Table of Contents

State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 18-0017

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

December 19, 2018

Our Reference: SPA AR 18-0017

Ms. Dawn Stehle
Deputy Director
Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, Arkansas 72203-1437

Dear Ms. Stehle:

Enclosed is a copy of approved Arkansas (AR) State Plan Amendment (SPA) 18-0017, with an effective date of March 1, 2019. This SPA, submitted under the authority of §1915(i) of the Act, works concurrently with other §1915 authorities to deliver Home and Community Based Services (HCBS) to Provider-led Arkansas Shared Savings Entity (PASSE) enrollees whose eligibility is approved based on a high level of need.

This letter affirms that AR 18-0017 is approved effective March 1, 2019 as requested by the State.

We are enclosing the CMS-179 and the following amended plan pages.

- Attachment 2.2-A, pages 29-30
- Attachment 3.1-I, pages 1-36, 41-50
- Attachment 4.19-B, Page 18

If you have any questions regarding this matter you may contact Stacey Shuman at 214-767-6479, or by email at stacey.shuman@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

CC: Billy Bob Farrell, DMCH Dallas
Stacey Shuman, DMCH Dallas
Ralph Lollar, CMS Baltimore
Kathy Poisal, CMS Baltimore
Matthew Weaver, CMS Baltimore
Deanna Clark, CMS Baltimore
Dennis Smith, DHS Arkansas
Elizabeth Pittman, DHS Arkansas

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 2018-017	2. STATE ARKANSAS
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE March 1, 2019	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 USC 1915(i)	7. FEDERAL BUDGET IMPACT: a. FFY 2019 $0 b. FFY 2020 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.2-A, pages 29-30 Attachment 3.1-I, pages 1-36 Attachment 3.1-I, pages 41-50 Attachment 4.19-B, page 18	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: None, New Pages None, New Pages None, New Page None, New Page

10. SUBJECT OF AMENDMENT: This 1915(i) State Plan Amendment is to offer Home and Community Based Services to individuals with a high level of behavioral health or developmental disability need. This Amendment works concurrently with the 1915(b) PASSE Waiver and only individuals enrolled in the PASSE are eligible to receive services through this 1915(i) SPA. Therefore, the fiscal impact is captured in the PASSE 1915(b) Waiver and there is not specific fiscal impact of this SPA.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: Division of Medical Services PO Box 1437, Slot S295 Little Rock, AR 72203-1437 Attention: Dave Mills
13. TYPED NAME: Tami Harlan	
14. TITLE: Director, Division of Medical Services	
15. DATE SUBMITTED: 10/3/18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: October 1, 2018	18. DATE APPROVED: December 19, 2018
PLAN APPROVED – ONE COPY [redacted]	
19. EFFECTIVE DATE OF APPROVED MATERIAL: March 1, 2019	20. SI[redacted]ICIAL:
21. TYPED NAME: Bill Brooks	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health (DMCH)

23. REMARKS:

FORM HCFA-179 (07-92)

f]

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; 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):*

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

***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)*		
	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 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.

(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.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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	Mar. 1, 2019	Feb. 29, 2020	30,000
Year 2	Mar. 1, 2020	Feb. 28, 2021	
Year 3	Mar. 1, 2021	Feb. 28, 2022	
Year 4	Mar. 1, 2022	Feb. 28, 2023	
Year 5	Mar. 1, 2023	Feb. 28, 2024	

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.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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 who completes the independent assessment. Eligibility is determined by DMS using the results of the independent assessment and the individual's diagnoses.

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State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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 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.

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

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

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

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

The individual must receive a minimum of a Tier 2 functional assessment for HCBS behavioral health services. To meet 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, 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 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 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 individual must receive a minimum of a Tier 2 functional assessment for HCBS behavioral health services. To meet 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, 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 individuals identified functional deficits due to their behavioral health diagnosis.	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: 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, 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	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 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	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 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

	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 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.	to receive services in the CES Waiver or an ICF/IID.	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 is a danger to his or herself or other, and 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)*):

Targeted to individuals with a behavioral health diagnosis, who are age four and older.

☐ **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:

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: One.
ii.	**Frequency of services.** The state requires (select one):
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 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."

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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):*

The Provider Led Arkansas Shared Savings Entity (PASSE) Care coordinator is responsible for providing care coordination to all clients receiving State plan HCBS services, including development of the PCSP. The care coordination service is offered through the 1915(b) Waiver. These care coordinators must meet the following 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 makes contact with DHS Beneficiary Support regarding receiving HCBS state plan services, DHS informs the individual 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 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 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 risk assessment.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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 provider agreement.

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

The State has a Beneficiary 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):*

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 the PASSE to submit the PCSP for all individuals in the sample. DMS or the EQRO conducts a retrospective review of provided PCSPs based on identified program, financial, and administrative elements critical to quality assurance. 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				

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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. 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 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 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 the same or similar work.	
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

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and	N/A	N/A	1. All other provider standards and

Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses			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):*
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:	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):*
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):*
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

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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 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 recovering members to direct their resources and support systems. Activities include training to assist the member to improve employability, and to successfully adapt and adjust to a particular environment. 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 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 members 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 member's PCSP. 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 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. 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.

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

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

(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):*
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):*
Home and	DMS	Annually. Proof of

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, supportive 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):

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

☐ 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):*
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):*
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, of 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

State: Arkansas
Date Received: 1 October, 2018
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Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and	N/A	N/A	1. All other provider standards and

Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses			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):*
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 treatment. Pharmaceutical Counseling involves providing medication information orally or in written form 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

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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

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

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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 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):

State: Arkansas
Date Received: 1 October, 2018
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Transmittal Number: 18-0017

☐ 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):*
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):*
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: 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):

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

☐ 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):*
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):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and	DMS	Annually. Proof of credentialing must be submitted to DMS.

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: 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 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 s facilitators, emphasizing self-improvement.

Therapeutic Communities services may be 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	

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
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Provider Qualifications *(For each type of provider. Copy rows as needed)*:

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

State: Arkansas
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☐ 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):*
Home and	N/A	N/A	1. All other provider standards and

Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses			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):*
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: Respite

Service Definition (Scope)*:*

Temporary direct care and supervision for a beneficiary 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 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):*
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. 12/19/2018

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 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

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.

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):*
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):*
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 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):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses		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):*
Home and Community Based Services Provider for Persons with Developmental	DMS	Annually. Proof of credentialing must be submitted to DMS.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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: Recovery Support Partners (for Substance Abuse)

Service Definition (Scope)*:*

A continuum of care provided to recovering members living in the community. Recovery Support partners may educate and assist the individual 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):*

Must be in the PCSP.

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):

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

☐	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):*
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):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and	DMS	Annually. Proof of credentialing must be submitted to DMS.

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: 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):

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

☐	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):*
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):*

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

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
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):*
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 beneficiaries 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 in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and fosters independence**.**

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary'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):

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

☐	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):*
Home and Community Based Services Provider	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as

for Persons with Developmental Disabilities and Behavioral Health Diagnoses			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):*
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

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 no 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 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. (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.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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):*

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

8. Opportunities for Participant-Direction

a. **Participant–Employer Authority** *(individual can select, m 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.*

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

Quality Improvement Strategy

Quality Measures

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

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

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

3. Providers meet required qualifications.

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

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

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

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

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

Requirement	Requirement 1: 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 the requirements of 42 CFR §441.725. Numerator: Number of PCSPs that adequately and appropriately address the beneficiary'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 DMS. The sample size will be determined using a confidence interval of 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 and the EQRO

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

Requirement	Requirement 1: Service Plans
Frequency	Sample will be selected and reviewed annually.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PASSE will be responsible for remediating deficiencies in PCSPs of their attributed beneficiaries. 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.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and findings will be reported to the PASSE annually. 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)*	The percentage of beneficiaries 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 who are evaluated and assessed for eligibility. Denominator: The total number of beneficiaries who are identified for the 1915(i) HCBS State Plan Services eligibility process.
Discovery Activity One *(Source of Data & sample size)*	A 100% sample of the application packets for beneficiaries who undergo the eligibility process will be reviewed for compliance with the timeliness standards. The data will be collected from the Independent Assessment Vendor, the DDS Psychology Unit, and/or the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS and the EQRO

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

Discovery Evidence Two	The Percentage of beneficiaries for whom the appropriate eligibility process and instruments were used to determine initial eligibility for HCBS State Plan Services. Numerator: Number of beneficiaries' application packets that reflect appropriate processes and instruments were used. Denominator: Total Number of application packets reviewed.
Discovery Activity Two	A 100% sample of the application packets for beneficiaries 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	DMS and the EQRO
Discovery Evidence Three	The percentage of beneficiaries who are re-determined eligible for HCBS State Plan Services before their annual PCSP expiration date. Numerator: The number of beneficiaries who are re-determined eligible timely (before expiration of PCSP). Denominator: The total number of beneficiaries re-determined eligible for HCBS State Plan Services.
Discovery Activity Three	A 100% sample of the application packets for beneficiaries 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	DMS and the EQRO

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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 contract monitor. 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 percentage of providers certified and credentialed by the PASSE. Numerator: Number of provider agencies that obtained annual certification in accordance with PASSE's standards. Denominator: Number of HCBS provider agencies reviewed.
Discovery Activity *(Source of Data & sample size)*	100% of HCBS providers credentialed by the PASSEs will be reviewed by DMS or its agents during the annual readiness review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS and the EQRO

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.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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).
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of provider owned apartments or homes that meet the home and community-based settings requirements. Denominator: Number of provider owned apartments and homes 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 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 each year.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS and 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.
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.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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

Discovery Evidence *(Performance Measure)*	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

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.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHS'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.

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.
Discovery	
Discovery Evidence One *(Performance Measure)*	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.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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

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 and its agents are responsible for oversight of the PASSE's including review of the quarterly Beneficiary Expenditure Report 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	

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

Discovery Evidence *(Performance Measure)*	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)*	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 EQRO

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 is received.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMS's IDSR Office and its agents are responsible for oversight of the PASSE's including readiness review. This review will include an 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.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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 percentage 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	Percentage of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions. Numerator: 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 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	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 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

State: Arkansas
Date Received: 1 October, 2018
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Transmittal Number: 18-0017

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 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 Organizations (EQRO) to assist with analyzing the encounter data and data provided by the PASSEs on their quarterly reports.

The State's Beneficiary Support Team 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 and annually by the EQRO.

Network adequacy will be monitored on an ongoing basis.

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, encounter data, grievance reports, 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 State will randomly audit each PCSP that is maintained by each PASSE to ensure compliance.

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

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
	HCBS Psychosocial Rehabilitation
	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (Specify below): All HCBS Services provided under the 1915(i): Payment for these services will be made by the PASSE Organized Care entity who will receive a PMPM for each member enrolled in the PASSE. The PMPM was developed based on historical utilization of services by the population being enrolled in the PASSEs. Please see the 1915(b) PASSE Waiver, Appendix D, for more information.

State: Arkansas
Date Received: 1 October, 2018
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Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* ____ %

State: Arkansas
Date Received: 1 October, 2018
Date Approved: 19 December, 2018
Effective Date: 1 March, 2019
Transmittal Number: 18-0017

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26- 05, and Baltimore, Maryland 21244-1850.

State: Arkansas
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