TOC required

201.000 Arkansas Independent Assessment (ARIA) System Overview

~~1-1-191~~201-~~1-22~~3

The Arkansas Independent Assessment (ARIA) system is comprised of several parts that are administered through separate steps for each eligible Medicaid ~~individual~~client served through one of the state's waiver programs, or state plan personal care services~~.~~, or Early Intervention Day Treatment (EIDT) services. The purpose of the ARIA system is to perform a functional-needs assessment to assist in the development of a~~n individual~~client's Person-~~-~~Centered Service Plan (PCSP), or personal care services plan. As such, it assesses a~~n individual~~client's capabilities and limitations in performing activities of daily living such as bathing, toileting, and dressing. It is not a medical diagnosis, although the medical history of a~~n individual~~client is an important component of the assessment as a functional deficiency may be caused by an underlying medical condition. ~~In the case of an individual in need of behavioral health services, or waiver services administered by the Division of Developmental Services (DDS), t~~The independent assessment does not determine whether a~~n individual~~client is Medicaid eligible as that determination is made prior to and separately from the assessment of a~~n individual~~client. For clients seeking services under ARChoices and Living Choices waivers and the PACE program who are not eligible at the time of application, the independent assessment is used, along with financial eligibility, as part of the determination for Medicaid eligibility.

Federal statutes and regulations require states to use an independent assessment for determining eligibility for certain services offered though Home and Community Based Services (HCBS) waivers. It is also important to Medicaid ~~beneficiaries~~clients and their families that any type of assessment is based on tested and validated instruments that are objective and fair to everyone. In 2017, Arkansas selected the ARIA system which is being phased in over time among different population groups. When implemented for a population, the ARIA system replaces and voids any previous IA systems.

The ARIA system is administered by a vendor under contract with the Arkansas Department of Human Services (DHS). The basic foundation of the ARIA system is MnCHOICES, a comprehensive functional assessment tool originally developed by state and local officials in Minnesota for use in assessing the long-term services and supports (LTSS) needs of elderly ~~individual~~clients. Many ~~individual~~clients with developmental disabilities (DD)/intellectual disabilities (ID) and ~~individual~~clients with severe behavioral health needs also have LTSS needs. Therefore, the basic MnCHOICES tool has common elements across the different population groups. DHS and its vendor further customized MnCHOICES to reflect the Arkansas populations.

ARIA is administered by professional assessors who have successfully completed the vendor's training curriculum. The assessor training is an important component of ensuring the consistency and validity of the tool. The assessment tool is a series of more than 300 questions that might be asked during an interview conducted in person for any initial independent assessment. The interview may include family members and friends as well as the Medicaid ~~beneficiary~~client. How a question is answered may trigger another question. Responses are weighted based on the service needs being assessed. The ~~MnChoices~~ ARIA instrument is computerized and uses computer program language based on logic (an algorithm) to generate a tier assignment for each ~~individual~~client. An algorithm is simply a sequence of instructions that will produce the exact same result in order to ensure consistency and eliminate any interviewer bias. Reassessments may be conducted in person or through the use of interactive video that is recorded with the permission of the client or telephonically that is recorded with the permission of the client and the approval of the respective DHS program staff.

The results of the assessment are provided to the ~~individual~~client and program staff at DHS. The results packet includes the ~~individual~~client's tier result, scores, and answers to all questions

asked during the IA. **Click here to see an example results packet**. ~~Individual~~Clients have the opportunity to review those results and may contact the appropriate division for more information on their individual results, including any explanations for how their scores were determined. Depending upon which program the ~~individual~~client participates in, the results may also be given to service providers. The results will assign a~~n individual~~client into a tier which subsequently is used to develop the ~~individual~~client's PCSP. The tiers and tiering logic are defined by DHS and are specific to the population served (personal care, ARChoices, Living Choices, PACE, DD/ID, BH). DHS and the vendor provide internal quality review of the IA results as part of the overall process. The tier definitions for each population group/waiver group are available in the respective section of this Manual. In the case of a~~n individual~~client whose services are delivered through the Provider-led Arkansas Shared Savings Entity (PASSE), the tier is used in the determination of the actuarially sound global payment made to the PASSE. ~~Beginning January 1, 2019, e~~Each PASSE is responsible for its network of providers and payments to providers are based on the negotiated payment arrangements.

For ~~beneficiaries~~ clients receiving state plan personal care, the IA determines initial eligibility for services, then is used to inform the amount of services the ~~beneficiary~~client is to receive.

For clients who receive HCBS services, the IA results are used to develop the PCSP with the individual Medicaid ~~beneficiary~~client. ~~The Medicaid beneficiary (or a parent or guardian on the individual's behalf) will sign the PCSP. Depending upon which program the individual participates in, department staff or a provider is responsible for ensuring the PCSP is implemented.~~ The DHS ARIA vendor does not participate in the development of the PCSP, nor in the provision of services under the approved plan.

There are four key features of every Medicaid home and community based services (HCBS) waiver:

A. It is an alternative to care in an institutional setting (hospital, nursing home, intermediate care facility for individuals with developmental disabilities), therefore the individual must require a level of services and supports that would otherwise require that the individual be admitted to an institutional setting;

B. The state must assure that the individual's health and safety can be met in a non-institutional setting;

C. The cost of services and supports is cost effective in comparison to the cost of care in an institutional setting; and,

D. The PCSP should reflect the preferences of the individual and must be signed by the individual or their designee.

~~The PCSP, as agreed to by the Medicaid beneficiary, therefore represents the final decision for setting the amount, duration and scope of HCBSs for that individual.~~

201.100 Developmental Screen Overview ~~1-1-19~~01-1-223

Additionally, the vendor will perform developmental screens for children seeking admission into an Early Intervention Day Treatment (EIDT) program~~, the successor program to Developmental Day Treatment Clinic Services (DDTCS) and Child Health Management Services (CHMS) described in Act 1017 of 2013. Ark. Code Ann. § 20-48-1102~~. The implementation of the screening process supports Arkansas Medicaid's goal of using a tested and validated assessment tool that objectively evaluates a~~n individual~~client's need for services.

The developmental screen is the Battelle Developmental Inventory screening tool, which is a norm-referenced tool commonly used in the field to screen children for possible developmental delays. The state has established a broad baseline and will use this tool to screen children to determine if further evaluation for services is warranted. The screening results can also be used by the EIDT provider to further determine what evaluations for services a child should receive.

203.000 Appeals

~~1-1-19~~01-1-23

Appeal requests for the ARIA system must adhere to the policy set forth in the **Medicaid Provider Manual Section 160.000 Administrative Reconsideration and Appeals**. ~~which can be accessed at https://medicaid.mmis.arkansas.gov/Provider/Docs/all.aspx.~~

203.100 Notice of Actions for Appeals

12-1-22

Applicant and participant appeals are the responsibility of the Department of Human Services (DHS), Office of Appeals and Hearings. DHS uses the Notice of Action to provide notice to a participant when an adverse action is taken to deny, suspend or terminate eligibility for PASSE in part or in whole. The Notice of Action explains the action taken; the effective date of the action; and the reason(s) for the action. It also explains the appeal process, including how to request an appeal; that the participant has the right to request a fair hearing; the time by which an appeal and a request for a hearing must be submitted; and that if the participant files an appeal within the timeframe specified in the notice, the case will automatically remain open and any services and benefits he or she had been receiving will continue until the hearing decision is made, unless the participant informs DHS that he or she does not wish to continue receiving the benefits pending the appeal hearing decision. The Notice of Action also informs the participant that if he or she does not elect to discontinue benefits and the appeal hearing decision is not in his or her favor, he or she may be liable for the cost of any benefits received pending the appeal hearing decision. Notices of Action and the opportunity to request a fair hearing are kept in the participant's case record. An applicant's request for an appeal must be received by the DHS Office of Appeals and Hearings no later than 30 days from the date on the Notice of Action. PASSE participants have the right to appeal any action that involuntarily reduces or terminates some or all their services or benefits, even if their eligibility remains active. The DHS Office of Appeals and Hearings is responsible for these types of appeals. Information regarding hearings and appeals is included with the participant's tier determination notice. The Notice of Action will be retained for five years from the date of last approval, closure, or denial. The Notice of Action form and the system-generated Notice of Action are available in Spanish and large print formats.

The Office of Medicaid Provider Appeals is responsible for hearing service provider appeals. Requests for appeals must be received by the Office of Medicaid Provider Appeals no later than thirty (30) days from the date on the Notice of Action. Provider appeals do not trigger continuance of service for which the client is liable.

210.100 Referral Process

~~1-1-19~~01-1-~~22~~23

Independent Assessment (IA) referrals are initiated by the Division of Aging, Adult, and Behavioral Services (DAABHS) and Behavioral Health (BH) Service providers identifying a ~~beneficiary~~ client who may require services in addition to behavioral health counseling services and medication management. Requests for functional assessment shall be transmitted to the Department of Human Services (DHS) or its designee. Supporting documentation related to treatment services necessary to address functional deficits may be provided.

D~~H~~MS or its ~~designee~~ vendor will review the request and make a determination to either:

A. Finalize a referral and send~~t~~ it to the vendor for a BH IA

B. Provide notification to the requesting BH service provider that more information is needed

C. Provide notification to the requesting entity

Reassessments will occur annually~~,~~ unless a change in ~~circumstances~~ condition requires a new assessment.

210.300 Tiering

~~1-1-19~~01-1-23

A. Tier definitions:

1. Tier 1 ~~means~~ indicates the score reflected that the ~~individual~~client can continue Counseling and Medication Management services but is not eligible for the additional array of services available in Tier 2 ~~or~~and Tier 3.
2. Tier 2 ~~means~~ indicates the score reflected difficulties with certain functional behaviors allowing eligibility for a full array of ~~non-residential~~ services to help the ~~beneficiary~~client function in home and community settings and move towards recovery.
3. Tier 3 ~~mean~~indicates ~~in~~ the score reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services ~~including 24 hours a day/7 days a week residential services,~~ to help the ~~beneficiary~~ client ~~move towards reintegrating back into the community~~function in home and community settings and move toward recovery.

B. Tier Logic:

1. ~~Beneficiaries~~Clients age 18 and over

	Tier 1 – Counseling and Medication Management Services	Tier 2 – Counseling, Medication Management, and Support Services	Tier 3 – Counseling, Medication Management, Support~~, and Residential~~ Services
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score of 4 **AND** Intervention Score of 1 or 2 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA	Mental Health Diagnosis Score of 4 **AND** Intervention Score of 3 or 4 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 3 or 4 **AND**	

		Frequency Score of 4 or 5 in any ONE of the following Psychosocial Subdomains: Difficulties Regulating Emotions Susceptibility to Victimization Withdrawal Agitation Impulsivity Intrusiveness	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 1, 2, 3 or 4 **AND** Frequency Score of 1, 2, 3, 4 or 5 in the following Psychosocial Subdomain: Psychotic Behaviors	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 4 **AND** Frequency Score of 4 or 5 in the following Psychosocial Subdomain: Manic Behaviors	
		OR	
		Mental Health Diagnosis Score of 4 **AND** PHQ-9 Score of 3 or 4 (Moderately Severe or Severe Depression) **OR** Geriatric Depression Score of 3 (>=10)	
		OR	
		Mental Health Diagnosis Score	

		of 4 **AND** Substance Abuse or Alcohol Use Score of 3	

When you see "**AND"**, this ~~means~~ indicates you must have a score in this area **AND** a score in another area. When you see "**OR**", this ~~means~~ indicates you must have a score in this area **OR** a score in another area.

2. ~~Beneficiaries~~Clients Under Age 18

	Tier 1 – Counseling and Medication Management Services	**Tier 2 – Counseling, Medication Management, and Support Services**	**Tier 3 – Counseling, Medication Management, Support~~, and Residential~~ Services**
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score >= 2 **AND** Injurious to Self: Intervention Score of 1, 2 or 3 **AND** Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score >=2 **AND** Injurious to Self: Intervention Score of 4 **AND** Frequency Score of 1, 2, 3, 4 or 5
		OR	
		Mental Health Diagnosis Score >=2 **AND** Aggressive Toward Others, Physical: Intervention Score of 1, 2 or 3 **AND** Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score >=2 **AND** Aggressive Toward Others, Physical: Intervention Score of 4 **AND** Frequency Score of 2, 3, 4 or 5
		OR	
		Mental Health Diagnosis Score >=2 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Aggressive Toward Others,	Mental Health Diagnosis Score >=2 **AND** Psychotic Behaviors: Intervention Score of 3 or 4 **AND** Frequency Score of 3, 4 or 5

		Verbal/Gestural Wandering/Elopement	
		OR	
		Mental Health Diagnosis Score >=2 **AND** Intervention Score of 2, 3 or 4 **AND** Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Socially Unacceptable Behavior Property Destruction	
		OR	
		Mental Health Diagnosis Score >=2 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Agitation Anxiety Difficulties Regulating Emotions Impulsivity Injury to Others, Unintentional Manic Behaviors Susceptibility to Victimization Withdrawal	
		OR	
		Mental Health Diagnosis Score >=2 **AND** **PICA**: Intervention Score of 4	
		OR	
		Mental Health Diagnosis Score >=2	

		AND **Intrusiveness**: Intervention Score of 3 or 4 **AND** Frequency Score of ~~-~~4 or 5	
		OR	
		Mental Health Diagnosis Score > = 2 **AND** **Psychotic Behaviors**: Intervention Score of 1 or 2 **AND** Frequency Score of 1 or 2	
		OR	
		Mental Health Diagnosis Score >=2 **AND** Psychosocial Subdomain Score >=5 and <=7 **AND** Pediatric Symptom Checklist Score >15	

210.400 Possible Outcomes ~~1-1-19~~01-1-23

A. For a ~~beneficiary~~client receiving a Tier 1 determination:

1. Eligible for Counseling and Medication Management services and may continue Tier 1 services with a certified behavioral health service provider or Independently Licensed Practitioner (ILP).
2. Not eligible for Tier 2 or Tier 3 services.
3. Not eligible for ~~auto-~~assignment to a Provider-led Arkansas Shared Savings Entity (PASSE) or to continue participation with a PASSE.

B. For a ~~beneficiary~~client receiving a Tier 2 or Tier 3 determination:

1. Eligible for services contained in Tier 1 and ~~Tier 2~~higher.

~~2. Not eligible for Tier 3 services.~~

~~3~~2. Eligible for ~~auto-~~assignment to a PASSE or to continue participation with a PASSE, unless in the Spend down category of eligibility.

a. ~~On January 1, 2019, t~~The PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.

b. The PASSE will be responsible for providing care coordination, ~~an~~ assisting the ~~beneficiary~~client in accessing all needed services and~~, after January 1, 2019, for~~ providing those services.

~~C. For a beneficiary receiving a Tier 3 determination:~~

~~1. Eligible for services contained in Tier 1, Tier 2 and Tier 3.~~

~~2. Eligible for auto-assignment to a PASSE or to continue participation with a PASSE.~~

~~a. On January 1, 2019, the PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.~~

~~b. The PASSE will be responsible for providing care coordination and assisting the beneficiary in accessing all needed services and, after January 1, 2019, for ensuring those services are provided.~~

220.100 Independent Assessment Referral Process

~~1-1-19~~01-1-23

A. Independent Assessment (IA) referrals are initiated by the Division of Developmental Disabilities (DDS) when a ~~beneficiary~~client has been determined, at one time, to meet the institutional level of care for I/DD. DDS will send the referral for a Developmental Disabilities (DD) Assessment to the current IA Vendor. DDS will make IA referrals for the following populations:

1. Clients receiving services under the Community and Employment Supports (CES) 1915(c) Home and Community Based Services Waiver.
2. Clients on the CES Waiver Waitlist.
3. Clients applying for or currently living in a private Intermediate Care Facility (ICF) for ~~individual~~clients with intellectual or developmental disabilities.
4. Clients who are applying for placement at a state-run Human Development Center (HDC).

To continue to receive services within these populations, all ~~individual~~clients referred will have to undergo the Independent Assessment.

B. All populations, except for those served at an HDC, will be reassessed every three (3) years.

1. A~~n individual~~client can be reassessed at any time if there is a change of ~~circumstances~~ condition that requires a new assessment.
2. ~~Individual~~Clients in an HDC will only be assessed or reassessed if they are seeking transition into the community.

220.300 Tiering

~~1-1-19~~1-23

A. Tier Definitions:

1. Tier 2 ~~means~~ indicates that the score reflected difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings ~~beneficiary scored high enough in certain areas to be eligible for paid services and supports~~.
2. Tier 3 ~~means~~ indicates that the score reflected greater difficulties with certain functional behaviors allowing eligibility for a full array of services to help the client function in home and community settings ~~beneficiary scored high enough in certain areas to be eligible for the most intensive level of services,~~ **~~including 24 hours a day/7 days a week~~** ~~paid supports and services~~.

B. Tiering Logic:

1. DDS Tier Logic is organized by categories of need, as follows:
   a. Safety: Your ability to remain safe and out of harm's way

b. Behavior: behaviors that could place you or others in harm's way

c. Self-Care: Your ability to take care of yourself, like bathing yourself, getting dressed, preparing your meals, shopping, or going to the bathroom

Tier 2: Institutional Level of Care	**Tier 3: Institutional Level of Care ~~and may need 24 hours a day 7 days a week paid supports and services to maintain current placement~~**
Safety Level High A. [Self-Preservation Score > = 4 **AND** B. Caregiving Capacity/Risk Score > = 6 **AND** C. Caregiving/Natural Supports Score > = 6 **AND** D. Mental Status Evaluation Score (in the home) = 3 or 4 **AND** E. Mental Status Evaluation Score (in the community) = 2]	A. [Self-Preservation Score > = 16 **AND** B. Caregiving Capacity/Risk Score = 11 **AND** C. Caregiving/Natural Supports Score of = 7 **AND** D. Mental Status Evaluation Score (in the home) Score = 5 **AND** E. Mental Status Evaluation Score (in the community) Score = 3]
Safety Level Medium A. [Self-Preservation Score > = 4 **AND** B. Caregiving Capacity/Risk Score > = 6 **AND** C. Caregiving/Natural Supports Score > = 6 **AND** D. Mental Status Evaluation Score (in the home) = 2 **AND** E. Mental Status Evaluation Score (in the community) = 2]	
Safety Level Low A. [Self-Preservation Score > = 4 **AND** B. Caregiving Capacity/Risk Score > = 6 **AND** C. Caregiving/Natural Supports Score > = 6 **AND** D. Mental Status Evaluation Score (in the home) = 1 **AND**	

E. Mental Status Evaluation Score (in the community) Score = 1]	
Behavior Level High A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 5 - < = 7 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement; **AND** C. Caregiving Capacity/Risk Score of > = 6 **AND** D. Caregiving/Natural Supports Score of > = 5] **OR** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 5 - < = 7 in at least THREE of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of > = 9 Caregiving/Natural Supports Score of >	**Behavior Level High** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 8 - < = 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement **OR** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 8 - < = 9 in at least THREE of the following Subdomains: Aggressive Toward Others Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Verbal/Gestural; Withdrawal

= 5]	
Behavior Level Low A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 3 - < = 4 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of < = 8 Caregiving/Natural Supports Score of < = 3] **OR** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of >=5-<=7 in at least one of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of < = 8 Caregiving/Natural Supports Score of < = 3]	**Behavior Level Low** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 8 - < = 9 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement] **OR** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 8 - < = 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal]
Self-Care Level High	**Self-Care Level High**

A. [Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following: *1. ADL's:* Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers 2. *Functional Communication:* Score of 2 or 3 in Functional Communication *3. IADLs:* Score of 3 in any of the following IADLs (Meal Preparation, Housekeeping, Finances, Shopping) *4. Safety:* Self-Preservation Score of >=4 **AND** a score in at least one of the following areas: Caregiving Capacity/Risk Score of > = 9 Caregiving/Natural Supports Score of > = 4 [Treatment/Monitoring Score of at least 2]	A. [Neurodevelopmental Score of 2 **AND** B. Treatments/Monitoring Score of at least 2 C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score > = 10 Caregiving/Natural Supports Score of = 7]
Self-Care Level Medium A. [Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following: *1. ADLs:* Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers	

2. *Functional Communication:* Score of 1 in Functional Communication 3. *IADLs* Score of 3 in any of the following IADLs: (Meal Preparation, Housekeeping, Finances, Shopping) 4. *Safety:* Self-Preservation Score of > = 2 **AND** a score in at least one of the following areas: Caregiving Capacity/Risk Score of > = 9 Caregiving/Natural Supports Score of > = 4]	
Self-Care Level Low A. [Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following combinations: Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers] **OR** [Neurodevelopmental Score of 2 **AND** Score of >=1 in any of the following: IADLs (Meal Preparation, Housekeeping, Finances, Shopping)]	**Self-Care Level Low** A. [Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following combinations: Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of >= 10 Caregiving/Natural Supports Score of 7]

When you see "**AND"**, this ~~means~~ indicates you must have a score in this area **AND** a score in another area. When you see "**OR**", this ~~means~~ indicates you must have a score in this area **OR** a score in another area.

220.~~300~~400 Possible Outcomes ~~1-1-19~~01-1-23

A. For ~~beneficiaries~~clients on the CES Waiver, Waiver Waitlist, or in an ICF:

Both Tier 2 and Tier 3 determinations will result in the ~~beneficiary~~client being eligible for ~~auto-~~assignment to a PASSE or to continue participation with a PASSE.

1. ~~On January 1, 2019, t~~The PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.
2. The PASSE will be responsible for providing care coordination and assisting the ~~beneficiary~~client in accessing all eligible services and, ~~after January 1, 2019,~~ for ensuring those services are delivered.

B. For ~~beneficiaries~~clients seeking admission to an HDC:

1. Tier 2 Determination:
   a. Not eligible for admission into an HDC, will be conditionally admitted to begin transitioning to community settings.
   b. Eligible for ~~auto-~~assignment to a PASSE or to continue participation with a PASSE.
      i. ~~After January 1, 2019, t~~The PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.
      ii. The PASSE will be responsible for providing care coordination and assisting the ~~beneficiary~~client in accessing all eligible services and, ~~after January 1, 2019,~~ for ensuring those services are provided.
2. Tier 3 Determination:
   a. Eligible for HDC admission.
   b. Not eligible for ~~auto-~~assignment to a PASSE or to continue participation with a PASSE, if the client chooses admission to the HDC.

C. If the ~~beneficiary~~client does not receive a tier on the assessment, the vendor will refer him or her back to DDS for re-evaluation of institutional level of care.

220.~~400~~500 Developmental Screens ~~1-1-19~~01-1-23

~~-~~All children birth through the eighth birthday, who are seeking initial enrollment or reenrollment in an Early Intervention Day Treatment (EIDT), ~~or the predecessor programs, Developmental Day Treatment Clinic Services (DDTCS) or Child Health Management Services (CHMS) on or after July 1, 2018,~~ must undergo a developmental screen to determine the necessity of further evaluation.

A provider can request that a child be “opted-out” of the screening process. An opt-out request will be approved if:

A. The child has one of the following diagnoses:
   1. Intellectual disability;
   2. Epilepsy/Seizure disorder;
   3. Cerebral palsy;
   4. Down Syndrome;
   5. Spina Bifida; or
   6. Autism Spectrum Disorder

B. The diagnosis is documented on a record that is signed and dated by a physician.

220.~~410~~510 Battelle Developmental Inventory Screen ~~1-1-19~~01-1-23

A. The screening tool that will be used by the vendor is the most recent edition of the Battelle Developmental Inventory (BDI) Screening Tool. The BDI screens children in the following five domains: adaptive, personal/social, communication, motor, and cognitive.

B. Definitions used for the screening process:

1. Cut Score - The lowest score a ~~beneficiary~~client could have for that age range and standard deviation in order to pass a particular domain.
2. Pass - The child's raw score is higher than the cut score, and the child is not referred for further evaluation.
3. Refer – The child's raw score is lower than the cut score, and the child is referred for further evaluation of service need.
4. Age Equivalent Score - The age at which the raw score for a subdomain is typical.
5. Raw Score – Is the score the child actually received on that domain. It is compared to the cut score to determine if the child receives a pass or refer.
6. Standard Deviation - A measurement used to quantify the amount of variation; the standard deviation will be applied to the child's raw score so that their score can be compared to the score of a child with typical development.

C. The standard deviation of -1.5 will be applied to all raw scores. Any score that is more than 1.5 standard deviations below that of a child with typical development will be referred for further evaluation for EIDT services.

D. Assessors who administer the Battelle Developmental Inventory screen must meet the qualifications of a DD assessor, listed in Section ~~X20~~202.200 and undergo training specific to administering the tool.

220.~~420~~520 Referral Process ~~1-1-19~~01-1-23

A. BDI referrals are initiated by EIDT providers when a family or guardian is seeking EIDT day habilitation services for a child who may need those service. No EIDT day habilitation or assessment services can be billed until a child is referred for further evaluation by the BDI or is approved for an opt-out, as described in section 220.400. ~~Requests for screens or opt-out requests must be entered at **https://ar-ia.force.com/providerportal/s/**.~~ **Request a screen or request to opt-out**.

B. For a request for a BDI screen, the vendor will have fourteen (14) days from the date of the referral to complete the screen. The vendor will schedule at least two days a month to be onsite at each EIDT provider's facility to complete BDIs for all referrals received before the cut-off date. The cut-off date is two (2) business days prior to the scheduled onsite visit by the vendor.

C. Opt-out requests submitted through the portal link above will be reviewed by D~~H~~DS staff to determine if it meets the criteria set out in section 220.400 above.

1. If the Opt-Out request is approved by D~~H~~DS, the vendor will send a results letter to the family indicating that the child may be referred for further evaluation.
2. If the opt-out request is denied by D~~H~~DS, the referral will be sent out to the vendor so that a BDI can be completed at the next scheduled onsite visit.

230.200 Assessor Qualifications 01-1-23

Assessors will have the same qualifications outlined in Section 220.200.

~~230~~240.000 PERSONAL CARE SERVICES

~~230~~240.100 Referral Process

~~1-1-19~~01-1-23

Independent Assessment (IA) referrals are initiated by Personal Care (PC) service providers identifying a ~~beneficiary~~client who may require PC services. ~~After January 1, 2019, individual~~Clients who are enrolled in a PASSE will not require a personal care assessment to continue services. Requests for functional assessment shall be transmitted to the Department of Human Services (DHS) or its designee, and will require supporting documentation. Supporting documentation that must be provided include:

A. A provider completed form that has been provided by DHS; and

B. A referral form, if it is an initial referral.

DHS or its designee will review the request and make a determination to either:

A. Finalize a referral and send it to the vendor for a PC IA.

B. Provide notification to the requesting entity that more information is needed, and that the

C. PC provider may resubmit the request with the additional information.

D. Provide notification to the requesting entity the request is denied, for example, if a functional assessment has been performed within the previous ten (10) months and there is no change of ~~circumstances~~ condition to justify reassessment.

PC IA Reassessments must occur annually~~,~~ but may occur more frequently if a change of ~~circumstances~~ condition necessitates such.

~~230~~240.200 Assessor Qualifications

~~1-1-19~~01-1-23

In addition to the qualifications listed in Section 202.000, PC assessors must be a Registered Nurse licensed in the State of Arkansas.

240.300 Tiering

~~1-1-19~~01-1-23

A. Tiering Definitions:

1. Tier 0 ~~means~~ indicates the client ~~you~~ did not score high enough in any of the Activities of Daily Living (ADLs) such as Eating, Bathing, Toileting, to meet the state's eligibility criteria for Personal Care Services. A Tier 0 ~~means~~ indicates that the client ~~you~~ did not need any "hands on assistance" in being able to bathe ~~yourself~~themselves, feed ~~yourself~~ themselves and dress ~~yourself~~ themselves as examples.

2. Tier 1 ~~means~~ indicates the client~~you~~ scored high enough in at least one of the Activities of Daily Living (ADLs) such as Eating, Bathing, Toileting, to be eligible for the state's Personal Care Services. A Tier 1 ~~means~~ indicates that you needed "hands on assistance" to be able to bathe themselves~~yourself~~, dress themselves~~yourself~~, or feed themselves~~yourself~~, as examples.

B. Tiering Logic:

	Tier 0	Tier 1

Functional Status (ADLs)	Score < 3 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Score of > = 3 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning

~~230~~240.400 Possible Outcomes

~~1-1-19~~01-1-23

Upon successful completion of an IA, the tier determination will determine eligibility of service levels. Possible outcomes include:

A. Tier 0 Determination:

1. Not currently eligible for Personal Care services.
2. May be reassessed when a change in ~~circumstances~~ condition necessitates a re-assessment.

B. Tier 1 Determination:

1. Currently eligible for up to 256 units (64 hours) per month of personal care services. The hour limit does not apply to clients under the age of 21.
2. The PC IA is submitted to DHS or its designee who reviews it, along with any information submitted by the provider to authorize the set amount of service time per month.

The PC IA is not used to assign clients to a PASSE.

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

Administration and Operation

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

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

Supported Employment; Behavior Assistance; Adult Rehabilitation Day Treatment; Peer Support; Family Support Partners; Residential Community Reintegration; ~~Respite; Mobile Crisis Intervention~~~~Crisis~~Respite; Crisis Stabilization Intervention; Assertive Community Treatment; Intensive In-Home Services Therapeutic Host Home; Recovery Support Partners (for Substance Abuse); Substance Abuse Detox (Observational); Pharmaceutical Counseling; Supportive Life Skills Development~~,~~; Child and Youth Support; Partial Hospitalization, Supportive Housing; and Therapeutic Communities.

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

***Select one*:**

○	**Not applicable**
X	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
X	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:* *Provider-Led Arkansas Shared Savings Entity (PASSE) Program,* AR.0007.R00.01

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

X	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

		☐	§1915(b)(2) (central broker)	X	§1915(b)(4) (selective contracting/limit number of providers)
	☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
	☐	**A program authorized under §1115 of the Act.** *Specify the program*:			

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

~~X~~	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	~~X~~	The Medical Assistance Unit *(name of unit)*:	The Division of Medical Services (DMS)
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
○	The State plan HCBS benefit is operated by *(name of agency)*		
X	Division of Aging, Adult and Behavioral Health Services (DAABHS)		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐x	☐	☐
2 Eligibility evaluation	☑	☐x	☐	☐
3 Review of participant service plans	☑	☐x	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	X☐	☑	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	X☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐x	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The PASSEs will assist with 4, 5, 6, and 8.
The contracted actuary will assist with 8.
The External Quality Review Organization (EQRO) that contracts with DMS will assist with 3, 5, and 10.
DAABHS, as the operating agency, will assist with 1, 2, 3, 8, 9, & 10

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

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	~~March 1, 2019~~ January 1, 2023	~~Feb. 29, 2020~~December 31, 2023	~~30,000~~ 38,000
Year 2	~~March 1, 2020~~January 1, 2024	~~Feb. 28, 2021~~December 31, 2024	
Year 3	~~March 1, 2021~~January 1, 2025	~~Feb. 28, 2022~~December 31, 2025	
Year 4	~~March 1, 2022~~January 1, 2026	~~Feb. 28, 2023~~December 31, 2026	
Year 5	~~March 1, 2023~~January 1< 2027	~~Feb. 28, 2024~~December 31, 2027	

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

Financial Eligibility

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

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

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

Evaluation/Reevaluation of Eligibility

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

O	Directly by the Medicaid agency
X	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	Evaluations and re-evaluations are conducted by DHS's ~~third-party contractor~~ contracted vendor who completes the independent assessment. Eligibility is determined ~~by DMS~~ using the results of the independent assessment and the individual's diagnosis~~es~~.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The assessor must have a Bachelor's Degree or be a registered nurse with one (1) year of experience with mental health populations.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

~~Individuals are referred for the independent assessment based upon their current diagnosis and~~

~~utilization of services. Measurement is completed through an assessment of functional deficit through a face-to-face evaluation of the beneficiary, caregiver report, and clinical record review. The assessment measures the beneficiary's behavior in psychosocial sub-domains and intervention domain that evaluates the level of intervention necessary to managed behaviors as well as required supports to maintain beneficiary a r in home and community settings. After completion of the independent assessment of functional need, DMS makes the final eligibility determination for all clients based on the results of the independent assessment and the individual's diagnosis contained in his or her medical record. Eligibility is re-evaluated on an annual basis.~~

The target group for eligibility determination for HCBS services are those individuals who have active Arkansas Medicaid coverage and are receiving mental health treatment services with an Arkansas enrolled provider. The treating provider makes a referral for participants who are receiving treatment for a mental health condition who they have identified as needing treatment beyond the counseling services they are receiving. Participants who are not receiving counseling services can be referred for an evaluation through the AR Department of Human Services Division of Aging, Adult and Behavioral Health services. The Division will review historical documentation and refer for the evaluation.

The needs-based eligibility is determined through completion of a tool used to evaluate the functional deficit related to the mental health diagnosis. The evaluation tool was developed is the MnCHOICES, a comprehensive functional assessment tool originally developed by state and local officials in Minnesota for use in assessing the long-term services and supports (LTSS) needs of elderly individuals. This tool was adapted to measure the functional deficits of individuals with a mental health diagnosis. The evaluation tool is administered by a contractor Optum Health Solutions who hires and trains assessors to administer the evaluation tool. The score from this assessment is processed with the mental health diagnosis and Medicaid eligibility to establish HCBS eligibility.

Medicaid eligibility is established though existing Medicaid eligibility groups and only those with existing Medicaid eligibility receive the evaluation to determine HCBS eligibility.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The evaluation is administered by assessors who have successfully completed the vendor's training curriculum. The assessor training is an important component of ensuring the consistency and validity of the tool.
The re-evaluation uses the same tool and assessor as the initial evaluation.

The results of the functional evaluation are coupled with the diagnosis and used to determine the eligibility for HCBS.

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

~~The individual~~ member ~~must receive a minimum of a Tier 2~~ ~~on the independent~~ ~~functional assessment for HCBS behavioral health services. To meet a Tier 2, the individual~~member ~~must have difficulties with certain behaviors that require a full array of non-residential services to help with functioning in home and community-based settings and moving towards~~ recovery and ~~is not a harm to his or herself or others. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.~~

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

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

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The client~~individual~~ must receive a minimum of a Tier 2 functional assessment for HCBS behavioral health services. To meet a Tier 2, the client~~individual~~ must have difficulties with	Must meet at least one of the following three criteria as determined by a licensed medical professional: 1. The individual is unable to perform either of the following:	1) Diagnosis of developmental disability that originated prior to age of 22; 2) The disability has continued or is expected to continue indefinitely; and 3)The disability	There must be a written certification of need (CON) that states that an individual is or was in need of inpatient psychiatric services. The certification must be made at the time of admission, or if an individual applies

certain behaviors that require a full array of ~~non-residential~~ services to help with functioning in home and community-based settings and moving towards recovery~~,~~ and is not a harm to his or herself or others. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors. 1915(i) services must be appropriate to address the ~~i~~client's~~ndividuals~~ identified functional deficits due to their behavioral health diagnosis.	A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/ locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or, B. At least two (2) of the three (3) activities of daily living (ADLs) of transferring/ locomotion, eating or toileting without assistance from another person; or, 2.The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or, 3.The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening. 4.No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic	constitutes a substantial handicap to the person's ability to function without appropriate support services, including but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. Must also be in need of and able to benefit from active treatment and unable to access appropriate services in a less restrictive setting. Individuals must be assessed a Tier 2 or Tier 3 to receive services in the CES Waiver or an ICF/IID.	for Medicaid while in the facility, the certification must be made before Medicaid authorizes payment. Tests and evaluations used to certify need cannot be more than one (1) year old. All histories and information used to certify need must have been compiled within the year prior to the CON. In compliance with 42 CFR 441.152, the facility-based and independent CON teams must certify that: A. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary; B. Proper treatment of the beneficiary's psychiatric condition requires inpatient services under the direction of a physician and C. The services can be reasonably expected to prevent further regression or to improve the beneficiary's condition so that the services will no longer be needed. Specifically, a physician must make a medical necessity determination that services must be provided in a hospital setting because the ~~client~~ member is a danger to his or herself or other~~,~~ and cannot safely remain in the community setting.

	change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.		

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

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

~~Targeted to individuals with a behavioral health diagnosis, who are age four and older.~~1.) Targeted to individuals age 4 and older with a mental health diagnosis, ~~.~~

~~-~~2.) Adults up to and including 133 percent of the FPL who meet the other criteria specified in Section1902(a)(10)(A)(i)(VIII) of the Social Security Act and covered under the Arkansas Section 1115 Demonstrative Waiver ("ARHOME") who are determined to be "Medically Frail".

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

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

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. ☑ **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: ~~One.~~ 1	
ii.	**Frequency of services**. The state requires (select one):	
	X	**The provision of 1915(i) services at least monthly**
		Monthly monitoring of the individual when services are furnished on a less than monthly basis If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

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

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

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

This State Plan Amendment, along with the concurrent 1915(b) PASSE Waiver and 1915(c) Community and Employment Supports (CES) Waiver, will be subject to the HCBS Settings requirements.

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

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

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The assessor must have a Bachelor's Degree or be a registered nurse with one (1) year of experience with mental health populations.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

1. Be a registered nurse, a physician or have a bachelor's degree in a social science or a health-related field; or

2. Have at least one (1) year experience working with developmentally or intellectually disabled clients or behavioral health clients.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

From the time ~~an individual~~a member ~~-~~makes contact with ~~DHS Beneficiary Support~~ DHS PASSE unit regarding receiving HCBS state plan services, DHS informs the ~~individual~~ member and their caregivers of their right to make choices about many aspects of the services available to them and their right to advocate for themselves or have a representative advocate on their behalf. It is the responsibility of everyone at DHS, the PASSE who receives the member ~~attribution~~ and provides care coordination, and the services providers to make sure that the PASSE member is aware of and is able to exercise their rights and to ensure that the member and their caregivers are able to make choices regarding their services.

Immediately following enrollment in a PASSE, the PASSE care coordinator must develop

an interim service plan (ISP) for member. If the member was already enrolled in a program that required PCSPs, then that PCSP may be the ISP for the member. The ISP may be effective for up to 60 days, pending completion of the full PCSP. **The State Medicaid Agency (SMA) approves the processes and templates related to PCSPs and conducts a retrospective review of a sample of PCSPs annually.**

The PASSE's care coordinator is responsible for scheduling and coordinating the PCSP development meeting. As part of this responsibility the care coordinator must ensure that anyone the member wishes to be present is invited. Typically, the development team will consist of the member and their caregivers, the care coordinator, service providers, professionals who have conducted assessments or evaluations, and friends and persons who support the member. The care coordinator must ensure that the member does not object to the presence of any participants to the PCSP development meeting. If the member or the caregiver would like a party to be present, the care coordinator is responsible for inviting that individual to attend.

During the PCSP development meeting, everyone in attendance is responsible for supporting and encouraging the member to express their wants and desires and to incorporate them into the PCSP when possible. The care coordinator is responsible for managing and resolving any disagreements which arise during the PCSP development meeting.

After enrollment, and prior to the PCSP development meeting, the care coordinator must conduct a health questionnaire with the member. The care coordinator must also secure any other information that may be needed to develop the PCSP, including, but not limited to:

a) Results of any evaluations that are specific to the needs of the member;
b) The results of any psychological testing;
c) The results of any adaptive behavior assessments;
d) Any social, medical, physical, and mental health histories; and
~~e) A~~a risk assessment.

The PCSP development team must utilize the results of the independent assessment, the health questionnaire, and any other assessment information gathered. The PCSP must include the member's goals, needs (behavioral, developmental, and health needs), and preferences. All needed services must be noted in the PCSP and the care coordinator is responsible for coordinating and monitoring the implementation of the PCSP.

The PCSP must be developed within 60 days of enrollment into the PASSE. At a minimum, the PCSP must be updated annually.

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Before a member can access HCBS state plan services, they must be enrolled in a PASSE under the 1915 (b) Provider Led Shared Savings Entities Waiver. The PASSE is responsible for providing all needed services to all enrolled members and may limit a member's choice of providers based on its provider network. The provider network must meet minimum adequacy standards set forth in the 1915(b)Waiver, the PASSE Provider Manual, and the PASSE Pprovider Aagreement.

The member has 90 days after initial enrollment to change their assigned PASSE. Once a year, there is an 30-day open enrollment period that lasts at least 30 days, in which the member may change his or hertheir PASSE for any reason. At any time during the year, a member may change his or her their PASSE for cause, as defined in 42 CFR 438.56.

The State has a DHS PASSE UnitBeneficiary Support Office to assist the member in changing PASSE's, including informing the member of their rights regarding choosing another PASSE and how to access information on each PASSE's provider network. The Beneficiary Support Office will begin reaching out to a beneficiary once it is determined he or she meets the qualifications to be enrolled in a PASSE.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

DAABHS, DMS, or the External Quality Review Organization (EQRO) arranges for a specified number of service plans to be reviewed annually, using the sampling guide, "A Practical Guide for Quality Management in Home and Community-Based Waiver Programs," developed by Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample. The sample size is based on a 95% confidence interval with a margin of error of +/- 8%. An online calculator is used to determine the appropriate sample size for the Waiver population. To determine the "nth" integer, the sample is divided by the population. Names are drawn until the sample size is reached.

DMS or the EQRO then requires theThe PASSE is required to submit the PCSP for all individuals in the sample. DAABHS DMS or the EQRO conducts a retrospective review of provided PCSPs based on identified program, financial, and administrative elements critical to quality assurance. DAABHS DMS or the EQRO reviews the plans to ensure they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the member, and for financial and utilization components. DMS or the EQRO communicates findings from the review to the PASSE for remediation. Systemic findings may necessitate a change in policy or procedures. A pattern of non-compliance from one PASSE may result in sanctions to that PASSE under the PASSE Provider Manual and Provider Agreement.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

	Medicaid agency		Operating agency		Case manager
X	Other (*specify*):	The PASSE			

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

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

~~Helps members acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany members on interviews and providing ongoing support and/or on-the-job training once the member is employed. This service replaces traditional vocational approaches that provide immediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society~~Supportive Employment is designed to help members acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany members ~~and as~~on interviews and providing ongoing support and/or on-the-job training once the ~~client~~member is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate members from mainstream society.

Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, trainingand systematic instruction, job coaching, benefits and work-incentives planning and management, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the ~~client~~ member to be successful in integrating into the job setting.

Services may be provided in integrated community work settings in the general workforce. Services may be provided in the home when provided to establish home-based self-employment. Services maybe provided in either a small group setting or on an individual basis.

Transportation is not included in the rate for this service.

Supported employment must be competitive, meaning that wages must be at or above the State's minimum wage or at or above the customary wage and level of benefits paid by the employer for thesame or similar work.

Service settings may vary depending on individual need and level of community integration, and may include the member's home.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

~~Persons with Developmental Disabilities and Behavioral Health Diagnoses~~		

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

	Participant-directed	☑	Provider managed

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

Service Title: Behavior Assistance

Service Definition (Scope)*:*

A specific outcome oriented intervention provided individually or in a group setting with the member and/or their caregivers that will provide the necessary support to attain the goals of the PCSP and the behavioral health treatment plan. Service activities include applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The service activity should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

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

Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title:	Adult Rehabilitation Day Treatment

Service Definition (Scope):

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

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

~~Adult rehabilitation day treatment includes training and assistance to live in and maintain a household of their choosing in the community. In addition, activities can include transitional services to assist clients after receiving a higher level of care. The goal of this service is to promote and maintain community integration.~~

~~Adult rehabilitative day treatment is a~~An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified ~~-~~ beneficiaries~~-~~ that are aimed at long-term recovery and maximization of self-sufficiency~~.~~, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person and family centered, recovery based, culturally competent, and provided needed accommodation for any disability and must have measurable outcomes.~~These activities must also have measurable outcomes directly related to themembers PCSP. Day treatment~~ These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness.

The intent of these services is to restore the fullest possible integration of the ~~client~~ beneficiary as an active and productive ~~client~~ member of his or her family, social and work community and/or culture with the least amount of ongoing professional intervention.~~ Meals and transportation are not included in the rate for Adult Rehabilitation Day Treatment.~~ Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement the beneficiary's behavioral health treatment plan.

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

~~All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordancewith 1905(r) of the Social Security Act. Meals and transportation are not included in the rate for Adult Rehabilitation Day Treatment.~~

~~Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and~~

~~self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement the member's behavioral health treatment plan or PCSP.~~ ~~Staff to member ratio: 1:15 maximum.~~
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*
☐ Categorically needy *(specify limits):*
None.
☐ Medically needy *(specify limits):*
N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral	DMS	Annually. Proof of

HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~		credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title: Peer Support

Service Definition (Scope)*:*

A person-centered service where adult peers provide expertise not replicated by professional training.

Peer support providers are trained peer specialists who work with members to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Peer support specialists may assist with navigation of multiple systems (housing, support~~ive~~ed employment, supplemental benefits, building/rebuilding natural supports, etc.) which improve the member's functional ability. Services are provided on an individual or group basis~~,~~ and may be provided in the home or the community.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.

☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title: Family Support Partners

Service Definition (Scope)*:*

A service provided by peer counselors, or~~f~~ Family Support Partners (FSP), who model recovery and resiliency for caregivers of children and youth with behavioral health care needs. FSP come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A FSP may assist, teach and model appropriate child-rearing strategies, techniques and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the member's family in securing resources and developing natural supports.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

~~Behavioral Health Diagnoses~~			

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title:	Pharmaceutical Counseling

Service Definition (Scope)*:*

A one-to-one or group intervention by a nurse with member(s) and/or their caregivers, related to their ~~psychopharmalogical~~ psychopharmacological treatment. Pharmaceutical Counseling involves providing medication information orally or in ~~written form~~writing to the member and/or their caregivers. The service should encompass all the parameters to make the member and/or family understand the diagnosis prompting the need for medication and any lifestyle modifications required.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*
☐ Categorically needy *(specify limits):*
None.
☐ Medically needy *(specify limits):*
N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

~~Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~		

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

	Participant-directed	☑	Provider managed

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

Service Title: Supportive Life Skills Development

Service Definition (Scope):

A service that provides support and training for youth and adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the member into their community as they develop their recovery plan or habilitation plan. This service is designed to assist members in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist members in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Services are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

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

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

In a group setting, a ~~client~~ member to staff ratio of 10:1.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):	
☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

~~Diagnoses~~		

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

	Participant-directed	☑	Provider managed

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

Service Title: Child and Youth Support

Service Definition (Scope):

Clinical services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of illness and training the parents in effective interventions and techniques for working with the schools.

Service activities may include an In-Home Case Aide, which is ~~an~~ intensive therapy in the member's home or a community-based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out-of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver

Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~			program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
~~Home and~~ Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title:	Therapeutic Communities

Service Definition (Scope)*:*

A setting that emphasizes the integration of the member within his or her community; progress is

measured within the context of that community's expectation. Therapeutic Communities are highly structured environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the member on their PCSP. Therapeutic Communities employ community-imposed consequences and earned privileges as part of the recovery and growth process. These consequences and privileges are decided upon by the individual ~~beneficiaries~~ members living in the community. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the community setting. Participants and staff members act as facilitators, emphasizing self-improvement. These activities must also have measurable outcomes directly related to the member's PCSP and treatment plan.

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

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Behavioral Health Diagnoses			

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title:	Residential Community Reintegration

Service Definition (Scope)*:*

Serves as an intermediate level of care between Inpatient Psychiatric facilities and outpatient behavioral health services. The program provides 24 hours per day intensive therapeutic care in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied with less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. Community reintegration may be offered as a step-down or transitional level of care to prepare a youth for less intensive treatment.
Residential Community Reintegration programs must ensure (1) there are a minimum of two direct care staff available at all times; and (2) educational services are provided to all beneficiaries enrolled in the program.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*
☐ Categorically needy *(specify limits):*
None.
☐ Medically needy *(specify limits):*
N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

~~Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~		

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

	Participant-directed	☑	Provider managed

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

Service Title: Respite

Service Definition (Scope):

Temporary direct care and supervision for a ~~beneficiary~~ member due to the absence or need for relief of the non-paid primary caregiver. Respite can occur at medical or specialized camps, day-care programs, the member's home or place of residence, the respite care provider's home or place of residence, foster homes, or a licensed respite facility. Respite does not have to be listed in the PCSP.

The primary purpose of Respite is to relieve the member's principal care-giver of the member with a behavioral health need so that stressful situations are de-escalated, and the care-giver and member have a therapeutic and safe outlet. Respite must be temporary in nature. Any services provided for less than fifteen (15) days will be deemed temporary. Respite provided for more than 15 days would trigger a need to review the PCSP.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.
(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

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

Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title:	~~Mobile Crisis Intervention~~Assertive Community Treatment (ACT)

Service Definition (Scope):

~~A face-to-face therapeutic response to a member experiencing a behavioral health crisis for the purpose of identifying, assessing, treating and stabilizing the situation and reducing immediate risk of danger to the member or others consistent with the member's risk management/safety plan, if available. This service is available 24 hours per day, seven days per week, and 365 days per year; and is available after hours and on weekends when access to immediate response is not available through appropriate agencies.~~

~~The service includes a crisis assessment, engagement in a crisis planning process, which may result in the development /update of one or more Crisis Planning Tools (Safety Plan, Advanced Psychiatric Directive, etc.) that contain information relevant to and chosen by the beneficiary and family, crisis intervention and/or stabilization services including on-site face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services and supports, including access to appropriate services along the behavioral health continuum of care.~~

~~The duration of the service is short in nature and should not be any longer than needed to complete the activities listed above.~~

~~Services may be provided in an institutional setting to prevent hospitalization for an acute behavioral health crisis.~~ Assertive Community Treatment (ACT) is an evidence-based practice provided by a multidisciplinary team providing comprehensive treatment and support services available 24 hours a day, seven (7) days a week wherever and whenever needed. Services are provided in the most integrated community setting possible to enhance independence and positive community involvement. An individual appropriate for services through an ACT team has needs that are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community. Typically, this service is targeted to individuals who have serious mental illness or co-occurring disorders, multiple diagnoses, and the most complex and expensive treatment needs.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.

☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Therapeutic Host Homes
Service Definition (Scope):	
A home or family setting that that consists of ~~high~~highly intensive, individualized treatment for the member whose behavioral health or developmental disability needs are severe enough that they would be at risk of placement in a restrictive residential setting. A therapeutic host parent is trained to implement the key elements of the member's PCSP in the context of family and community life, while promoting the PCSP's overall objectives and goals. The host parent should be present at the PCSP development meetings and should act as an advocate for the member.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

~~Behavioral Health Diagnoses~~			

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title: Aftercare Recovery Support ~~Recovery Support Partners~~ (for Substance Abuse)

Service Definition (Scope)*:*

A continuum of care provided to recovering members living in the community based on their level of need. This service includes educating face-to-face monitoring, and supporting the individual with accessing supports and servicesneeded. The service assists the recovering ~~client~~ member to direct their resources and support systems and provide face-to-face supportive services including monitoring of symptoms, assessment of relapse factors and referral when appropriate. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

Support.Aftercare Recovery Support can occur in following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and

- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

All medically necessary 1905(a) services are covered for EPSDT eligible members in accordancewith 1905(r) of the Social Security Act. A continuum of care provided to recovering members living in the community. Recovery Support partners may educate and assist the memberindividual with accessing supports and needed services, including linkages to housing and employment services. Additionally, the Recovery Support Partner assists the recovering member with directing their resources and building support systems. The goal of the Recovery Support Partner is to help the member integrate into the community and remain there.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title: Substance Abuse Detoxification (Observational)

Service Definition (Scope):

A set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize the member by clearing toxins from his or her body. Detoxification (detox) services are short term and may be provided in a crisis unit, inpatient, or outpatient setting. Detox services may include evaluation, observation, medical monitoring, and addiction treatment. The goal of detox is to minimize the physical harm caused by the abuse of substances and prepare the member for ongoing substance abuse treatment.

~~Typically, detox services are provided for less than five (5) days.~~

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title: Partial Hospitalization

Service Definition (Scope):

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and there should be a staff-to-patient ratio sufficient to ensure necessary therapeutic services. Partial Hospitalization may be appropriate as a time-limited response to stabilize acute symptoms, transition (step-down from inpatient), or as a stand-alone service to stabilize a deteriorating condition and avert hospitalization.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for~~	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

~~Persons with Developmental Disabilities and Behavioral Health Diagnoses~~			

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)~~Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses~~	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title: Supportive Housing

Service Definition (Scope)*:*

Supportive Housing is designed to ensure that ~~clients~~ members have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists ~~beneficiaries~~ members in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and ~~fosters independence~~ facilitates the individual's recovery journey.

Supportive Housing includes assessing the members individual housing needs and presenting options,

assistingin securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history), searching for housing, communicating with landlords, coordinating the move, providing training in how to be a good tenant, and establishing procedures and contacts to retain housing.

Supportive Housing can occur in the following:

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

Service settings may vary depending on individual need and level of community integration and may include the beneficiary's members's home.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits)*:

None.

☐ Medically needy *(specify limits)*:

N/A

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Behavioral HealthAgency Or Community Support System Provider (CSSP)Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title:	Crisis Stabilization Intervention

Service Definition (Scope):

Crisis Stabilization Intervention is scheduled face-to-face treatment activities provided to a member who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the member and his/her family.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope

than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

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

Service Title:	Intensive In-Home (IIH)

Service Definition (Scope):

The Intensive In-Home (IIH) service is a team approach that is used to address serious and chronic emotional or behavioral issues for children (youth) who are unable to remain stable in the community without intensive interventions. Services are multifaceted: counseling, skills training, interventions, or resource coordination, and are delivered in the member's home or in a community setting. The parent or caregiver must be an active participant in the treatment and individualized services that are developed in full partnership with the family. IIH team provides a variety of interventions that are available at the time the family needs. These interventions include "first responder" crisis response, as indicated in the care plan: twenty-four (24) hours per day, seven (7) days per week, three hundred

sixty-five (365) days per year. The licensed professional is responsible for monitoring and documenting the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the care plan. The licensed professional then consults with identified medical professionals (such as primary care and psychiatric) and non-medical providers (child welfare and juvenile justice), engages community and natural supports, and includes their input in the care planning process. .
Additional needs-based criteria for receiving the service, if applicable *(specify)*:
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies)*:
☐ Categorically needy *(specify limits)*:
None.
☐ Medically needy *(specify limits)*:
N/A

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

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

	Participant-directed	☑	Provider managed

2. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

a) Relatives may be paid to provide HCBS services, provided they are not the parent, legally responsible individual, or legal guardian of the member.

b) The HCBS services that relatives may provide are: supported employment, peer support, family support partners, therapeutic host home, life skills development, and respite.

c) All relatives who are paid to provide the services must meet the minimum qualifications set forth in ~~this~~ ~~Waiver~~ in the states certification policy which include a minimum of a high school diploma, background checks and training specific to the population and service provided and may not be involved in the development of the Person Centered Service Plan (PCSP).

d) These individuals must be monitored by the PASSE to ensure the delivery of services in accordance with the PCSP. Each month, the care coordinator will monitor the delivery of services and check on the welfare of the member.

e) Payments are not made directly from the Medicaid agency to the relative. Instead, the State pays the PASSE a per member per month (PMPM) prospective payment for each attributed member. The PASSE may then utilize qualified relatives to provide the service.

Participant-Direction of Services

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

Election of Participant-Direction. (S*elect one):*

⊙	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):**

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

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

3. **Participant-Directed Services**. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. **Financial Management.** (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

5. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

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

8. Opportunities for Participant-Direction

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

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

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

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

Quality Improvement Strategy

Quality Measures

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

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

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

3. **Providers meet required qualifications.**

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

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

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

~~7.~~

~~8.~~6. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

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

Requirement		Requirement 1: Service Plans Address Needs of Participants, are reviewed annually and document choice of services and providers.
Discovery		
	Discovery Evidence *(Performance Measure)*	The percentage of PCSPs developed by PASSE Care Coordinators that ~~Meet~~ which provide 1915(i) State Plan HCBS that meet the requirements of 42 CFR §441.725. Numerator: Number of PCSPs that adequately and appropriately address the ~~beneficiary's~~ **~~client~~member**'s needs. Denominator: Total Number of PCSPs reviewed.
	Discovery Activity *(Source of Data & sample size)*	A representative sample will be used based on the sample size selected for PCSP review by DAABHS or EQRO ~~DMS.~~ The sample size will be determined using a confidence interval of 95 percent confidence level and +/- 5 percent margin of error.~~95% with a margin of error of +/- 8%.~~ The data will be derived from the PASSE and must include copies of the PCSP and

		all updates, the Independent Assessment, the health questionnaire and other documentation used at the PCSP development meeting.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~DMS~~ DAABHS ~~, DMSand theor~~ the EQRO~~.~~
	Requirement	Requirement 1: Service Plans
	Frequency	Sample will be selected and reviewed ~~annually.~~quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PASSE will be responsible for remediating deficiencies in PCSPs/treatment plans of their ~~attributed beneficiaries.~~members. If there is a pattern of deficiencies noticed, action will be taken against the PASSE, up to and including, instituting a corrective action plan or sanctions pursuant to the PASSE Provider Agreement and the Medicaid Provider Manual~~.~~
	Frequency *(of Analysis and Aggregation)*	Findings~~Data will be and findings~~ will be reported to the PASSE ~~annually~~ on a quarterly basis. If a pattern of deficiency is noted, this may be made public.

Requirement	Requirement 2: Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence One *(Performance Measure)*	All clients must be independently assessed in order to qualify for 1915(i) State plan HCBS eligibility. There are system edits in place that will not allow those who have not received an independent assessment to received 1915(i) State Plan HCBS. In order to maintain eligibility for 1915(i) State plan HCBS, the ~~beneficiary client~~member must be re-assessed on an annual basis. Numerator: The number of clients who are evaluated and assessed for eligibility within 14 days after the date of successful contact. ~~-~~Denominator: The total number of clients~~beneficiaries~~ who are referred for the 1915(i) HCBS State Plan Services. ~~The percentage of beneficiaries members who were found to meet the eligibility criteria and to have been assessed for eligibility in a timely manner and without undue delay.~~ ~~Numerator: The number of beneficiaries members who are evaluated and assessed for eligibility.~~ ~~Denominator: The total number of beneficiaries members who are identified for the~~

	~~1915(i) HCBS State Plan Services eligibility process.~~
Discovery Activity One *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error ~~100% sample of~~of 100% of the application packets for ~~beneficiaries~~ members who undergo the eligibility process will be reviewed for compliance with the timeliness standards. The data will be collected from the Independent Assessment Vendor, a documented mental health diagnosis, ~~the DDS Psychology Unit,~~ and/or the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**~~DMS~~ DHS PASSE Unit , DMS Waiver Compliance Unit, ~~and the~~or the EQR~~O~~O**
Discovery Evidence Two	The Percentage of ~~beneficiaries~~ members for whom the appropriate eligibility process and instruments were used to determine initial eligibility for HCBS State Plan Services. Numerator: Number of members~~beneficiaries~~' application packets that reflect appropriate processes and instruments were used. Denominator: Total Number of application packets reviewed.
Discovery Activity Two	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% ~~100% sample~~ of the application packets for ~~beneficiaries~~ members who went through the eligibility determination process will be reviewed. The data will be collected from the Independent Assessment Vendor, the DDS Psychology Unit, and/or the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibility	**DHS PASSE Unit~~DMS~~ or~~and~~ the EQRO ~~EQRO~~**
Discovery Evidence Three	The percentage of members~~beneficiaries~~ who are re-determined eligible for HCBS State Plan Services before their annual PCSP expiration date. Numerator: The number of ~~beneficiaries~~ members who are re-determined eligible timely (before expiration of PCSP). Denominator: The total number of ~~beneficiaries~~ members re-determined eligible for HCBS State Plan Services.
Discovery Activity Three	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100%~~A 100% sample~~ of the application packets for ~~beneficiaries~~ members who went through the eligibility re-determination process will be reviewed. The data will be collected from the Independent Assessment Vendor, the DDS Psychology Unit, and/or the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibilities	DHS PASSE Unit or ~~DMS and/or~~ the EQRO

	Requirement	Requirement 2: Eligibility Requirements
	Frequency	Sample will be selected and reviewed quarterly.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	For DDS determinations: The Psychology Unit Manager reviews 100% of all applications submitted within the previous quarter for process and instrumentation review. If a pattern of deficiency is found, the Psychology Unit Manager works with the Psychology Staff to develop a corrective action plan, to be implemented within 10 days. Results are tracked and submitted to the appropriate DMS office quarterly, along with any corrective action plans. For Independent Functional Assessments: The Independent Assessment Vendor is responsible for developing and implementing a quality assurance process, which includes monitoring for accuracy, data consistency, integrity, and completeness of assessments, and the performance of staff. This must include a desk review of assessments with a statistically significant sample size. Of the reviewed assessments, 95% must be accurate. The Independent Assessment Vendor submits monthly reports to ~~DHS's~~ DMS's Independent Assessment ~~contract monitor~~Contract Manager. When deficiencies are noted, a corrective action plan will be implemented with the Vendor. For the DHS Dual Diagnosis Evaluation Committee: The Committee will examine all application packets ~~reviewed to ensure review was timely and accurate~~. The Committee will submit quarterly reports to the appropriate DMS staff; these reports will identify any systemic deficiencies and corrective action that will be taken. If corrective action was taken in the previous quarter, the quarterly report will update DMS on the implementation of that corrective action plan.
	Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.

	Requirement	Requirement 3: Providers meet required qualifications.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent~~age~~ of providers certified and credentialed by ~~the PASSE~~DPSQA. Numerator: Number of provider agencies that obtained annual certification in accordance with DPSQA's~~APASSE's~~ standards. Denominator: Number of HCBS provider agencies reviewed.
	Discovery Activity *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% ~~100%~~ of HCBS providers credentialed by the PASSEs will be reviewed ~~by DMS or its agents during the annual readiness review~~by the Division of Provider Services and Quality Assurance(DPSQA)~~annually.~~. ~~-~~ Without this certification, the provider cannot enroll or continue to be enrolled in Arkansas Medicaid.
	Monitoring Responsibilities *(Agency or entity*	DMS ~~and the EQRO~~Waiver Compliance Unit

	that conducts discovery activities)	
	Requirement	Requirement 3: Providers meet required qualifications.
	Frequency	Annually~~, during readiness review.~~
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Remediation associated with provider credential and certification that is not current would include additional training for the PASSE, as well as remedial or corrective action, including possible recoupment of PMPM payments. Additionally, if a PASSE does not pass the annual readiness review, enrollment in the PASSE may potentially be suspended.
	Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported annually.

Requirement	Requirement 4: Settings that meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of provider owned apartments or homes that meet the home and community-based settings requirements. **Numerator: Number of provider owned apartments and homes, , respite providers, therapeutic host homes, and supportive housing providers that are reviewed by DMS or its agents.** Denominator: Number of provider owned apartments and homes, , **respite providers, therapeutic host homes, and supportive housing providers** that meet the HCBS Settings requirements in 42 CFR 441.710(a)(1) & (2). ~~Numerator: Number of provider owned apartments and homes that are reviewed by the DMS Settings review teams.~~
Discovery Activity *(Source of Data & sample size)*	Review of the Settings Review Report sent to the PASSEs. The reviewed apartments or homes will be randomly selected. A typical review will consist of at least 10% of each PASSE providers' apartments and homes (if they own any) each year.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~DMS~~**DPSQA** ~~and~~ **or** the EQRO
Requirement	Requirement 4: Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Frequency	~~Provider owned homes and apartments will be reviewed and the report compiled~~

		~~annually.~~Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PASSE will be responsible for ensuring compliance with HCBS Settings requirements. If there is a pattern of deficiencies noticed by DMS or its agents, action will be taken against the PASSE, up to and including, instituting a corrective action plan or sanctions pursuant to the PASSE Provider Agreement.
	Frequency *(of Analysis and Aggregation)*	Annually.

Requirement	Requirement 5: The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent~~age~~ of policies developed must be promulgated in accordance with the DHS agency review process and the Arkansas Administrative Procedures Act (APA). Numerator: Number of policies ~~and procedures~~ appropriately promulgated in accordance with agency policy and the Arkansas Administrative Procedures Act (APA); Denominator: Number of policies ~~and procedures~~ promulgated. ~~Number and percentage of policies developed must be promulgated in accordance with the DHS agency review process and the Arkansas Administrative Procedures Act (APA). Numerator: Number of policies and procedures appropriately promulgated in accordance with agency policy and the APA; Denominator: Number of policies and procedures promulgated.~~
Discovery Activity *(Source of Data & sample size)*	100% of policies developed must be reviewed for compliance with the agency policy and the APA.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS ~~and the EQRO~~Waiver Compliance Unit
Requirement	Requirement 5: The SMA retains authority and responsibility for program authority and oversight.
Frequency	~~Continuously, and as needed, as each policy is developed and promulgated.~~Annually
Remediation	
Remediation	DMS~~HS~~'s policy unit is responsible for compliance with Agency policy and with

	Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	the APA. In cases where policy or procedures were not reviewed and approved according to DHS policy, remediation includes DHS review of the policy upon discovery, and approving or removing the policy.
	Frequency *(of Analysis and Aggregation)*	Each policy will be reviewed for compliance with applicable DHS policy and the APA.

Requirement		Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) ~~participants~~ members by qualified providers.
Discovery		
	Discovery Evidence One *(Performance Measure)*	Number and percent of encounter claims reviewed that are coded and paid in accordance with the reimbursement methodology specified and only for services rendered. Numerator: Number of encounter claims reviewed that are coded and paid in accordance with the reimbursement methodology specified and only for services rendered. Denominator: Number of encounter claims reviewed. ~~Number and percentage of services delivered and paid for with the PMPM as specified by the member's PCSP. Numerator: Number of provider agencies reviewed or investigated who delivered and paid for services as specified in the PCSP. Denominator: Total number of provider agencies reviewed or investigated~~.
	Discovery Activity One *(Source of Data & sample size)*	Utilization review of a random sampling of member's services will be conducted to compare services delivered to the member's PCSP.
	Discovery Evidence Two	Each PASSE meets its own established Medical Loss Ratio (MLR). Numerator: Number of PASSE's that meet the MLR; Denominator: Total number of PASSE's
	Discovery Activity Two	The PASSE must report its MLR on the Benefits Expenditure Report ~~,~~ required to be submitted to DMS on a quarterly basis.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~DMS and the EQRO~~ DAABHS, DMS or the EQRO
	Requirement	Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
	Frequency	Quarterly.
Remediation		

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~DMS's IDSR Office~~DHS's PASSE Unit and its agents are responsible for oversight of the PASSE's including review of the quarterly Beneficiary Expenditure Report, the MLR, and the utilization review.
Frequency *(of Analysis and Aggregation)*	Data will be gathered quarterly.

Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Numerator: Number and percent of HCBS Providers meeting requirement for Abuse, neglect, and exploitation training compliant with State Law provider agreements evidenced by attendance documents. Denominator: Number of HCBS providers. ~~Number and percentage of HCBS Provider entities that meet criteria for abuse and neglect, including unexplained death, training for staff. Numerator: Number of provider agencies investigated who complied with required abuse and neglect training, including unexplained death set out in the Waiver and the PASSE provider agreement; Denominator: Total number of provider agencies reviewed or investigated.~~
Discovery Activity *(Source of Data & sample size)*	During the review or investigation of Arkansas Medicaid enrolled HCBS providers, DPSQA ensures that appropriate training is in place regarding unexplained death, abuse, neglect, and exploitation for all PASSE Providers. ~~100% of PASSE training records will be reviewed at the annual readiness review; additionally, training records for individual HCBS providers or employees may be reviewed when there is a compliant of abuse or neglect.~~
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~DMS and the EQRDPSQAO~~DMS Waiver Compliance Unit
Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
Frequency	Annually, and continuously, as needed, when a compliant complaint is received.
Remediation	
Remediation Responsibilities *(Who corrects,*	DQPSA will investigate all complaints regarding unexplained death, abuse, neglect, and exploitation.~~DMS's PASSE unit and its agents are responsible for oversight of the PASSE's including readiness review. This review will include an~~

	analyzes, and aggregates remediation activities; required timeframes for remediation)	~~audit of all training records.~~
	Frequency *(of Analysis and Aggregation)*	Data will be gathered annually. ~~at readiness review.~~ Individual Provider training records will be reviewed ~~at the time of any complaint investigation~~as necessary.

Requirement		Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
Discovery		
	Discovery Evidence One *(Performance Measure)*	Number and percent~~age~~ of PASSE Care Coordinators and HCBS Providers who reported critical incidents to DMS or DDS within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Total number of critical incidents that occurred and were reviewed.
	Discovery Activity One *(Source of Data & sample size)*	DMS and DDS will review all the critical incident reports they receive on a quarterly basis.
	Discovery Evidence Two	Number and ~~P~~percent~~age~~ of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions. Numerator: Number of HCBS providers who adhered to PASSE policies for the use of restrictive interventions as documented on an incident report~~Number of incident reports reviewed where the Provider adhered to PASSE policies for the use of restrictive interventions~~; Denominator: Number of individuals for whom the provider utilized restrictive intervention as documented on an incident report.
	Discovery Activity Two	DMS, DPSQA and DDS will review the critical incident reports regarding the use of restrictive interventions and will ensure that PASSE policies were properly implemented when restrictive intervention was used.
	Discovery Evidence Three	Number and percent of PASSE Care Coordinators and Waiver Providers who reported critical incidents within required time frames. Numerator: Number of PASSE Care Coordinators and waiver providers who reported critical incidents within required time frames; Denominator: Total number of critical incidents. ~~Percentage of PASSE Care Coordinators and HCBS Providers who took corrective actions regarding critical incidents to protect the health and welfare of the member. Numerator: Number of critical incidents reported when PASSE Care Coordinators and HCBS Providers took protective action in accordance with State Medicaid requirements and policies; Denominator: Number of critical incidents reported.~~

	Discovery Activity Three	DMS, DPSQA and DDS will review the critical incident reports received to ensure that PASSE policies were adequately followed and steps were taken to ensure that the health and welfare of the member was ensured.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS ~~and the EQRO~~or the EQRO

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

By using encounter data, the State will have the ability to measure the amount of services provided compared to what is described within the Person Centered Service Plan (PCSP) that is required for members ~~individuals~~ receiving HCBS State Plan services. The state will utilize the encounter data to monitor services provided to determine a baseline, median and any statistical outliers for those service costs.
Additionally, the state will monitor grievance and appeals filed with the PASSE regarding HCBS State Plan services under the broader Quality Improvement Strategy for the 1915(b) PASSE Waiver.

2. Roles and Responsibilities

The State will work with an External Quality Review Organization~~s~~ (EQRO) to assist with analyzing the encounter data and data provided by the PASSEs on their quarterly reports.

The ~~State's Beneficiary Support Team~~DHS PASSE ~~team~~ unit will proactively monitor service provision for individuals who are receiving 1915(i) services. Additionally, the team will review PASSE provider credentialing and network adequacy.

3. Frequency

Encounter data will be analyzed quarterly by the ~~State~~ DHS PASSE unit and annually by the EQRO.

Network adequacy will be monitored ~~on an ongoing basis~~quarterly.

4. Method for Evaluating Effectiveness of System Changes

The ~~State~~ DHS PASSE Unit will utilize multiple methods to evaluate the effectiveness of system changes. These may include site reviews, contract reviews, encounter data, ~~grievance reports~~complaints, and any other information that may provide a method for evaluating the effectiveness of system changes.

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

~~The~~ DAABHS or the EQRO ~~State~~ will randomly audit each PCSP that is maintained by each PASSE to ensure compliance.

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

Administration and Operation

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

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

Partial Hospitalization; Adult Rehabilitative Day Treatment; Supported Employment; Supportive Housing; Adult Life Skills Development; Therapeutic Communities; Peer Support; **Respite; Crisis Stabilization and Intervention; Assertive Community Treatment; and** Aftercare Recovery Support

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

***Select one*:**

x	**Not applicable**
~~x~~	**Applicable**
Check the applicable authority or authorities:	
	Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
	Waiver(s) authorized under §1915(b) of the Act *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
Specify the §1915(b) authorities under which this program operates (*check each that applies*):	
	§1915(b)(1) (mandated enrollment to managed care)
	§1915(b)(3) (employ cost savings to furnish additional services)
	§1915(b)(2) (central broker)
	§1915(b)(4) (selective contracting/limit number of providers)
	A program operated under §1932(a) of the Act. *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
~~X~~	**A program authorized under §1115 of the Act.** *Specify the program*: ~~Arkansas Works~~

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

~~X~~	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	~~X~~	The Medical Assistance Unit *(name of unit)*:	The Division of Medical Services (DMS)
		Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
X	The State plan HCBS benefit is operated by *(name of agency)*		
	Division of Aging, Adult and Behavioral Health Services (DAABHS)		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non- State Entity
1. Individual State plan HCBS enrollment	☑			
2. Eligibility evaluation	☑			
3. Review of participant service plans	☑		☑	
4. Prior authorization of State plan HCBS	☑		☑	
5. Utilization management	☑		☑	
6. Qualified provider enrollment	☑			
7. Execution of Medicaid provider agreement	☑			

8. Establishment of a consistent rate methodology for each State plan HCBS	☑		☑	
9. Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑			
10. Quality assurance and quality improvement activities	☑		☑	

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

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

The contracted actuary will assist with 8.

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

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	~~Jan.~~ 1, 20~~19~~ January 1, 2023	~~Dec.~~ 31, ~~2019~~ December 31, 2023	~~2,000~~**500**
Year 2	~~Jan. 1, 2020~~January 1, 2024	~~Dec. 31, 2020~~December 31, 2024	
Year 3	~~Jan. 1, 2021~~January 1, 2025	~~Dec. 31, 2021~~December 31, 2025	
Year 4	~~Jan. 1, 2022~~January 1, 2026	~~Dec. 31, 2022~~December 31, 2026	
Year 5	~~Jan. 1, 2023~~January 1, 2027	~~Dec. 31, 2023~~December 31, 2027	

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

Financial Eligibility

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

2. Medically Needy (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.

☑ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

	Directly by the Medicaid agency
X	By Other (*specify State agency or entity under contract with the State Medicaid agency*): Evaluations and re-evaluations are conducted by DHS's ~~third-party contractor~~**contracted vendor** who completes the independent assessment. Eligibility is determined by ~~DMS~~ using the results of the independent assessment and the **client's**~~individual's~~ diagnosis~~es~~.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the ~~individual~~ **client** responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

For the behavioral health population, the assessor must have:
a. Bachelor's Degree (in any subject) or be a registered nurse,
b. One (1) year of experience with mental health populations.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether **clients**~~individuals~~ meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Behavioral Health clients:
1) Must have a documented behavioral health diagnosis, made by a ~~physician~~**physician/Advanced Practice Registered Nurse (APRN),** and contained in the **client's**~~individual~~'s medical record; and
2) Must have been determined a Tier 2 or Tier 3 by the independent assessment of functional need related to diagnosis.

Behavioral health clients must undergo the Independent Assessment and be determined a Tier 2 or Tier 3 annually.

Clients~~Individuals~~ **who meet Medicaid eligibility criteria, financial eligibility for 1915 (i) and 1915 (i) needs based eligibility** are referred for the independent assessment based upon their current diagnosis and utilization of services. After completion of the independent assessment of functional need, **DAABHS**~~DMS~~ makes the eligibility determination for all clients based on the results of the independent assessment and the individual's diagnosis contained in his or her medical record. Eligibility is re-evaluated on an annual basis. **Reassessments may be conducted in person or through the use of interactive video that is recorded with the permission of the client or telephonically that is recorded with the permission of the client and the approval of the respective DHS program staff.**

4. ☑ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the client's~~individual's~~ support needs, and may include other risk factors: *(Specifythe needs-based criteria):*

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

~~For the behavioral health population: .The individual must receive a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services~~.
The needs based criteria is used to evaluate and reevaluate eligibility for State plan HCBS. The evaluation consists of a tool developed to determine functional deficits related to a behavioral health diagnosis. **The tool** measures the **client's** behavior in psychosocial sub-domains and intervention domain and the level of intervention necessary to managed behaviors as well as required supports to maintain **client** in home and community settings. The domains are: adaptive, personal/social, communication, motor, and cognitive. The functional evaluation takes into account the **client's** ability to provide his or her own support, as well as other natural support systems, as well as the level of need to accomplish ADLs and IADLs.
Tier logic was developed to evaluate the need for HCBS and produces a tier score of 1, 2, or 3. Individuals that receive a score of Tier 2 or Tier 3 are eligible for State plan HCBS. The same tool is used for initial evaluation and re-evaluation.

~~To receive at least a Tier 2, the individual must have difficulties with certain behaviors that require a full array of non-residential services to help with functioning in home and community-based settings and moving towards recovery. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.~~

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

~~The domains are: adaptive, personal/social, communication, motor, and cognitive. The functional assessment takes into account the~~ **client's**~~individuals' ability to provide his or her own support, as well as other natural support systems, as well as the level of need to accomplish ADLs and IADLs.~~

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

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, **clients**~~individuals~~ receiving institutionalservices and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chartbelow to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)

For the behavioral health population: The ~~individual~~ **client** must receive a Tier 2 or Tier 3 on the functional ~~assessment~~ evaluation for HCBS behavioral health services. To receive at least a Tier 2, the **client**~~individual~~ must have difficulties with certain behaviors that require a full array of non- residential services to help with functioning in home and community-based settings and moving towards recovery. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.	Must meet at least one of the following three criteria as determined by a licensed medical professional: 1. The **client**~~individual~~ is unableto perform either of the following: A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or, B. At least two (2) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without limited assistance from another person; or,	1) Diagnosis of developmental disability that originated prior to age of 22; 2) The disability has continued or is expected to continue indefinitely; and 3) The disability constitutes a substantial handicap to the person's ability to function without appropriate support services, including but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training	There must be a written certification of need (CON) that states that a **client**~~n individual~~is or was in need of inpatient psychiatric services. The certification must be made at the time of admission, or if a~~n~~ **client** ~~individual~~ applies for Medicaid while in the facility, the certification must be made before Medicaid authorizes payment. Tests and evaluations used to certify need cannot be more than one (1) year old. All histories and information used to certify need must have been compiled within the year

The domains are: adaptive, personal/social, communication, motor, and cognitive. The functional ~~assessment~~ evaluation takes into account the client~~individual~~s' ability to provide his or her own support, as well as other natural support systems, as well as the level of need to accomplish ADLs and IADLs. 1915(i) services must be appropriate to address the client~~individual~~'s identified functional deficits due to their behavioral health diagnosis.	2. The client~~individual~~ has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another client~~individual~~ because he or sheengages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or, 3. The client~~individual~~ has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening. 4. No client~~individual~~ who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that client~~individual~~ shall not receive waiver services or benefits when subject to a condition or change of condition which would render the client~~individual~~ ineligible if expected to last more than twenty-one (21) days.	and employment. Must also be in need of and able to benefit from active treatment and unable to access appropriate services in a less restrictive setting.	prior to the CON. In compliance with 42 CFR 441.152, the facility-based and independent CON teams must certify that: A. Ambulatory care resources available in the community do not meet the treatment needs of the client~~beneficiary~~; B. Proper treatment ofthe ~~beneficiary's~~ client's psychiatric condition requires inpatient services under the direction of a physician and C. The services can be reasonably expected to prevent further regression or to improve the ~~beneficiary's~~ client's condition so that the services will no longer be needed. Specifically, a physician must make a medical necessity determination that services must be provided in a hospital setting because the client cannot safely remain in the community setting.

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

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The State will target this 1915(i) State plan HCBS benefit to clients~~individual~~s in the following eligibilitygroups:

1.) **Clients**~~Individual~~s who qualify for Medicaid through spend-down eligibility.

~~2.) Adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and covered under the Arkansas Section 1115 Demostrative Waiver ("Arkansas Works") who are determined to be "Medically Frail".~~

The 1915(i) State plan HCBS benefit is targeted to ~~individualss~~ **clients** with a behavioral health diagnosis whohave high needs as indicated on a functional assessment.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of **client**~~individual~~s or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible **clients**~~individuals~~ within the initial 5-year approval. *(Specify the phase-in plan):*

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

8. ☑**Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. ☑ **Reasonable Indication of Need for Services.** In order for an **client**~~individual~~ to be determined to need the 1915(i) State plan HCBS benefit, a **client**~~n individual~~ must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the **client**~~participant~~ requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that a **client**~~n individual~~ mustrequire in order to be determined to need the 1915(i) State plan HCBS benefit is: One.
ii.	**Frequency of services.** The state requires (select one):
X	**The provision of 1915(i) services at least monthly**
	Monthly monitoring of the individual when services are furnished on a less than monthly basis If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

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

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to **client**~~individual~~s who reside and receive HCBS in their home or in the community, not in an institution.

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

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

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of **clients**~~individual~~s determined to be eligible for the State plan HCBSbenefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each **client**~~individual~~ determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the **client**~~individual~~'s circumstances or needs change significantly, and at the request of the **client**~~individual~~.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the **clients**~~individuals~~ who will be responsible for conducting the independent assessment, including specific training in assessment of **client**~~individual~~s with need for HCBS. *(Specify qualifications):*

   For the behavioral health population, the assessor must have:
   a. Bachelor's Degree (in any subject) or be a registered nurse,
   b. One (1) year of experience with mental health populations.

5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

   Allowable practitioners that can develop the PCSPand~~/~~ Treatment Plan are:

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

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

6. **Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the ~~participants~~ **client's** authority to determine who is includedin the process):*

   During the development of the **Person-Centered Service Plan**/Treatment Plan for the individual, everyone in attendance is responsiblefor supporting and encouraging the **client** ~~member~~ to express their wants and desires and to incorporate them into the **PCSP and**Treatment Plan when possible.

The **PCSP** Treatment Plan is a plan developed in cooperation with the ~~beneficiary~~ **client** to deliver specific mental health services to restore, improve, or stabilize the ~~beneficiary's~~ **client's** mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the **client**~~beneficiary~~, and time limitations for services. The plan must be congruent with the age and abilities of the ~~beneficiary~~**client**, ~~client~~**person**-centered and strength-based; with emphasis on needs as identified by the ~~c~~beneficiary **client** and demonstrate cultural competence. The State Medicaid Agency (SMA) retains administrative authority and the process for making PCSPs may be subject to approval of the SMA.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Each participant has the option of choosing their 1915(i) State plan service provider. If, at any point during the course of treatment, the current provider cannot meet the needs of the participant, they must inform the participant as well as their Primary Care Physician / Person Centered Medical Home

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

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

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

9. **Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

	Medicaid Agency	X	Operating Agency		Case Manager

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Supported Employment
Service Definition (Scope):	
Supported Employment is designed to help **clients** ~~beneficiaries~~ acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany **clients**~~beneficiaries~~ on interviews and providing ongoing support and/or on-the-job training once the **client**~~beneficiary~~ is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate ~~beneficiaries~~ **clients** from mainstream society. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the **client** ~~waiver participant~~ to be successful in integrating into the job setting. Services may be provided in integrated community work settings in the general workforce. Services may be provided in the home when provided to establish home-based self-employment. Services may be provided in either a small group setting or on an individual basis. Transportation is not included in the rate for this service. Supportive~~ed~~ employment must be competitive, meaning that wages must be at or above the State's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work. Service settings may vary depending on individual need and level of community integration, and may include the ~~beneficiary's~~ **client's** home.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):* Quarterly Maximum of Units: 60
☑	Medically needy *(specify limits):*

	Quarterly Maximum of Units: 60		
Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or **Community Support System Provider (CSSP)**	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurance	• Enrolled as a Behavioral Health Agency **or Community Support System Provider (CSSP)** in Arkansas Medicaid • Cannot be on the National or StateExcluded Provider List. Individuals who perform 1915(i) AdultBehavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i)Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider –non-degreed 2. Qualified Behavioral Health Provider –Bachelors 3. Registered Nurse – (Must be licensed asan RN in the State of Arkansas) ~~3.~~4. **Community Support Staff** All performing providers must have successfully complete and document courses of initial training and annual re- training sufficient to perform all tasks assigned by the mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency **Or Community Support System Provider (CSSP)**	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies **and CSSP providers** must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs). **IOCs are also conducted when a complaint is filed.**

Service Delivery Method. *(Check each that applies)*:			
	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Adult Rehabilitation Day Treatment
Service Definition (Scope)*:*	

A continuum of care provided to recovering **clients**~~members~~ living in the community based on their level ofneed. This service includes educating and assisting the **clients**~~member~~s with accessing supports and servicesneeded. The service assists recovering **clients** ~~members~~ to direct their resources and support systems.

Activities include training to assist the **clients** ~~member~~ to improve employability, and to successfully adapt andadjust to a particular environment. Adult rehabilitation day treatment includes training and assistance tolive in and maintain a household of their choosing in the community. In addition, activities can include transitional services to assist **clients**~~members~~ after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

Adult rehabilitative day treatment is an array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified **client**'**s**~~member~~s that are aimed at long-term recovery and maximization of self-sufficiency. These rehabilitative day activities are person and family centered, recovery based, culturally competent, and provided needed accommodation for any disability.These activities must also have measurable outcomes directly related to the **clients**~~beneficiary~~'s treatment plan. Day treatment activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness.

The intent of these services is to restore the fullest possible integration of the **client**~~beneficiary~~ as an active and productive member of his or her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement the **client**~~member~~'s behavioral health treatment plan. Meals and transportation are not included in the rate for Adult Rehabilitation Day Treatment.

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

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

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

Staff to ~~member~~ **client** ratio: 1:15 maximum

Daily Maximum of Units: 6

	Quarterly Maximum of Units: 90
☑	Medically needy *(specify limits)*: Staff to ~~member~~ **client** ratio: 1:15 maximumDaily Maximum of Units: 6 Quarterly Maximum of Units: 90

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Behavioral Health Agency **Or Community Support System Provider (CSSP) (enhanced level)**	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency **or Community Support System Provider (CSSP)** in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) **. Community Support Staff** ~~3.~~ All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional. ~~.~~

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency **Community Support System Provider (CSSP)**	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies **and CSSP Providers** must be re-certified every 3 years as well as maintain national accreditation.
		Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs). **IOCs are also conducted when a complaint is filed.**

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

	Participant-directed	☑	Provider managed

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

Service Title: Adult Skills Development

Service Definition (Scope)*:*

Adult Skills Development services are designed to assist ~~beneficiaries~~ **clients** in acquiring the skills needed tosupport an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., resource and medication management, self-care, household maintenance, health, wellness and nutrition).

Service settings may vary depending on individual need and level of community integration~~,~~ and may include the **client**~~beneficiary~~'s home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

~~The Master Treatment Plan should address the recovery objective of each activity performed under Life Skills Development and Support.~~

Adult Skills Development can occur in following:

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

Transportation is not included in the rate for this service.

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

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

Daily Maximum of Units: 8

Yearly Maximum of Units: 292

☑ Medically needy *(specify limits):*

Daily Maximum of Units: 8

Yearly Maximum of Units: 292

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency **Or Community Support System Provider (CSSP)**	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	1. Enrolled as a Behavioral Health Agency **or Community Support System Provider** in Arkansas Medicaid 2. Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 3. Qualified Behavioral Health Provider –non-degreed 4. Qualified Behavioral Health Provider – Bachelors 5. Registered Nurse – (Must

			be licensed asan RN in the State of Arkansas) **6. Community Support Staff** All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional. ~~1.~~

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency **Or** **Community Support System Provider (CSSP)**	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies **and CSSP Providers** must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly
		on-site inspections of care (IOCs). **IOCs are also conducted when a complaint is filed.**

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

	Participant-directed	☑	Provider managed

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

Service Title:	Partial Hospitalization

Service Definition (Scope)*:*

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of **no more than** 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum: intake, individual therapy, group therapy, and psychoeducation.

Partial Hospitalization shall be at a minimum **of** (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a **client**~~beneficiary~~ receives other services during the week but also receives Partial Hospitalization, the ~~beneficiary~~ **client** must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.

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

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

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Yearly Maximum of Units: 40 A provider may not bill for any other services on the same date of service.
☑	Medically needy *(specify limits):*
	Yearly Maximum of Units: 40 A provider may not bill for any other services on the same date of service.

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

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

Behavioral Health Agency **or CSSP Provider**	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency **or CSSP Provider** in Arkansas Medicaid • Certified by the Division of Provider Services and Quality Assurance as a Partial Hospitalization Provider. • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must be a mental health professional or work under the direct supervision of a mental health professional Allowable performing providers under the direct supervision of a mental health professional providing 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider –non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed asan RN in the State of Arkansas) **4. Community Support Staff** All performing providers under the direct supervision of a mental health professional must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency **or CSSP Provider**	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies **and CSSP Providers** must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies
		are required to have yearlyon-site inspections of care (IOCs). **IOCs are also conducted**

		when a complaint is filed.

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

	Participant-directed	☑	Provider managed

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

Service Title: Therapeutic Communities

Service Definition (Scope):

A setting that emphasizes the integration of the client member within his or her community; progress is measured within the context of that community's expectation. Therapeutic Communities are highly structured environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the clientmember on their treatment planPCSP/and treatment plan. Therapeutic Communities employ community-imposed consequences and earned privileges as part of the recovery and growth process. These consequences and privileges are decided upon by the individualclientsbeneficiaries living in the community. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the community setting. Participants and staff clients membersact as facilitators, emphasizing self-improvement.

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

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

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

Must be determined to be Tier 2 or 3 by the functional independent assessment.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.
(Choose each that applies):

☑ Categorically needy *(specify limits):*

None.

A provider may not bill for any other services on the same date of service.

☑ Medically needy *(specify limits):*

None.

A provider may not bill for any other services on the same date of service.

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

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

Behavioral Health Agency **Or Community Support System Provider (CSSP) (enhanced level)**	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency **or Community Support System Provider** in Arkansas Medicaid • Certified by the Division of Provider Services and Quality Assurance as a Therapeutic Communities Provider. • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) **4.Community Support Staff** All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional. •

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency **Community Support System Provider**	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies **and CSSP provider** must be re-certified every 3years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs). **IOCs are also**

		conducted when a complaint is filed.

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

	Participant-directed	☑	Provider managed

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

Service Title: Supportive Housing

Service Definition (Scope)*:*

Supportive Housing is designed to ensure that **clients** ~~beneficiaries~~ have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports inthe community. This service assists **client**~~beneficiarie~~s in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey.

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

Supportive Housing can occur in following:

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

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Quarterly Maximum of Units: 60
☑	Medically needy *(specify limits):*
	Quarterly Maximum of Units: 60

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

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

Behavioral Health Agency **Or Community Support System Provider (CSSP)**	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency **or Community Support System Provider** in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional.
			Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: . Qualified Behavioral Health Provider – non-degreed . Qualified Behavioral Health Provider – Bachelors . Registered Nurse – (Must be licensed asan RN in the State of Arkansas) . **Community Support Staff** All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency **Or Community Support System Provider (CSSP)**	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies **and CSSP providers** must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs). **IOCs are also conducted when a complaint is filed.**

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

	Participant-directed	☑	Provider managed

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

Service Title:	Peer Support

Service Definition (Scope)*:*

Peer Support is a **person** ~~consumer~~ centered service provided by individuals (ages 18 and older) who self- identifies as a person in recovery from substance abuse and/or mental health challenges and thus is able to provide expertise not replicated by professional training. Certified as a Peer Recovery Specialist. Peer provider specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with **clients** ~~beneficiaries~~ to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with naviga**ting** ~~tion~~ of multiple systems (housing, supported employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact **client** ~~beneficiarie~~s' functional ability. Services are provided on an individual or group basis, and in either the ~~beneficiary's~~ **client's** home or community environment.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Yearly Maximum of Units: 120
☑	Medically needy *(specify limits):*
	Yearly Maximum of Units: 120

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

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

Behavioral Health Agency **Or Community Support System Provider (CSSP)**	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurance	. Enrolled as a Behavioral Health Agency **or Community Support System Provider** in Arkansas Medicaid . Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional **and be certified as Peer Recovery Specialists**. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: . Qualified Behavioral Health Provider – non-degreed ~~.~~4. Qualified Behavioral Health Provider – Bachelors ~~.~~5. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) . **Community Support Staff** All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency **Community Support System Provider**	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies **and CSSP providers**must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs). **IOCs are also**

		conducted when a complaint is filed.

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

	Participant-directed	☑	Provider managed

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

Service Title: Aftercare Recovery Support **(for Substance Abuse)**

Service Definition (Scope):

A continuum of care provided to recovering ~~individuals~~ **clients** living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering ~~individual~~ **client** to direct their resources and support systems. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

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

Aftercare Recovery Support can occur in following:

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

All medically necessary 1905(a) services are covered for EPSDT eligible ~~individuals~~ **clients** in accordancewith 1905(r) of the Social Security Act.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Yearly Maximum of Units: 292
☑	Medically needy *(specify limits):*
	Yearly Maximum of Units: 292

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency **Or Community Support System Provider**	Department of Human Services, Division of Provider Services and Quality Assurance	Behavioral Health Agencies **and CSSPs** must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs). **IOCs are also conducted when a complaint is filed.**

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

	Participant-directed	☑	Provider managed

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

Service Title: **Respite**

Service Definition (Scope):

Temporary direct care and supervision for a client due to the absence or need for relief of the non-paid primary caregiver. Respite can occur at medical or specialized camps, day-care programs, the client's home or place of residence, the respite care provider's home or place of residence, foster homes, or a licensed respite facility. Respite does not have to be listed in the PCSP.

The primary purpose of Respite is to relieve the client's principal caregiver of the client with a behavioral health need so that stressful situations are de-escalated, and the caregiver and client have a therapeutic and safe outlet. Respite must be temporary in nature. Any services provided for less than fifteen (15) days will be deemed temporary. Respite provided for more than 15 days should trigger a need to review the PCSP.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	8 hours with extension of benefits allowed
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency or Community Support System Provider	**N/A**	**Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurance**	• **Enrolled as a Behavioral HealthAgency or Community Support System Provider in Arkansas Medicaid** • **Cannot be on the National or StateExcluded Provider List.** **Individuals who perform 1915(i) AdultBehavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional.**

			Allowable performing providers of 1915(i)Adult Behavioral Health Services for Community Independence are the following: **5. Qualified Behavioral Health Provider –non-degreed** **6. Qualified Behavioral Health Provider –Bachelors** **7. Registered Nurse – (Must be licensed asan RN in the State of Arkansas)** **8. Community Support Staff** **All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.**

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider	**Department of Human Services, Division of Provider Services and Quality Assurance**	**Behavioral Health Agencies and CSSPs must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agenciesare required to have yearly on-site inspections of care(IOCs). IOCs are also conducted when a complaint is filed.**

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

	Participant-directed	☑	Provider managed

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

Service Definition (Scope):

Crisis Stabilization Intervention are scheduled face-to-face treatment activities provided to a client who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the client and his/her family. Activities include therapeutic interventions to stabilize and maintain the individual in home setting and are unique to the client's needs. These services build upon the relationship to the other services being provided to the client.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits)*:
	Daily maximum units: 12; Yearly maximum units: 72
	Medically needy *(specify limits)*:

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Behavioral Health Agency Or Community Support System Provider (CSSP)	**N/A**	**Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurance**	• **Enrolled as a Behavioral HealthAgency or Community Support System Provider in Arkansas Medicaid** • **Cannot be on the National or StateExcluded Provider List.** **Individuals who perform 1915(i) AdultBehavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional.**

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Behavioral Health Agency Or Community Support System Provider (CSSP)	**Department of Human Services, Division ofProvider Services and Quality Assurance**	**Behavioral Health Agencies and CSSPs must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agenciesare required to have yearly on-site inspections of care (IOCs).**

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

	Participant-directed	☑	Provider managed

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

Service Title:	**Assertive Community Treatment**
Service Definition (Scope):	

Assertive Community Treatment (ACT) is an evidence-based practice provided by a multidisciplinary team providing comprehensive treatment and support services available 24 hours a day, seven (7) days a week wherever and whenever needed. Services are provided in the most integrated community setting possible to enhance independence and positive community involvement. An individual appropriate for services through an ACT team has needs that are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community. Typically, this service is targeted to individuals who have serious mental illness or co-occurring disorders, multiple diagnoses, and the most complex and expensive treatment needs.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240,services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	Daily limit: 1; Yearly Maximum: 180
	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Behavioral Health Agency Or Community Support System Provider (CSSP)	**N/A**	**Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurance**	• **Enrolled as a Behavioral HealthAgency or Community Support System Provider in Arkansas Medicaid** • **Cannot be on the National or StateExcluded Provider List.** **Individuals who perform 1915(i) AdultBehavioral Health Services for Community Independence Behavioral Health Services must Work under the direct supervision of a mental health professional.**

			Allowable performing providers of 1915(i)Adult Behavioral Health Services for Community Independence are the following: **. Qualified Behavioral Health Provider –non-degreed** **0. Qualified Behavioral Health Provider –Bachelors** **1. Registered Nurse – (Must be licensed asan RN in the State of Arkansas)** **2. Community Support Staff** **All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional.**

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	**Department of Human Services, Division ofProvider Services and Quality Assurance**	**Behavioral Health Agenciesand CSSPs must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agenciesare required to have yearly on-site inspections of care (IOCs).**

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

	Participant-directed	☑	Provider managed

2. ☑**Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

a) Medicaid Enrolled Behavioral Health Agencies **and Community Support System Providers** are able to provide State Plan HCBS under authority of this 1915(i). Relatives of **clients**~~beneficiaries~~ who are employed by a Behavioral Health Agency **or Community Support System Providers** as a Qualified Behavioral Health Provider or Registered Nurse may be paid to provide HCBS services, provided they are not the parent, legally responsible individual, or legal guardian of the **client**~~member~~.
b) The HCBS services that relatives may provide are: supportive housing, supported employment, adult rehabilitative day treatment, therapeutic communities, partial hospitalization and life skills development.
c) All relatives who are paid to provide the services must meet the minimum qualifications set forth in this 1915(i) and may not be involved in the development of ~~the master treatment plan.~~**the PCSP/ andtreatment plan.**
d) All services are retrospectively/retroactively reviewed for medical necessity. Each Behavioral Health Agency **or Community Support System Provider** is subject to Inspections of Care (IOCs) as well as monitoring by the Office of Medicaid Inspector General.
~~e) Personal care is not an included benefit of this 1915(i) HCBS State Plan.~~

Participant-Direction of Services

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

Election of Participant-Direction. (Select one):

⊙	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

2. **Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.

○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state~~,~~ or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

3. **Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. Financial Management. (*Select one)* :

	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

5. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

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

8. Opportunities for Participant-Direction

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

	The state does not offer opportunity for participant-employer authority.
	Participants may elect participant-employer Authority *(Check each that applies):*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

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

Quality Improvement Strategy

Quality Measures

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

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

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

3. Providers meet required qualifications.

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

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

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

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

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

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

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agentsDAABH,orthe EQRO. and DMS

Requirement	Requirement 1, B: Service Plans
Frequency	When services are approved for medical necessity retrospectively/retroactively.Quarterly **Sample will be selected and reviewed quarterly**
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Behavioral Health Agency **or Community Support System Provider** will be responsible for remediating deficiencies in **PCSP**/ and treatment plan**s** of their beneficiaries.client. If there is a pattern of deficiencies noticed, action may be taken against the Behavioral Health Agency **or Community Support System Provider**, up to and including, instituting a corrective action plan or sanctions pursuant to the Medicaid Provider Manual.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and fFindings will be reported **to the Behavioral Health Agency or Community Support System Provider** on a annuala **quarterly** basis. If a pattern of deficiency is noted, this may be made public.
Requirement	Requirement 2, A: Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence One *(Performance Measure)*	All **clients**beneficiaries must be independently assessed in order to qualify for 1915(i) State plan HCBS eligibility. There are system edits in place that will not allow those who have not received an independent assessment to received 1915(i) StatePlan HCBS. In order to maintain eligibility for 1915(i) State plan HCBS, the beneficiary **client** must be re-assessed on an annual basis. Numerator: The number of **clients**beneficiaries who are evaluated and assessed foreligibility in a timely mannerwithin 14 days. Denominator: The total number of **clients**beneficiaries who are identified for the 1915(i)HCBS State Plan Services eligibility process.
Discovery **Activity One** *(Source of Data & sample size)*	**A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error**A 100% sample **of 100% of** the application packets for **clients**neficiaries who undergo the eligibility process will be reviewed for compliance with the timeliness standards. The data will be collected from the Independent Assessment Vendor.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**DAABHS, or** DMS ~~**or** or its agents or the EQRO~~
Discovery Evidence Two	~~The Percentage of beneficiaries~~ The number and percentage of **clients** for whom the appropriate eligibility process and instruments were used to determine initial eligibility for HCBS State Plan Services. Numerator: Number of **clients** ~~beneficiaries~~' application packets that reflect appropriateprocesses and instruments were used. Denominator: Total Number of application packets reviewed.
Discovery Activity Two	**A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error** ~~**A 100% sample of 100%**~~ of the application packets for **clients** ~~eneficiaries~~ who went through the eligibility determination process will be reviewed. The data will be collected from the Independent Assessment Vendor.
Monitoring Responsibility	**DAABHS or** DMS ~~or its agents.or the EQRO~~
Discovery Evidence Three	The number and percentage of ~~beneficiaries~~**clients** who are re-determined eligible for HCBS State Plan Services before their annual treatment plan expiration date. Numerator: The number of **clients**~~beneficiaries~~ who are re-determined for eligibility timely (before expiration of treatment plan). Denominator: The total number of **clients**~~beneficiaries~~ re-determined eligible for HCBS State Plan Services.
Discovery Activity Three	**A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error** ~~**A 100% sample of a 100%**~~ of the application packets for **clients**~~beneficiaries~~ who went through the eligibility re-determination process will be reviewed. The data will be collected from the Independent Assessment Vendor.
Monitoring Responsibilities	**DAABHS or** DMS ~~or its agents.the EQRO~~
Requirement	Requirement 2~~, B~~: Eligibility Requirements
Frequency	Sample will be selected and reviewed quarterly.
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	For Independent Functional Assessments: The Independent Assessment Vendor is responsible for developing and implementing a quality assurance process, which includes monitoring for accuracy, data consistency, integrity, and completeness of assessments, and the performance of staff. This must include a desk review of assessments with a statistically significant sample size. Of the reviewed assessments, 95% must be accurate. The Independent Assessment Vendor submits monthly reports to DHS's ~~contract monitor~~**Independent Assessment Contract Manager**. When deficiencies are noted, a corrective action plan will be implemented with the Vendor.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.
Requirement	Requirement 3~~, A~~: Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of Behavioral Health Agencies and Community Support System providers certified and credentialed by DPSQA. Numerator: Number of Behavioral Health Agencies and Community Support System providers that obtained annual certification in accordance with DPSQA's standards. Denominator: Number of Behavioral Health Agencies and Community Support System providers reviewed.**~~In order to enroll as a Medicaid provider, a Behavioral Health Agency or Community Support System Provider must be certified by the Division of Provider Services and Quality Assurance.~~ ~~Numerator: Number of Behavioral Health Agencies and Community Support System Providers that currently have Division of Provider Services and Quality Assurance certification.~~ ~~Denominator: Number of Behavioral Health Agencies and Community Support System Providers enrolled in ArkansasMedicaid.~~
Discovery Activity *(Source of Data & sample size)*	**A statistically valid sample utilizing aconfidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error** ~~100%~~ **of 100%** of Behavioral Health Agencies **and Community Support System Providers** will be reviewed to ensure certification by **the** Division of Provider Services and Quality Assurance. Without this certification, the provider cannot enroll or continue to be enrolled in Arkansas Medicaid.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~DMS, DPSQA, or its agents~~**DMS Waiver Compliance Unit**
Requirement	Requirement 3: Providers meet required qualifications.
Frequency	**Annually**
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Remediation associated with provider credentials and certification that is not current would include additional training for the Behavioral Health Agencies and Community Support System providers as well as remedial or corrective action, including possible recoupment of payments. Additionally, if the Behavioral Health Agencies and Community Support System provider does not pass the annual readiness review, treatment/services may potentially be suspended.**
Frequency *(of Analysis and Aggregation)*	**Data will be aggregated and reported annually.**

Requirement	Requirement 4, A: Settings **that** meet the home and community-based setting requirements as specified in this SPA and in accordance with42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	~~Percentage of provider owned apartments or homes that meet the home andcommunity-based settings requirements.~~ Number and percent of provider owned apartments/homes reviewed that meet the home and community-based setting requirements as specified 42 CF 441.710(a)(1) & (2). Numerator: Number and percent of provider owned apartments/homes reviewed that meet the home and community-based setting requirements as specified in specified 42 CF 441.710(a)(1) & (2). Denominator: Total number of provider owned apartment/home settings reviewed ~~Denominator: Number of provider owned apartments and homes that meet theHCBS Settings requirements in 42 CFR 441.710(a)(1) & (2).~~ ~~Numerator: Number of provider owned apartments and homes that are reviewedby the DMS Settings review teams or its contracted vendor.~~
Discovery Activity *(Source of Data &sample size)*	Review of the Settings Review Report sent to the Behavioral Health Agencies. The reviewed apartments or homes will be randomly selected. A typical review will consist of at least 10% of each Behavioral Health Provider's apartments and homes (if they own any) each year.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~DMS~~**DQSQA** or **the EQRO** ~~its agents.~~
Requirement	**Requirement 4: Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Frequency	**Provider owned homes and apartments will be reviewed and the report compiled annually.assert**
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**The Behavioral Health Agencies will be responsible for ensuring compliance with HCBS Settings requirements. If there is a pattern of deficiencies noticed by DMS or its agents, action will be taken against the Behavioral Health Agency, up to and including, instituting a corrective action plan or sanctions pursuant to the Agency Agreement.**
Frequency *(of Analysis and Aggregation)*	**Annually.**

Requirement	Requirement 5~~, A~~: The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	**All must be** ~~Number and percentage of policies developed must be~~ promulgated in accordancewith the DHS agency review process and the Arkansas Administrative ProceduresAct (APA). Numerator: Number and percentage of policies developed that are promulgated in accordance with the DHS Agency review process and the Arkansas Administrative Procedures Act (APA) Denominator: Number of policies Promulgated ~~Numerator: Number of policies and procedures appropriately promulgated in accordance with agency policy and the APA;~~ ~~Denominator: Number of policies and procedures promulgated.~~
Discovery Activity *(Source of Data & sample size)*	100% of policies developed must be reviewed for compliance with the ~~a~~**A**gency policy and the APA.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS ~~or its agents~~**Waiver Compliance Unit or its agents**

Requirement	Requirement 5~~, B~~: The SMA retains authority and responsibility for program authority and oversight.
Frequency	~~Continuously, and as needed, as each policy is developed and promulgated.~~Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	~~DHS's~~ **DMS's** policy unit is responsible for compliance with Agency policy and with the APA. In cases where policy or procedures were not reviewed and approved according to DHS policy, remediation includes DHS review of the policy upon discovery, and approving or removing the policy.

Frequency *(of Analysis and Aggregation)*	Each policy will be reviewed for compliance with applicable DHS policy and the APA..~~Annually~~

Requirement	Requirement 6~~, A~~: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) ~~participants~~ **clients** by qualified providers.
Discovery	
Discovery Evidence One *(Performance Measure)*	The SMA will make payments to Behavioral Health Agencies **or Community Support System Providers** providing 1915(i) State plan HCBS. In order for payment to occur, the provider must be enrolled as a Medicaid provider. There is not an option for a non-enrolled provider to receive payment for a service. Numerator: Total number of encounters denied due to provider enrollment issues. Denominator: Total number of 1915 (i) encounters denied.
Discovery Activity One *(Source of Data & sample size)*	Review of claims payments via MMIS.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	~~DMS or its agents~~**DAABHS, DMS Waiver Compliance Unit or its agents**~~the EQRO.~~

Requirement	Requirement 7~~, A~~: The state identifies, addresses, and seeks to prevent incidents of unexplained death, abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent~~age~~ of Behavioral Health Agencies **and Community Support System Providers** that meet criteria for abuse and neglect, **including unexplained death,** ~~reporting~~ training for staff. Numerator: **Number of provider agencies investigated who complied with required abuse and neglect training, including unexplained death set out in the Waiver and the** ~~Number of provider agencies investigated wcertified or recertified who complied with required Abuse and neglect training set out in the~~ Behavioral Health Agencycertification; Denominator: Total number of provider agencies ~~reviewed or investigated.~~**certified or recertified**
Discovery Activity *(Source of Data & sample size)*	During certification or re-certification of Behavioral Health Agencies **and Community Support System Providers,** DPSQAwill ensure that appropriate training is in place regarding unexplained death, abuse, neglect, and exploitation for all Behavioral Health Agency **and Community Support System Provider** personnel.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS, DPSQA or its agentsDMS Waiver Compliance Unit

Requirement	Requirement 7, B. The state identifies, addresses, and seeks to prevent incidents of unexplained death, abuse, neglect, and exploitation, including the use of restraints.
Frequency	Annually, and continuously, as needed, when a compliant is received.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DQPSA will investigate all complaints regarding unexplained death, abuse, neglect, and exploitation.
Frequency *(of Analysis and Aggregation)*	Data will be gathered annually. Individual Provider training records will be reviewedAas necessary/
Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
Discovery	
Discovery Evidence One *(Performance Measure)*	Number and percent Behavioral Health Agencies or Community Support System Provider who reported critical incidents to DMS or DAABHS within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Total number of critical incidents that occurred and were reviewed.
Discovery Activity One *(Source of Data & sample size)*	DMS and DAABHS will review all the critical incident reports they receive on a quarterly basis.
Discovery Evidence Two	Number and Percent of Behavioral Health Agencies or Community Support System Provider Providers who adhered to Provider policies for the use estrictive interventions. Numerator: Number and percent of HCBS Providers meeting requirement for Abuse, neglect, and exploitation training compliant with State Law provider agreements evidenced by attendance documents. ominator: Number of HCBS providers.

Discovery Activity Two	**DMS will review the critical incident reports regarding the use of restrictive interventions and will ensure that Provider policies were properly implemented when restrictive intervention was used.**
Discovery Evidence Three	**Number and Percent of Behavioral Health Agencies or Community Support System Providers who took corrective actions regarding critical incidents to protect the health and welfare of the memberclient. Numerator: Number of critical incidents reported when Behavioral Health Agencies or Community Support System Provider took protective action in accordance with State Medicaid requirements and policies; Denominator: Number of critical incidents reported.**
Discovery Activity Three	**DMS and DAABHS will review the critical incident reports received to ensure that Provider policies were adequately followed and steps were taken to ensure that the health and welfare of the client was ensured.**
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**DMS or the EQRODMS Waiver Compliance Unit**

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The State will continuously monitor the utilization of 1915(i) FFS services for the eligible populations. The State will monitor **PCSPs**/ and treatment plans that are required for **clients** beneficiaries and will retrospectively/retrospectively approve services. The State will review historical claims data as well as review the person-centered service plans of individuals to ensure that the services provided are effective and helping the beneficiaryclient.

By using the data, the State will have the ability to measure the amount of services provided compared to what is described within the Person Centered Service Plan (PCSP) that is required for membersclients receiving HCBS State Plan services. The state will utilize the data to monitor services provided to determine a baseline, median and any statistical outliers for those service costs.

The State will work with an External Quality Review Organization (EQRO) to assist with analyzing the data and data provided by the Behavioral Health Agencies or Community Support System Provider on their quarterly reports.

The State will investigate and monitor any complaints about Behavioral Health Agencies providing any 1915(i) FFS services.

Additionally, the state will monitor grievance and appeals filed regarding HCBS State Plan services under the broader Quality Improvement Strategy for the 1915(b) Waiver.

2. Roles and Responsibilities

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

services.

3. Frequency

On-going monitoring will occur. **Quarterly and annual** ~~Yearly~~ reports will be analyzed and reviewed **by the** ~~by the State~~**.DMS Waiver Compliance Unit.**

Data will be analyzed quarterly by the Behavioral Health Agencies or Community Support System Provider Providers and annually by the EQRO.

Network adequacy will be monitored quarterly.

4. Method for Evaluating Effectiveness of System Changes

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

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

DAABHS or the EQRO will randomly audit each PCSP that is maintained by each of the Behavioral Health Agencies and Community Support System Providers to ensure compliance.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

	HCBS Case Management
	HCBS Homemaker
	HCBS Home Health Aide
	HCBS Personal Care
	HCBS Adult Day Health
	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☑	HCBS Day Treatment or Other Partial Hospitalization Services Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2019 and is effective for services provided on or after that date. All rates are published ~~https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx~~ **at the Fee Schedules website** .
	HCBS Psychosocial Rehabilitation
	HCBS Clinic Services (whether or not furnished in a facility for CMI)
~~☑~~	~~Other Services (Specify below):~~ ~~For all other services, the rate methodology is based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.~~ ~~**Therapeutic Communities**~~ ~~Effective the new rate for Therapeutic Communities is established with the highest intensity program set at 70% of the Arkansas State Hospital (ASH) inpatient rate, and the lowest intensity~~

	~~level of programming at 50% of the ASH inpatient rate. Because a rate comparison analysis of similar programs in other Region 6 states found no comparable programs, in- state facilities offering comparable levels of care were surveyed. Specifically, the rates for human development centers (HDCs) and the ASH were used for comparison because Therapeutic community provider actual costs for services were also considered in the rate setting process. A revised rate methodology was determined, focused on two levels of program intensity utilizing this method. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2019 and is effective for services provided on or after that date. All rates are published at https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.~~

The PASSE is responsible for providing all services to its members, including services contained in:

1) The State Plan

2) The 1915(i) State Plan Amendment, which includes the following services:

-Supportive Employment
-Behavior Assistance
-Adult Rehabilitation Day Treatment
-Peer Support
-Family Support Partners
-Pharmaceutical Counseling
-Supportive Life Skills Development
-Child and Youth Support
-Therapeutic Communities
-Residential Community Reintegration
-Respite
-Mobile Crisis Intervention
-Therapeutic Host Home
-Recovery Support Partners (for Substance Abuse)
-Substance Abuse Detoxification (Observational)
-Supportive Housing

3) The 1915(c) Community and Employment Supports Waiver for Home and Community Based Services, which includes the following services:

-Supportive Employment
-Supportive Living
-Adaptive Equipment

-Adaptive Equipment
-Community Transition Services
-Consultation
-Crisis Intervention
-Environmental Modifications
-Supplemental Support
- Respite
-Specialized Medical Supplies

These services are EXCLUDED and the PASSE will not be responsible for providing them:

1) Non-emergency medical transportation (NET)
2) Dental benefits in a capitated program
3) School-based services provided by school employees
4) Skilled nursing facility services
5) Assisted living facility services
6) Human Development Center Services
7) Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices Program.
8) 8) Transplant and Associated Services

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 191[illegible]b) of t[illegible] Act [illegible]hibits [illegible]estric[illegible]ions on b[illegible]eficiarie[illegible] access to e[illegible]ergency services and family

The PASSE is responsible for providing all services to its members, including services contained in:

1) The State Plan

2) The 1915(i) State Plan Amendment

3) The 1915(c) Community and Employment Supports Waiver for Home and Community Based Services

These services are EXCLUDED and the PASSE will not be responsible for providing them:

1) Non-emergency medical transportation (NET)
2) Dental benefits in a capitated program
3) School-based services provided by school employees
4) Skilled nursing facility services
5) Assisted living facility services
6) Human Development Center Services
7) Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices Program.
8) Transplant and Associated Services

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services.