is the subject of the proposed rule? This rule allows beneficiaries who are eligible for Arkansas Medicaid healthcare benefits on a medical spenddown basis and who are medically frail to have access to Tier 2 and Tier 3 Behavioral Health Services.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes No
If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes No
If yes, what is the effective date of the emergency rule? _____

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes

No

5. Is this a new rule? Yes No

If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes No

If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

Is this an amendment to an existing rule? Yes No

If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."** This State Plan Amendment and manual contains all new language and there is no markup.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

7. What is the purpose of this proposed rule? Why is it necessary? To ensure beneficiaries who are eligible for Arkansas Medicaid on a spenddown basis and who are medically frail to have access to Tier 2 and Tier 3 Behavioral Health Services. These populations are excluded from these services in the PASSE Program.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
<https://medicaid.mmis.arkansas.gov/general/comment/comment.aspx>

9. Will a public hearing be held on this proposed rule? Yes No
If yes, please complete the following:

Date: October 26, 2018
November 5, 2018

Time: 4:30
5:00

Springdale Public Library
405 South Pleasant Street
Springdale, Arkansas

Place: Arkansas Enterprises for the
Developmentally Disabled
105 East Roosevelt Road
Little Rock, Arkansas

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
11/12/18

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See attached.

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e). See attached.

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. Position unknown: PASSE entities, current OBH providers, beneficiaries who are not going into the PASSE or their guardians/caregivers.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT David McMahon

TELEPHONE 501-396-6421 **FAX** _____ **EMAIL:** David.mcmahon@dhs.arkansas.gov

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

SHORT TITLE OF THIS RULE _____

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

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

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

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

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

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

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

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

Current Fiscal Year

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	_____
Special Revenue	_____
Other (Identify)	<u>0</u>
Total	<u>0</u>

Next Fiscal Year

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	_____
Special Revenue	_____
Other (Identify)	<u>0</u>
Total	<u>0</u>

Services are currently provided under FFS. Change allows individuals not eligible for PASSE to receive services currently available that are transitioning to the PASSE.

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

Current Fiscal Year

Next Fiscal Year

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

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

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

Current Fiscal Year

Next Fiscal Year

\$ 0 _____

\$ 0 _____

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

Current Fiscal Year

Next Fiscal Year

\$ 0 _____

\$ 0 _____

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

Yes No

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

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

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

SUMMARY FOR ADULT BEHAVIORAL HEALTH SERVICES FOR COMMUNITY INDEPENDENCE AND

STATE PLAN AMENDMENT # 2018-16

This manual and State Plan Amendment creates the Adult Behavioral Health Services for Community Independence program, which are Tier II and Tier III home and community-based treatment and services provided by a Certified Behavioral Health Agency to individuals eligible for Medicaid based upon the following criteria:

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

If an individual falls into one of the above two categories, that individual will not be enrolled into a Provider-Led Arkansas Shared Savings Entity (PASSE) and, if determined by the Independent Assessment to be eligible for Tier II or Tier III services, will be provided access to those services through traditional Fee-for-Service Medicaid.

