EXHIBIT F

DEPARTMENT OF HUMAN SERVICES, BEHAVIORAL HEALTH SERVICES

SUBJECT: DHS Behavioral Health Provider Certification Manuals and Forms

DESCRIPTION: These Behavioral Health Provider Certification Manuals are required to implement the previously approved Behavioral Health Transformation package that was filed with the Secretary of State's Office on December 27, 2016 and given rule number 016.06.16-024. These manuals set out the requirements for certification to provide services as allowed under the transformation package.

These certification manuals and accompanying forms are necessary to implement the previously approved Behavioral Health Transformation package which accomplishes the goals within the Behavioral Health System. The rules are necessary t ensure that behavioral health care reimbursed by Medicaid is:

1, Family/consumer-driven and person-centered, to support and promote evidence-based, recovery-oriented practices that guide service delivery and payment efficiency;

2. Provides customized, culturally and linguistically competent, community-based services;

3. Offers the least restrictive care;

4. Utilizes a team-based approach to treatment decisions to address service needs; and

5. Ensures services are high quality based on data from outcomes and evaluation tools.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on May 11, 2017. The department received the following comments:

Jamie Frank

Comment: In Independently Licensed Practitioner Manual, Page 10, item D, requirement to provide individual and family therapy, as well as pharmacologic management services were not previously a requirement made of Licensed Psychologists who provided only assessment/testing services.

Will this exclusion remain true moving forward?

Response: The intent of the Behavioral Health transformation within Arkansas is to ensure that Psychological Testing is a component of determining treatment needs as part of a continuum of treatment. As psychologists can provide multiple other services within Tier 1 of the Outpatient Behavioral Health Services program, DHS does not want

psychological testing to occur outside of a treatment regimen. There is nothing that would limit a psychologist from conducting psychological testing for Behavioral Health Agency clients or based upon referrals from treating practitioners. If the psychologist cannot provide the required individual and family therapy for clients being tested, as well as have pharmacologic management service provisions for clients, then they will not be allowed to be certified as an independently licensed practitioner.
Comment: Why is there not a separate manual for Licensed Psychologists and no mention is made of services provided by Neuropsychologists or Neuropsychological Technicians which are licensed in this state?

Response: Due to changes within the Medicaid program, Licensed Psychologists are considered Independently Licensed Practitioners which can provide services independently of working for a Behavioral Health Agency. The allowable services to be billed by Independently Licensed Practitioners are contained within the Outpatient Behavioral Health Services (OBHS) Medicaid manual and do not include anything outside of those allowable services.

Lynley Christian

Comment: Until a few months ago I had been a LMHP and had a private practice Medicaid number. Since I rarely had requests for services from Medicaid recipients and the price structure was so low, I determined to let that go. While globally I agree with the new regulations, as it is bringing competition to RSPMI companies, by bringing each practice site and practitioner up to Joint Commission standards, the reality is that it will reduce good individual providers. I've been providing Mental Health services as a licensed professional for 25 years. As a private practitioner, a 1 man band so to speak, the manpower in me will not be able to invest or maintain this new design. I at least believe I have a great track record in providing excellent services and this is just going to close me out.

Which brings me to the paragraph defining Sites and a question: It clearly states that accepted sites include MD's, psychologist offices and clearly excludes schools, long term care facilities and childcare centers. My question is how are home based practices rated? Certain criteria such as separate entrance, security of records, etcetera or are they also not accepted at all?

Response: The definition of site means a distinct place of business dedicated to the delivery of Outpatient Behavioral Health Services. Each site where an Independently Licensed Practitioner performs services at must be certified by the Division of Behavioral Health Services. There is no restriction on home based practices and it is not implied within the policy. A new requirement for Independently Licensed Clinicians is that their site will be inspected in person prior to being issued a certification by DHS. The site requirements are explained in Section X. of the proposed rules and include the criteria

necessary for certification. These requirements are for certification by DHS to become enrolled as a Medicaid provider.

Roland Irwin, Mid-South Health Systems
Therapeutic Communities Certification Manual

Comment: 113.000 (b): We believe a staff-to-client ration of 1 staff to every 4 clients (8:00 a.m. – 5:00 p.m.) is adequate to provide necessary services and ensure client and staff safety. This ration also works nicely with a 16-bed unit.

Response: DHS is in agreement with this recommendation and has amended the certification manual to read:
(a) A Level 1 Therapeutic Community shall have no less than the following staff-to-client ratios to ensure safety of clients receiving services:

a. 1 staff member for every 4 clients during daytime (8:00 A.M. – 5:00 P.M.)

b. 1 staff member for every 8 clients during evening and overnight (5:00 P.M to 8:00 A.M.)

Comment: 115.000 (b): This section stipulates minimum hours per week of mental health professional services to be provided to each client. Based on our assessment these services can generally be covered in a 16-bed program with 3 full time therapists. However, in order to ensure that these requirements are met every single week over an extended period, we will have to employ an additional therapist. For example, in the event that a therapist is a scheduled for a week's vacation, and another therapist unexpectedly becomes ill that same week, it would not be possible to provide the full 10 hours of mental health professional services during that particular week. We recommend your consideration of the following options:
a. Require that 10 or more mental health professional hours be provided during xx percent of all weeks during each quarter of treatment (or during the client's episode of care). During weeks when the 10 hours of mental health professional services are not provided, each client must still receive a minimum of 42 hours of mental health treatment, OR
b. Require that each client receive an average of xx hours of mental health professional treatment each week. The average would need to be lower than 10 hours, because it would be nearly impossible to exceed 10 hours per client in any week with a mental health professional staffing pattern that is financially feasible.

Response: DHS is in agreement with Option 1 and have added the following sentence to Section 115.000 of the certification manual "The Therapeutic Community must ensure

that 10 hours of Professional Services are provided during 90% of all weeks during each quarter of treatment of the client."

Partial Hospitalization Certification Manual

Comment: 111.000: This section states the Registered Nurse is one of the five types of allowable staff that can be used to meet the ratio of 1 staff to every 5 clients. Please clarify if a Registered Nurse with psychiatric experience is allowed to provide a portion of the required 90 minutes of "documented service provided by a Mental Health Professional." I was unable to find where the term 'Mental Health Professional' excludes Registered Nurse, in either the Partial Hospitalization Certification Manual or the Outpatient Behavioral Health Services Manual.

Response: An RN is allowable meet the staff ratio of 1 to every 5 clients, but cannot provide Mental Health Professional services as they are not allowed to provide those services within the OBHS manual.

Behavioral Health Acute Crisis Unit Certification Manual

Comment: 111.000: While most admissions will be resolved within 4 days, our experience with crisis units indicates that some admissions will require considerably longer to reach stability. We understand that the expectation is that those requiring longer stays will be transferred to inpatient psychiatric hospitals. However, in some cases there will be no beds immediately available. Because of this, we ask that you consider implementing an option for extension of the 4-day limit.

Response: Yes, extension of benefits will be available based upon medical necessity.

Comment: 114.000 (E)(3): This section states that medical detoxification is a required service in Crisis Units. While we understand the importance of medical detox, we believe this requirement will make the successful development of Crisis Units across the state more difficult at best. Obtaining sufficient psychiatric coverage will be difficult due to this requirement.

Response: DHS does not intend for medical detoxification to be a required service within an Acute Crisis Unit. The sentence in 114.000 (E)(3) has been moved from under (e) Services shall minimally include, to a separate section in (f) which now states "Medically-supervised and co-occurring disorder capable detoxification may be provided in an Acute Crisis Unit if appropriately staffed and in compliance with procedures outlined in the Arkansas DHS Regional Alcohol and Drug Detoxification Manual.

Julie Meyer, PFH

Therapeutic Communities Certification

Comment: Will providers be required to be certified as a Behavioral Health Agency under the Behavioral Health Agency Certification policy to become certified as a provider of Therapeutic Community services?

Response: All existing certified RSPMI sites as of July 1, 2017 will be grandfathered in as Behavioral Health Agencies. DHS will allow sites to who are certified as a Therapeutic Community to provide the Therapeutic Communities service even if the entire agency has not switched from providing Rehabilitative Services for Persons with Mental Illness (RSPMI) services to Outpatient Behavioral Health Services (OBHS).

Comment: "Mental Health Paraprofessional" language is still located within the definition of "Qualified Behavioral Health Provider" on page 3.

Response: The sentence under #4 for the "Qualified Behavioral Health Provider" definition has been amended to read "Acknowledges in writing that all qualified behavioral health provider services are controlled by client care plans and provided under the direct supervision of a mental health professional." This sentence previously read "Acknowledges in writing that all mental health paraprofessional services are controlled by client care plans and provided under the direct supervision of a mental health professional.

Comment: How will the State determine if an individual qualifies for Level 1 or Level 2 Therapeutic Communities?

Response: The determination between Level 1 and Level 2 Therapeutic Communities will be based upon results from the independent assessment and the placement that the client needs.

Comment: What is the definition of "secure facility" in regards to the requirements of Level 1?

Response: A "secure facility" means a locked facility.

Comment: Can Level 1 and Level 2 clients reside in the same setting?

Response: No. A Level 1 Therapeutic Community client must reside in a locked facility. A Level 2 Therapeutic Community client cannot reside in a locked facility.

Comment: What is the staffing ratio expectations for both levels of Therapeutic Communities in the evening and overnight?

Response: The staffing ratio is spelled out in Section 113.000 for Level 1 Therapeutic Communities and Section 118.000 for Level 2 Therapeutic Communities. For Level 1 Therapeutic Communities, 1 staff member for every 4 clients during daytime (8:00 A.M.

– 5:00 P.M.) and 1 staff member for every 8 clients during evening and overnight (5:00 P.M to 8:00 A.M.). For Level 2 Therapeutic Communities, 1 staff member for every 8 clients during daytime (8:00 A.M. – 5:00 P.M.) and appropriate staff supervision shall be documented in policies and procedures of the Therapeutic Community for clients during evening and overnight (5:00 P.M to 8:00 A.M.). Level 2 Therapeutic Communities must have the ability for residents to be seen by appropriate caregivers when necessary 24 hours a day. Appropriate supervision must be documented and maintained at Level 2 Therapeutic Communities.

Comment: Will 911 clients be presumptively eligible for Therapeutic Communities?

Response: During the initial phases of the Behavioral Health transformation, 911 clients will be presumptively eligible in Tier 3 for Therapeutic Communities.

Comment: Will 911 clients be subject to an Independent Assessment?

Response: Yes, 911 clients will still receive an Independent Assessment.

Comment: Will 911 clients be presumptively eligible for a specific level of Therapeutic Communities?

Response: Depending on the level of care necessary for a 911 client, presumptive eligibility will be based upon the level of acuity of the client. If a 911 client needs services in a locked facility, then that client would be presumptively eligible for Level 1 Therapeutic Communities.

Comment: Since rates for Therapeutic Communities are being promulgated within this policy, will rates for Acute Crisis Units, Partial Hospitalization, and Outpatient Behavioral Health Services be available for public comment and then promulgated?

Response: Rates are not being promulgated for Therapeutic Communities in this promulgation. Rates aren't promulgated but are posted for notice only--the notice includes a link to the site showing proposed rate sheets, then once the related underlying rule or methodology is promulgated and effective the rates are also effective and posted to the "fee schedules" section on the Medicaid site.

Comment: How were the rates for Therapeutic Communities determined?

Response: The rates for Therapeutic Communities were determined by the following methodology as outlined within the Arkansas State Plan, "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."

Behavioral Health Acute Crisis Unit Certification

Comment: Will providers be required to be certified as a Behavioral Health Agency under the Behavioral Health Agency Certification policy to become certified as a Behavioral Health Acute Crisis Unit provider?

Response: All existing certified RSPMI sites as of July 1, 2017 will be grandfathered in as Behavioral Health Agencies. DHS will allow sites to who are certified as an Acute Crisis Unit to provide the Acute Crisis Unit service even if the entire agency has not switched from providing Rehabilitative Services for Persons with Mental Illness (RSPMI) services to Outpatient Behavioral Health Services (OBHS).

Comment: Will Acute Crisis Units have to be licensed as a substance abuse provider through the Division of Behavioral Health Services?

Response: The Acute Crisis Unit must be certified by DHS as an acute crisis unit. If the acute crisis unit will provided detoxification services, they will be required to be licensed by DHS as defined in the Regional Alcohol and Drug Detoxification Manual.

Comment: Does the Division of Behavioral Health Services plan to update the Arkansas DHS Regional Alcohol and Drug Detoxification Manual?

Response: No

Comment: Will staff within an Acute Crisis Unity have to be trained and certified as a Regional Detoxification Specialist?

Response: If the Acute Crisis Unit will be providing detoxification services, yes, the staff would have to be trained and certified.

Comment: "Mental Health Paraprofessional" language is still located within the definition of "Qualified Behavioral Health Provider" on page 5.

Response: The sentence under #4 for the "Qualified Behavioral Health Provider" definition has been amended to read "Acknowledges in writing that all qualified behavioral health provider services are controlled by client care plans and provided under the direct supervision of a mental health professional." This sentence previously read "Acknowledges in writing that all mental health paraprofessional services are controlled

by client care plans and provided under the direct supervision of a mental health professional.

Comment: What licensure requirements/qualifications are necessary for nurses in the Acute Crisis Unit setting?

Response: A nurse in an Acute Crisis Unit must be an Arkansas licensed nurse in good standing.

Comment: Is a nurse required to be on-site 24 hours a day?

Response: Yes

Partial Hospitalization Certification

Comment: Will providers be required to be certified as a Behavioral Health Agency under the Behavioral Health Agency Certification policy to become certified as a provider of Partial Hospitalization?

Response: All existing certified RSPMI sites as of July 1, 2017 will be grandfathered in as Behavioral Health Agencies. DHS will allow sites to who are certified as a Partial Hospitalization program to provide Partial Hospitalization services even if the entire agency has not switched from providing Rehabilitative Services for Persons with Mental Illness (RSPMI) services to Outpatient Behavioral Health Services (OBHS).

Comment: The certification policy outlines the requirement for 1:5 staffing ratio. Why aren't QBHPs included in the staff-to-patient ratio? See page 6.

Response: The staff required to meet the 1:5 staffing ratio are those listed on Page 6 in Section 111.000.

Behavioral Health Agency Certification

Comment: How will rates be determined for Outpatient Behavioral Health Services?

Response: The rates for Outpatient Behavioral Health Services were determined by the following methodology as outlined within the Arkansas State Plan, "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."

Comment: Where can rates for Behavioral Health Agency services be located?

Response: Rates are posted for notice only--the notice includes a link to the site showing proposed rate sheets, then once the related underlying rule or methodology is promulgated and effective the rates are also effective and posted to the "fee schedules" section on the Medicaid site. The rates have been shared multiple times with a variety of stakeholders anytime that they were requested and are included in response to this question.

Comment: What are the staffing requirements for Intensive Outpatient Substance Abuse treatment?

Response: The requirements for Intensive Outpatient Substance Abuse Treatment are located in the Outpatient Behavioral Health Services Medicaid manual.

Comment: Can an agency list more than one Clinical Director for their organization?

Response: Yes.

Comment: Will there be a separate certification process promulgated for Planned Respite?

Response: Yes.

Comment: Will the certification policies for Peer Support Specialists, Family Support Partner, and Youth Support Partner be promulgated?

Response: Certification requirements for these specialties are currently being developed by DHS. Those requirements will be shared when finalized.

Comment: To provide co-occurring or substance abuse services, will providers have to be licensed as a substance abuse provider by the Division of Behavioral Health Services?

Response: A Behavioral Health Agency will have to be licensed as a substance abuse provider by the Division of Behavioral Health Services.

Comment: What is considered "standardized mapping application"?

Response: A standardized mapping application could include Google Maps, MapQuest, etc.

Comment: What is the purpose of the 50 mile radius policy in the Outpatient Behavioral Health Services program?

Response: This ensures that if services are necessary for individuals, particularly in a crisis situation, that the provider would be able to make a reasonable accommodation to seek out and assist the client within a reasonable time frame.

Comment: The language within Section V.I.2. does not align with current CARF Accreditation standards and language.

Response: National Accreditation is required to be certified as a Behavioral Health Agency. DHS recognizes CARF as a national accreditation entity using this existing language within the RSPMI program.

Comment: Please provide details on how and when providers will transition from RSPMI to the BHA certification.

Response: All existing certified RSPMI sites as of July 1, 2017 will be grandfathered in as Behavioral Health Agencies. The agency must then inform DHS and its contractors when they intend to switch to providing OBH services. Agencies can continue to provide RSPMI services under existing RSPMI rules until June 30, 2018. The presumption will be that a provider will provide RSPMI services unless they specifically notify DHS and its contractors that they will now provide OBH services.

Jared Sparks, Ozark Guidance
Partial Hospitalization

Comment: Section 111.000, Service Definition – Partial Hospitalization – "This service shall include at a minimum, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) hours a day of which 90 minutes must be a documented service by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than 4 (four) days in that week.

Does the individual therapy, group therapy, and psychoeducation have to occur each day or do those services only have to be part of the service array that must be provided during the week or course of treatment?

Response: Individual therapy, group therapy, and psychoeducation do not have to occur each day. These services are included as part of the service array that must be provided during the week and course of treatment.

Comment: Does the 90 minutes of MHP service have to be provided each day or can it average to 90 minutes a day? For example, if group and family therapy occurred one day, resulting in 120 minutes of services, can another day only have 60 minutes of service provided by an MHP?

Response: 90 minutes of MHP services MUST occur each day with documentation of circumstances arise required. The Partial Hospitalization program must adhere to the OBHS manual requirements. Documentation of rationale for not meeting the minimum requirements is required.

Comment: Does the "5 hours a day" only consist of services identified in the OBHS manual or are there other acceptable structured activities, such as education… or what we currently provide as rehabilitative day service for children? For example, would it be acceptable to provide three hours of education by a certified teach and two hours of MHP services per day?

Response: No, the 5 hours a day of services must be from the services identified within the OBHS manual.

Comment: Are there OBHS services or other activities that QBHPs can provide in Partial Hospitalization that contributed to the minimum five hours of services a day?

Response: Yes, QBHPs can provide allowable QBHP services in Partial Hospitalization that contribute to the minimum five hours of services a day.

Comment: Do all services provided to clients receiving Partial Hospitalization fall under Partial Hospital Certification policies? For example, can medical services be provided and billed separately from Partial Hospitalization if a client is receiving Partial Hospitalization?

Response: If billing under the Outpatient Behavioral Health Services (OBH) program, a beneficiary cannot receive any other OBH services on that same date as the Partial Hospitalization rate is a per diem which would include all OBH services. This does not restrict the beneficiary from receiving medical services outside of the OBH program.

Comment: If the per diem is not used because a client does not participate in the full 5 hour day, can the provide bill for individual services as delivered?

Response: The only way that a provider can be reimbursed for services provided in the Partial Hospitalization service is if they meet the requirements of the service definition. Providers are required to document any instances in which the minimum amount of hours are not met.

Comment: What is the minimum hourly required participation to receive per diem reimbursement for a week of services? For example, if an adult client leaves one hour early on two days of the week, resulting in the client receiving 18 of the 20 hours of available services, is that client still eligible for the per diem? If not, how is that reimbursed?

Response: In order to be reimbursed, the provider must meet the requirements of the service definition. If the beneficiary receives other OBH services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of service on no less than 4 (four) days in that week. Documentation of not meeting the minimum requirement is necessary.

Comment: 113.000 – Organization Structure and 117.000 Facility Environment

(a) The partial hospitalization unit shall be a separate, identifiable organizational unit with its own director, or supervisor, and staffing pattern…
(b) A partial hospitalization program is defined by its staff and organizational structure rather than by a specific building or facility.

Do the clients receiving partial hospitalization treatment have to receive services separately rom other levels of care? For example, can partial hospitalization clients be in the same psychotherapy group with clients of a therapeutic day treatment? (In the proposed model, PH clients would routinely transition to and from TDT) If clients are not allowed to share age and treatment appropriate services, specific services such as the required group may not be available or effective. For example, there may be 10 partial hospitalization clients sharing a building with 60 therapeutic day treatment clients. If PH and TDT clients are not able to share the same group, there may not be enough age appropriate PH only clients to have a safe and effective group. You could conceivable be required to have 7 and 17 year olds in the same group therapy to meet the service definition requirement of PH.

Response: The two statements from the manual mean that a Partial Hospitalization program shall be a separate unit, with separate staffing patterns, than other programs offered by providers. This does not mean that PH clients may only receive services with other PH clients. Age appropriate group therapy requirements still exist and programs shall make accommodations for that within their existing clientele.

Comment: If clients are able to receive services outside of those identified in OBHS as part of the 5 hour day, may those services be provided with clients from another level of

care. For example, could PH clients share the same classroom with age related Therapeutic Day Treatment clients?

Response: Allowable services for meet the 5 hour day are those included within the OBHS manual, which also specified age requirements and restrictions for those services.

David Kuchinski, Birch Tree

Comment: If you total the available reimbursement for the service array for Tier 2 averaged over a year that amount comes out to $35-$45 per day. As a result, there is a significant drop off in service availability from Level 2 Therapeutic Communities at $175 a day to Tier 2 at $35-45 per day as individual's transition to more autonomous living arrangements.
Could an Extension of Benefits be offered for Tier 2 Services based on medical necessity for transition from Therapeutic Communities?

Response: Yes, authorizations for all OBH services are allowed to have extensions of benefits if medically necessary.

Therapeutic Communities Certification Manual

Comment: The progress note log presents potential EHR security rights challenges. Having to allow different roles (MHPP, MHP, MD, etc.) to share a progress note, we'd have to allow each to share security rights, which would be inappropriate for several reasons.
Could it be possible to break out the "log" into a few service groups, in order to maintain security rights by role, all of which would tie together by date of service and all of which would still be reviewed and be "signed off on" by the MHP?
Response: The log is required for purposes of ensuring that clients are receiving services while in a Therapeutic Community. This is particularly necessary for auditing purposes. The way your entity handles the daily service log is completely up to you as long as it is made available to auditing entities when asked.

Comment: Section 114.000, Level 1/2, Physician Services - Psychiatric Nurse Practitioners are not listed in this section and/or other section in this Manual and the other Certification Manuals. Could Psychiatric Nurse Practitioners be added to the pertinent sections or have a definition that defines a "prescriber"?
Response: The following sentence has been added to both Level 1 and Level 2 Physician Services requirements "This service can also be provided by an Advanced Practice Nurse (Adult Psychiatric Mental Health Clinical Nurse Specialist; Child Psychiatric Mental Health Clinical Nurse Specialist; Adult Psychiatric Mental Health APN; Family

Psychiatric Mental Health APN) as allowable within the Outpatient Behavioral Health Services Medicaid Manual."

Comment: Based on the definition of Critical Incidents and the requirements in the standard, "requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention", would require a substantially increased volume of reporting.
A suggestion could be that Critical Incidents that meet (1) are documented and monitored internally, with a quality assurance and improvement process that would be made available for review and/or audit by appropriate agency.
Response: This suggestion has resulted in removing (1) from the incidents requiring reporting to DHS. It now states, in a new section, "The Therapeutic Community shall document and monitor internally, with a quality assurance and improvement process that will be made available for review and/or audit by an appropriate agency the following:

(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to DHS Provider Certification within twenty-four (24) hours of the incident being documented."

Comment: Section 168.000 (c) - The requirement that clinical staff be trained in non-violent intervention within 30 and shall occur prior direct patient contact presents challenges to practical application. For example, new hires have contact with patients in new hire training before they receive this training by the end of the week. MHP's could not provide services until training is offered, which may be 1 time per month.
Could the standard be edited to read that until staff received the non-violent training that staff shall only work in proximity of staff with the non-violent training?
Response: No, this is a required training that is necessary prior to client contact.

Comment: Section 172.000 (b) (1) - At our Therapeutic Community sites, we do not "administer medications" because MHPP's are not authorized/licensed to do so. We only administer at our Crisis Unit by RN's.
Could this standard be edited to read "Written procedures for medication administration or monitoring…"?

Response: The sentence has been amended to read "Written procedures for medication administration or monitoring shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications."

Comment: The Level 2 Services within Therapeutic Communities will work exceptionally well for the majority of Birch members and allowing Birch to operationalize an effective Recovery-oriented treatment milieu. These standards were well thought out and allows the provider to apply best practices for effective ROI. As a result the members will benefit greatly!

Response: Thank you.

Acute Crisis Unit Certification

Comment: It will be an ongoing challenge to resolve all Acute Crisis Unit stays within the 4 day limit due to the following issues;

1. Many of the referrals we accept from ASH and/or private hospitals are not completely stable upon discharge. We at times step an individual down directly to our Crisis Unit because they are not stable to be admitted outside of a locked unit. Further, we have a sizeable group of individuals that at any one time meet criteria to be in a private hospital or ASH, and we manage them between the home branch and the Crisis Unit several times to save the state money and to keep them out of the hospital.

2. Private hospitals only average a length of stay of 5 days due to AMFC limits. Often, we receive our member back from the private hospital just as acute and we'll keep the member at HH until they stabilize further or re-hospitalize.

3. Private hospitals won't accept individuals when their Medicaid days (24) are used up or if they are highly aggressive.

4. ASH is over full! It takes us 2-3 weeks to get individuals accepted to ASH, but only if we swap one of theirs for one of ours. A recent referral remained on the ASH waiting list for 46 days before they were admitted.

Could an Extension of Benefits be offered to extend the 4 day limit for this service based on medical necessity and attempts to hospitalize?

Response: Yes, extension of benefits will be available based upon medical necessity.

Comment: The wording here indicates that medically monitored detoxification would be prescribed as needed and suggests that this would be a mandatory service if the patient needed it. If this is a mandatory service based on need, this would be way out of Birch's level of expertise and would not be able to meet this standard.
If this is interpretation is not correct, could the standard be edited to reflect that the provider has the option of providing this service and/or referring out to an appropriate facility if needed?

Response: DHS does not intend for medical detoxification to be a required service within an Acute Crisis Unit. The sentence in 114.000 (E)(3) has been moved from under (e) Services shall minimally include, to a separate section in (f) which now states "Medically-supervised and co-occurring disorder capable detoxification may be provided in an Acute Crisis Unit if appropriately staffed and in compliance with procedures outlined in the Arkansas DHS Regional Alcohol and Drug Detoxification Manual.

Comment: We also ask for consideration that the medically fragile be eligible for Acute Crisis Units. We provide integrated care for acute, high-risk medical stepdown with our population at the Hope House. We do this because hospitals discharge after significant medical procedures to their home without adequate rehab or trained staff. Due to inability to self-care, immediate medical regression and potential for crisis, we place individuals at Hope House with skilled nursing to rehab and monitor. In our opinion it would be unethical to wait for crisis or regression to occur before we act.
Response: The Acute Crisis Unit is for a behavioral health crisis which is related to acute symptomology. The Acute Crisis Unit is not for a physical health crisis.

Comment: Section 157.000 (c)(1) - Same comment and request for this standard as mentioned above for Therapeutic Communities.
Response: This suggestion has resulted in removing (1) from the incidents requiring reporting to DHS. It now states, in a new section, "The Therapeutic Community shall document and monitor internally, with a quality assurance and improvement process that will be made available for review and/or audit by an appropriate agency the following:

(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to DHS Provider Certification within twenty-four (24) hours of the incident being documented."

Comment: Section 168.000 (c) - Same comment and request for this standard as mentioned above for Therapeutic Communities.
Response: No, this is a required training that is necessary prior to client contact.

Mental Health Council

Comment: Please date each document when it is issued so that providers or potential providers can be sure they are working from the most current document. Please post page numbers on documents. Mission statement was omitted in most recent document.

Response: Effective Date will be added to front page of each manual. Page numbers will be posted on each manual. Mission statement will be not included in certification manuals.

Comment: "Contemporaneous" means by the end of the performing provider's first work period following the provision of care of services to be documented, or as provided in the Outpatient Behavioral Health Services manual, whichever is longer. Can this requirement be more clearly defined? There is no statement in the OBHS Medicaid manual Documentation section referencing when documentation is due.

Response: The definition means that documentation must be completed by the performing provider during the first work period following the provision of care. If

documentation timeline changes are added to the OBHS manual, that statement would allow the OBHS manual to determine appropriate documentation timelines.

Comment: Compliance Timeline: DHS may authorize temporary compliance exceptions for new accreditation standards that require independent site surveys and specific subset accreditation. Such compliance exceptions expire at the end of the provider's accreditation cycle and may not be renewed or reauthorized.
Can this sentence be revised for clarity?

Response: This sentence has been in the DBHS RSPMI Certification manual since 2010. The intent is that if a national accreditation body changes their accreditation standards that would, in turn, require an onsite site survey for accreditation, DHS would have the ability to make an exception requiring accreditation for that specific program.

Therapeutic Communities Certification

Comment: The progress note log presents potential EHR security rights challenges. Having to allow different roles (MHPP, MHP, MD, etc.) to share a progress note, we'd have to allow each to share security rights, which would be inappropriate for several reasons.
Could it be possible to break out the "log" into a few service groups, in order to maintain security rights by role, all of which would tie together by date of service and all of which would still be reviewed and be "signed off on" by the MHP?

Response: The log is required for purposes of ensuring that clients are receiving services while in a Therapeutic Community. This is particularly necessary for auditing purposes. The way your entity handles the daily service log is completely up to you as long as it is made available to auditing entities when asked.

Comment: 113.000 (b): We believe a staff-to-client ration of 1 staff to every 4 clients (8:00 a.m. – 5:00 p.m.) is adequate to provide necessary services and ensure client and staff safety. This ration also works nicely with a 16-bed unit.

Response: DHS is in agreement with this recommendation and have amended the certification manual.

Comment: Section 114.000, Level 1/2, Physician Services - Psychiatric Nurse Practitioners are not listed in this section and/or other section in this Manual and the other Certification Manuals. Could Psychiatric Nurse Practitioners be added to the pertinent sections or have a definition that defines a "prescriber"?

Response: The following sentence has been added to both Level 1 and Level 2 Physician Services requirements "This service can also be provided by an Advanced Practice Nurse (Adult Psychiatric Mental Health Clinical Nurse Specialist; Child Psychiatric Mental

Health Clinical Nurse Specialist; Adult Psychiatric Mental Health APN; Family Psychiatric Mental Health APN) as allowable within the Outpatient Behavioral Health Services Medicaid Manual."

Comment: 115.000 (b): This section stipulates minimum hours per week of mental health professional services to be provided to each client. Based on our assessment these services can generally be covered in a 16-bed program with 3 full time therapists. However, in order to ensure that these requirements are met every single week over an extended period, we will have to employ an additional therapist. For example, in the event that a therapist is a scheduled for a week's vacation, and another therapist unexpectedly becomes ill that same week, it would not be possible to provide the full 10 hours of mental health professional services during that particular week. We recommend your consideration of the following options:

a. Require that 10 or more mental health professional hours be provided during xx percent of all weeks during each quarter of treatment (or during the client's episode of care). During weeks when the 10 hours of mental health professional services are not provided, each client must still receive a minimum of 42 hours of mental health treatment, OR

b. Require that each client receive an average of xx hours of mental health professional treatment each week. The average would need to be lower than 10 hours, because it would be nearly impossible to exceed 10 hours per client in any week with a mental health professional staffing pattern that is financially feasible.

Response: DHS is in agreement with Option 1 and have added the following sentence to Section 115.000 of the certification manual "The Therapeutic Community must ensure that 10 hours of Professional Services are provided during 90% of all weeks during each quarter of treatment of the client."

Comment: Based on the definition of Critical Incidents and the requirements in the standard, "requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention", would require a substantially increased volume of reporting.
A suggestion could be that Critical Incidents that meet (1) are documented and monitored internally, with a quality assurance and improvement process that would be made available for review and/or audit by appropriate agency.

Response: This suggestion has resulted in removing (1) from the incidents requiring reporting to DHS. It now states, in a new section, "The Therapeutic Community shall document and monitor internally, with a quality assurance and improvement process that will be made available for review and/or audit by an appropriate agency the following:

(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to DHS Provider Certification within twenty-four (24) hours of the incident being documented."

Comment: Section 168.000 (c) - The requirement that clinical staff be trained in non-violent intervention within 30 and shall occur prior direct patient contact presents challenges to practical application. For example, new hires have contact with patients in new hire training before they receive this training by the end of the week. MHP's could not provide services until training is offered, which may be 1 time per month.
Could the standard be edited to read that until staff received the non-violent training that staff shall only work in proximity of staff with the non-violent training?

Response: No, this is a required training that is necessary prior to client contact.

Comment: Section 172.000 (b) (1) - At our Therapeutic Community sites, we do not "administer medications" because MHPP's are not authorized/licensed to do so. We only administer at our Crisis Unit by RN's.
Could this standard be edited to read "Written procedures for medication administration or monitoring…"?

Response: The sentence has been amended to read "Written procedures for medication administration or monitoring shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications."

Partial Hospitalization Certification

Comment: Definition of restraint, "Restraint" refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of the individual's body. For clients: mechanical restraints shall not be used.

We recommend that the word "mechanical" be removed from the restraint list. But leave the sentence – For clients: "restraints shall not be used."

Response: The use of mechanical restraints is not allowed per the certification requirements.

Comment: 111.000 – Service Definition – Partial Hospitalization – First paragraph, last sentence – "If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than 4 (four) days a week." Please clarify in the PH service definition that if the beneficiary is offered services, at least, 4 days a week and does not attend, the services that were provided are to be documented and billed. Note that the

beneficiary was scheduled for additional days and did not attend. Document what attempts were made to engage the beneficiary.

Response: If the amount of services required to meet the service are not met, then Partial Hospitalization cannot be billed. Services can be billed as provided outside of Partial Hospitalization, but in order to be paid the per diem for Partial Hospitalization, the service definition requirements must be met. A provider is required to document if a client does not or cannot participate in treatment and why that level of care continues to be necessary if the beneficiary cannot participate regularly in the program.

Comment: 111.000: This section states the Registered Nurse is one of the five types of allowable staff that can be used to meet the ratio of 1 staff to every 5 clients. Please clarify if a Registered Nurse with psychiatric experience is allowed to provide a portion of the required 90 minutes of "documented service provided by a Mental Health Professional." I was unable to find where the term 'Mental Health Professional' excludes Registered Nurse, in either the Partial Hospitalization Certification Manual or the Outpatient Behavioral Health Services Manual.

Response: An RN is allowable meet the staff ratio of 1 to every 5 clients, but cannot provide Mental Health Professional services as they are not allowed to provide those services within the OBHS manual.

Acute Crisis Unit Certification

Comment: It will be an ongoing challenge to resolve all Acute Crisis Unit stays within the 4 day limit due to the following issues;

1. Many of the referrals we accept from ASH and/or private hospitals are not completely stable upon discharge. We at times step an individual down directly to our Crisis Unit because they are not stable to be admitted outside of a locked unit. Further, we have a sizeable group of individuals that at any one time meet criteria to be in a private hospital or ASH, and we manage them between the home branch and the Crisis Unit several times to save the state money and to keep them out of the hospital.

2. Private hospitals only average a length of stay of 5 days due to AMFC limits. Often, we receive our member back from the private hospital just as acute and we'll keep the member at HH until they stabilize further or re-hospitalize.

3. Private hospitals won't accept individuals when their Medicaid days (24) are used up or if they are highly aggressive.

4. ASH is over full! It takes us 2-3 weeks to get individuals accepted to ASH, but only if we swap one of theirs for one of ours. A recent referral remained on the ASH waiting list for 46 days before they were admitted.

Could an Extension of Benefits be offered to extend the 4 day limit for this service based on medical necessity and attempts to hospitalize?

Response: Yes, extension of benefits will be available based upon medical necessity.

Comment: The wording here indicates that medically monitored detoxification would be prescribed as needed and suggests that this would be a mandatory service if the patient needed it. If this is a mandatory service based on need, this would be way out of Birch's level of expertise and would not be able to meet this standard.
If this is interpretation is not correct, could the standard be edited to reflect that the provider has the option of providing this service and/or referring out to an appropriate facility if needed?

Response: DHS does not intend for medical detoxification to be a required service within an Acute Crisis Unit. The sentence in 114.000 (E)(3) has been moved from under (e) Services shall minimally include, to a separate section in (f) which now states "Medically-supervised and co-occurring disorder capable detoxification may be provided in an Acute Crisis Unit if appropriately staffed and in compliance with procedures outlined in the Arkansas DHS Regional Alcohol and Drug Detoxification Manual.

Comment: We also ask for consideration that the medically fragile be eligible for Acute Crisis Units. We provide integrated care for acute, high-risk medical stepdown with our population at the Hope House. We do this because hospitals discharge after significant medical procedures to their home without adequate rehab or trained staff. Due to inability to self-care, immediate medical regression and potential for crisis, we place individuals at Hope House with skilled nursing to rehab and monitor. In our opinion it would be unethical to wait for crisis or regression to occur before we act.

Response: The Acute Crisis Unit is for a behavioral health crisis which is related to acute symptomology. The Acute Crisis Unit is not for a physical health crisis.

Comment: 114.000 (E)(3): This section states that medical detoxification is a required service in Crisis Units. While we understand the importance of medical detox, we believe this requirement will make the successful development of Crisis Units across the state more difficult at best. Obtaining sufficient psychiatric coverage will be difficult due to this requirement.

Response: DHS does not intend for medical detoxification to be a required service within an Acute Crisis Unit. The sentence in 114.000 (E)(3) has been moved from under (e) Services shall minimally include, to a separate section in (f) which now states "Medically-supervised and co-occurring disorder capable detoxification may be provided in an Acute Crisis Unit if appropriately staffed and in compliance with procedures outlined in the Arkansas DHS Regional Alcohol and Drug Detoxification Manual.

Comment: Based on the definition of Critical Incidents and the requirements in the standard, "requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention", would require a substantially increased volume of reporting.
A suggestion could be that Critical Incidents that meet (1) are documented and monitored internally, with a quality assurance and improvement process that would be made available for review and/or audit by appropriate agency.

Response: This suggestion has resulted in removing (1) from the incidents requiring reporting to DHS. It now states, in a new section, "The Therapeutic Community shall document and monitor internally, with a quality assurance and improvement process that will be made available for review and/or audit by an appropriate agency the following:

(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to DHS Provider Certification within twenty-four (24) hours of the incident being documented."

Comment: Section 168.000 (c) - The requirement that clinical staff be trained in non-violent intervention within 30 and shall occur prior direct patient contact presents challenges to practical application. For example, new hires have contact with patients in new hire training before they receive this training by the end of the week. MHP's could not provide services until training is offered, which may be 1 time per month.
Could the standard be edited to read that until staff received the non-violent training that staff shall only work in proximity of staff with the non-violent training?

Response: No, this is a required training that is necessary prior to client contact.

Cookie Higgins, Centers for Youth and Families

Comment: Please date each document when it is issued so that providers or potential providers can be sure they are working from the most current document. Please post page numbers on documents. Mission statement was omitted in most recent document.

Response: Effective Date will be added to front page of each manual. Page numbers will be posted on each manual. Mission statement will be not included in certification manuals.

Behavioral Health Agency Certification

Comment: "Contemporaneous" means by the end of the performing provider's first work period following the provision of care of services to be documented, or as provided in the Outpatient Behavioral Health Services manual, whichever is longer. Can this

requirement be more clearly defined? There is no statement in the OBHS Medicaid manual Documentation section referencing when documentation is due.
Response: The definition means that documentation must be completed by the performing provider during the first work period following the provision of care. If documentation timeline changes are added to the OBHS manual, that statement would allow the OBHS manual to determine appropriate documentation timelines.

Comment: Compliance Timeline: DHS may authorize temporary compliance exceptions for new accreditation standards that require independent site surveys and specific subset accreditation. Such compliance exceptions expire at the end of the provider's accreditation cycle and may not be renewed or reauthorized.
Can this sentence be revised for clarity?

Response: This sentence has been in the DBHS RSPMI Certification manual since 2010. The intent is that if a national accreditation body changes their accreditation standards that would, in turn, require an onsite site survey for accreditation, DHS would have the ability to make an exception requiring accreditation for that specific program.

Partial Hospitalization Certification

Comment: Definition of restraint, "Restraint" refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of the individual's body. For clients: mechanical restraints shall not be used.

We recommend that the word "mechanical" be removed from the restraint list. But leave the sentence – For clients: "restraints shall not be used."

Response: The use of mechanical restraints is not allowed per the certification requirements.

Comment: 111.000 – Service Definition – Partial Hospitalization – First paragraph, last sentence – "If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than 4 (four) days a week." Please clarify in the PH service definition that if the beneficiary is offered services, at least, 4 days a week and does not attend, the services that were provided are to be documented and billed. Note that the beneficiary was scheduled for additional days and did not attend. Document what attempts were made to engage the beneficiary.

Response: If the amount of services required to meet the service are not met, then Partial Hospitalization cannot be billed. Services can be billed as provided outside of Partial Hospitalization, but in order to be paid the per diem for Partial Hospitalization, the service definition requirements must be met. A provider is required to document if a client does not or cannot participate in treatment and why that level of care continues to be necessary if the beneficiary cannot participate regularly in the program.

The proposed effective date is July 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12). Arkansas Code § 20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

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

EXHIBIT F

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Behavioral Health Services

DIVISION DIRECTOR Paula Stone, Interim Director

CONTACT PERSON Robbie Nix

ADDRESS PO Box 1437, Slot S295, Little Rock, AR 72203

PHONE NO. 501-686-9871 **FAX NO.** 501-404-4619 **E-MAIL** robbie.nix@dhs arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Robbie Nix

PRESENTER E-MAIL robbie.nix@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? DHS Behavioral Health Provider Certification Manuals and Forms

2. What is the subject of the proposed rule? These Behavioral Health Provider Certficiation Manuals are required to implement the previously approved Behavioral Health Transformation package that was filed final with the Secretary of State's office on December 27, 2016 and given rule number 016.06.16-024. These manuals set out the requirements for certification to provide services as allowed under the transformation package.

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."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? These certification manuals and accompanying forms are necessary to implement the previously approved Behavioral Health Transformation package which accomplishes the following goals within the Behavioral Health System:

The proposed rule is necessary to ensure that behavioral health care reimbursed by Medicaid is: (1) Family/consumer-driven and person-centered, to support and promote evidence-based, recovery-oriencted practices that guide service delivery and payment efficiency, (2) Provides customized, culturally and linguistically competent, community-based services, (3) Offers the least restrictive care, (4) Utilizes a team-based approach to treatment decisions to address service needs, and (5) Ensures services are high quality based on data from outcomes and evaluation tools.

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://www.medicaid.state.ar.us/general/comment/comment.aspx

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

Date: _____

Time: _____

Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
May 11, 2017

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. Medical associations, interested providers and advocacy organizations.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Behavioral Health Services

PERSON COMPLETING THIS STATEMENT _____

TELEPHONE _____ **FAX** 501-404-4619 **EMAIL:** _____

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 DHS Behavioral Health Provider Certification Manuals and Forms

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		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total $0 Total $0

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

Current Fiscal Year		Next Fiscal Year	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

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
$ 0

Next Fiscal Year
$ 0

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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
$

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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.

DHS Behavioral Health Provider Certification Manuals and Forms
Summary

Effective July 1, 2017, The Department of Human Services will implement new certification requirements and standards for providers of Outpatient Behavioral Health Services who are reimbursed by Arkansas Medicaid through the Outpatient Behavioral Health Services Program. These manuals and accompanying forms are necessary to implement the previously approved Behavioral Health Transformation Package.