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Arkansas Department of Human Services

Division of Behavioral Health Services

Certification Manual for Rehabilitative Services for Persons with Mental Illness (RSPMI)

Revised: 1/1/11

www.arkansas.gov/dhs/dmhs

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

Rehabilitative Services for Persons with Mental Illness (RSPMI)

Provider Certification Rules

The DBHS Mission Statement: To improve the quality of life for Arkansans by providing recovery-based, consumer driven behavioral health care utilizing evidence-based practices.

I. PURPOSE:

A. To assure that Rehabilitative Services for Persons With Mental Illness ("RSPMI") care and services comply with applicable laws, which require, among other things, that all care reimbursed by the Arkansas Medical Assistance Program ("Medicaid") must be provided efficiently, economically, only when medically necessary, and is of a quality that meets professionally recognized standards of health care.

B. The requirements and obligations imposed by §§ I-XIII of this rule are substantive, not procedural.

II. SCOPE:

A. Current RSPMI certification under this policy is a condition of Medicaid provider enrollment.

B. Division of Behavioral Health Services ("DBHS") RSPMI certification must be obtained for each site before application for Medicaid provider enrollment. An applicant may submit one application for multiple sites, but DBHS will review each site separately and take separate certification action for each site.

III. DEFINITIONS:

A. "Accreditation" means full accreditation (preliminary, expedited, probationary, pending, conditional, deferred or provisional accreditations will not be accepted) as an outpatient behavioral health care provider issued by at least one of the following:

- Commission on Accreditation for Rehabilitative Facilities (CARF)
  Behavioral Health Standards Manual
- The Joint Commission (TJC)
  Comprehensive Accreditation Manual for Behavioral Health Care
- Council on Accreditation (COA)
  Outpatient Mental Health Services Manual

B. "Adverse license action" means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

C. “Applicant” means an outpatient behavioral health care agency that is seeking DBHS certification as an RSPMI provider.

D. “Certification” means a written designation, issued by DBHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

E. “Client” means any person for whom an RSPMI provider furnishes, or has agreed or undertaken to furnish, RSPMI services.

F. “Client Information System” means a comprehensive, integrated system of clinical, administrative, and financial records that provides information necessary and useful to deliver client services. Information may be maintained electronically, in hard copy, or both.

G. “Compliance” means conformance with:

1. Applicable state and federal laws, rules, and regulations including, without limitation:

   a. Titles XIX and XXI of the Social Security Act and implementing regulations;
   b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5.
   c. All state laws and rules applicable to Medicaid generally and to RSPMI services specifically.
   d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;
   e. The Americans With Disabilities Act, as amended, and implementing regulations;
   f. The Health Insurance Portability and Accountability Act (“HIPAA”), as amended, and implementing regulations.

2. Accreditation standards and requirements.

H. “Contemporaneous” means within a single work period of the performing provider, that is, before the performing provider goes off duty for any reason other than a scheduled work break or meal.

I. “Coordinated Management Plan” means a plan that the provider develops and carries out to assure compliance and quality improvement.

J. “Corrective Action Plan” (CAP) means a document that describes both short-term remedial steps to achieve compliance and permanent practices and procedures to sustain compliance.

K. “Covered Health Care Practitioner” means: Allopathic physicians; allopathic interns and residents; osteopathic physicians; and osteopathic physician interns and residents; dentists and dentist residents; and other practitioner types which

may be or have been reported to the NPDB: pharmacists; pharmacy interns; pharmacists, nuclear; pharmacy assistants; pharmacy technicians; registered (professional) nurses; nurse anesthetists; nurse midwives; nurse practitioners; clinical nurse specialists; licensed practical or vocational nurses; nurses aides; certified nurse aides/certified nursing assistants; home health aides (homemakers); health care aides/direct care workers; certified or qualified medication aides; EMTs, basic; EMTs, cardiac/critical care; EMTs, intermediate; EMTs, paramedic; social workers; podiatrists; podiatric assistants; psychologists; school psychologists; psychological assistants, associates, examiners; counselors, mental health; professional counselors; professional counselors, alcohol; professional counselors, family/marriage; professional counselors, substance abuse; marriage and family therapists; dental assistants; dental hygienists; denturists; dieticians; nutritionists; ocularists; opticians; optometrists; physician assistants, allopathic; physician assistants, osteopathic; art/recreation therapists; massage therapists; occupational therapists; occupational therapy assistants; physical therapists; physical therapy assistants; rehabilitative therapists; respiratory therapy technicians; medical technologists; cytotechnologists; nuclear medicine technologists; radiation therapy technologists; radiologic technologists; acupuncturists; athletic trainers; homeopaths; medical assistants; midwives, lay (non nurse); naturopaths; orthotics/prosthetics fitters; perfusionists; psychiatric technicians; and any other type of health care practitioner which is licensed in one or more States.

L. “Cultural Competency” means the ability to communicate and interact effectively with people of different cultures, including people with disabilities and atypical lifestyles.

M. “DBHS” means the Arkansas Department of Human Services Division of Behavioral Health Services.

N. “Deficiency” means an item or area of noncompliance.

O. “DHS” means the Arkansas Department of Human Services.

P. “Emergency RSPMI services” means nonscheduled RSPMI services delivered under circumstances where a prudent layperson with an average knowledge of behavioral health care would reasonably believe that RSPMI services are immediately necessary to prevent death or serious impairment of health.

Q. “Medical Director” means a physician that oversees the planning and delivery of all RSPMI services delivered by the provider.

R. “Mental health paraprofessional” or “MHPP” means a person who:

1. Does not possess an Arkansas license to provide clinical behavioral health care;

2. Works under the direct supervision of a mental health professional;

3. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned by a mental health professional;

4. Acknowledges in writing that all mental health paraprofessional services are controlled by client care plans and provided under the direct supervision of a mental health professional.

S. "Mental health professional" or "MHP" means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

T. "Mobile care" means a face-to-face intervention with the client at a place other than a certified site operated by the provider. Mobile care must be:

1.Either clinically indicated in an emergent situation or necessary for the client to have access to care in accordance with the care plan;

2. Delivered in a clinically appropriate setting; and

3. Delivered where Medicaid billing is permitted if delivered to a Medicaid eligible client.

Mobile care may include medically necessary behavioral health care provided in a school that is within fifty (50) miles of a certified site operated by the provider.

U. "Multi-disciplinary team" means a group of professionals from different disciplines that provide comprehensive care through individual expertise and in consultation with one another to accomplish the client's clinical goals. Multi-disciplinary teams promote coordination between agencies; provide a "checks and balances" mechanism to ensure that the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals.

V. "NPDB" means the United States Department of Health and Human Services, Health Resources and Services Administration National Provider Data Bank.

W. "Performing provider" means the individual who personally delivers a care or service directly to a client.

X. "Professionally recognized standard of care" means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based

practice models is evidence of compliance with professionally recognized standards of care.

Y. “Provider” means an entity that is certified by DBHS and enrolled by DMS to provide RSPMI.

Z. “Quality assurance (QA) meeting” means a meeting held at least quarterly for systematic monitoring and evaluation of clinic services and compliance. *See also*, Medicaid RSPMI Manual, § 212.000.

AA**. “**Reviewer” means a person employed or engaged by:

1. DHS or a division or office thereof;
2. An entity that contracts with DHS or a division or office thereof.

BB. “RSPMI” means Rehabilitative Services for Persons With Mental Illness.

CC. “Site” means a distinct place of business dedicated to the delivery of RSPMI services within a fifty (50) mile radius. Each site must be a bona fide RSPMI behavioral health outpatient clinic providing all the services specified in this rule and the Medicaid RSPMI Manual. Sites may not be adjuncts to a different activity such as a school, a day care facility, a long-term care facility, or the office or clinic of a physician or psychologist.

DD. “Site relocation” means closing an existing site and opening a new site no more than fifty (50) miles from the original site.

EE. “Site transfer” means moving existing staff, program, and clients from one physical location to a second location that is no more than fifty (50) miles from the original site.

FF. “Supervise” as used in this rule means to direct, inspect, observe, and evaluate performance.

GG. “Supervision documentation” means written records of the time, date, subject(s), and duration of supervisory contact maintained in the provider’s official records.

IV. COMPLIANCE TIMELINE:

A. Certified RSPMI providers in operation as of the effective date of this rule must comply with this rule within forty-five calendar days.

B. DBHS may authorize temporary compliance exceptions for new accreditation standards that require independent site surveys and specific service subset accreditations. Such compliance exceptions expire at the end of the provider’s accreditation cycle and may not be renewed or reauthorized.

V. APPLICATION FOR DBHS RSPMI CERTIFICATION:

A. Applicants must complete DBHS application Form #1 and #2 which can be found at the following website: www.arkansas.gov/dhs/dmhs or

See Appendix # 5 and # 6

B. Applicants must submit the completed application forms and all required attachments for each proposed site to:

Department of Human Services
Division of Behavioral Health Services
Attn. Certification Office
305 S. Palm
Little Rock, AR 72205

C. Each applicant must be an outpatient behavioral health care agency:

1. Whose primary purpose is the delivery of a continuum of outpatient behavioral health services in a free standing independent clinic;
2. That is independent of any DBHS certified RSPMI provider.

D. RSPMI certification is not transferable or assignable.

E. The privileges of RSPMI certification are limited to the certified entity.

F. Providers may file Medicaid claims only for RSPMI care delivered by a performing provider engaged by the provider.

G. Applications must be made in the name used to identify the business entity to the Secretary of State and for tax purposes.

H. Applicants must maintain and document accreditation, and must prominently display certification of accreditation issued by the accrediting organization in a public area at each site. Accreditation must recognize and include all the applicant's RSPMI programs, services, and sites.

1. Initial accreditation must include an on-site survey for each service site for which provider certification is requested. Accreditation documentation submitted to DBHS must list all sites recognized and approved by the accrediting organization as the applicant's service sites.
2. Accreditation documentation must include the applicant's governance standards for operation and sufficiently define and describe all services or types of care (customer service units or service standards) the applicant intends to provide including, without limitation, crisis intervention/stabilization, in-home family counseling, outpatient treatment, day treatment, therapeutic foster care, intensive outpatient, medication management/pharmacotherapy.

3. Any outpatient behavioral health program associated with a hospital must have a free-standing behavioral health outpatient program national accreditation.

I. The applicant must attach the entity's family involvement policy to each application.

VI. APPLICATION REVIEW PROCESS

A. Timeline:

1. DBHS will review RSPMI application forms and materials within ninety (90) calendar days after the DBHS RSPMI certification policy office receives a complete application package. (DBHS will return incomplete applications to senders without review.)

2. For approved applications, a site survey will be scheduled within 20 calendar days of the approval date.

3. DBHS will mail a survey report to the applicant within 10 calendar days of the site visit. Providers having deficiencies on survey reports must submit an approvable corrective action plan to DBHS within thirty-five (35) calendar days after the date of a survey report.

4. DBHS will accept or reject each corrective action plan in writing within ten (10) calendar days after receipt.

5. Within thirty (30) calendar days after DBHS approves a corrective action plan, the applicant must document implementation of the plan and correction of the deficiencies listed in the survey report. Applicants who are unable, despite the exercise of reasonable diligence, to correct deficiencies within the time permitted may obtain up to ten (10) additional days based on a showing of good cause.

6. DBHS will furnish site-specific certificates via postal or electronic mail within ten (10) calendar days of issuing a site certification.

B. Survey Components: An outline of site survey components is available on the DBHS website: www.arkansas.gov/dhs/dmhs and is located in appendix # 7.

C. Determinations:

1. Application approved.

2. Application returned for additional information.

3. Application denied. DBHS will state the reasons for denial in a written response to the applicant.

VII. DBHS Access to Applicants/Providers:

A. DBHS may contact applicants and providers at any time;

B. DBHS may make unannounced visits to applicants/providers.

C. Applicants/providers shall provide DBHS prompt direct access to applicant/provider documents and to applicant/provider staff and contractors, including, without limitation, clinicians, paraprofessionals, physicians, administrative, and support staff.

D. DBHS reserves the right to ask any questions or request any additional information related to certification, accreditation, or both.

VIII. ADDITIONAL CERTIFICATION REQUIREMENTS

A. Training: Upon certification, applicants must enroll at least the following personnel: clinical supervisors, corporate compliance officers and billing personnel who must successfully complete the "DBHS RSPMI Operation Technical Assistance Training Program" ("Program") within five (5) months of the certification date. DHS will offer the program at least quarterly. *See* Appendix # 4 for training agenda.

B. Care and Services must:

1. Comply with all state and federal laws, rules, and regulations applicable to the furnishing of health care funded in whole or in part by federal funds; to all state laws and policies applicable to Arkansas Medicaid generally, and to RSPMI services specifically, and to all applicable Department of Human Services ("DHS") policies including, without limitation, DHS Participant Exclusion Policy § 1088.0.0. The Participant Exclusion Policy is available online at https://dhsshare.arkansas.gov/DHS%20Policies/Forms/By%20Policy.aspx

2. Conform to professionally recognized behavioral health rehabilitative treatment models.

3. Be established by contemporaneous documentation that is accurate and demonstrates compliance. Documentation will be deemed to be contemporaneous if recorded by the end of the performing provider's first work period following the provision of the care or services to be documented, or as provided in the RSPMI manual, § 252.110, whichever is longer.

C. Applicants and RSPMI providers must:

1. Be a legal entity in good standing;

2. Maintain all required business licenses;

3. Adopt a mission statement to establish goals and guide activities;

4. Maintain a current organizational chart that identifies administrative and clinical chains of command.

D. Applicants/providers must establish and comply with operating policy that at a minimum implements credible practices and standards for:

1. Compliance;

2. Cultural competence;

3. Provision of services, including referral services, for clients that are indigent, have no source of third party payment, or both, including:

a. Procedures to follow when a client is rejected for lack of a third-party payment source or when a client is discharged for nonpayment of care.

b. Coordinated referral plans for clients that the provider lacks the capacity to provide medically necessary RSPMI care and services. Coordinated referral plans must:

i. Identify in the client record the medically necessary RSPMI services that the provider cannot or will not furnish;

ii. State the reason(s) in the client record that the provider cannot or will not furnish the care;

iii. Provide quality-control processes that assure compliance with care, discharge, and transition plans.

E. Minimum Staffing: Staffing shall be sufficient to establish and implement care plans for each RSPMI client, and must include the following:

1. **Chief Executive Officer/Executive Director (or functional equivalent) (full-time position or full-time equivalent positions):** The person or persons identified to carry out CEO/ED functions:

a. Is/are ultimately responsible for applicant/provider organization, staffing, policies and practices, and RSPMI service delivery;

b. Must possess a master's degree in behavioral health care, management, or a related field and experience, and meet any additional qualifications required by the provider's governing body. Other job-related education, experience, or both, may be substituted for all or part of these requirements upon approval of the provider's governing body.

2. **Clinical Director (or functional equivalent) (full-time position or full-time equivalent positions):** The person or persons identified to carry out clinical director functions must:

a. Report directly to the CEO/ED;

b. Be the DBHS contact for clinical and practice-related issues;

c. Be accountable for all clinical services (professional and paraprofessional);

d. Be responsible for RSPMI care and service quality and compliance;

e. Assure that all services are provided within each practitioner's scope of practice under Arkansas law and under such supervision as required by law for practitioners not licensed to practice independently;

f. Assure and document in the provider's official records the direct supervision of MHP's, either personally or though a documented chain of supervision.

g. Assure that licensed mental health professionals directly supervise paraprofessionals. Direct supervision ratios must not exceed one licensed mental health professional to ten (10) mental health paraprofessionals;

h. Possess independent Behavioral Health licensure in Arkansas as a Licensed Psychologist, Licensed Certified Social Worker, (LCSW), Licensed Psychological Examiner – Independent (LPE-I), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), or an Advanced Practice Nurse or Clinical Nurse Specialist (APN or CNS) with a specialty in psychiatry or mental health and a minimum of two years clinical experience post master's degree.

3**. Mental Health Professionals:**

a. MHP's may:

i. Provide direct behavioral health care;

ii. Delegate and oversee work assignments of MHPP's;

iii. Ensure compliance and conformity to the provider's policies and procedures;

iv. Provide direct supervision of MHPP's;

v. Provide case consultation and in-service training;

vi. Observe and evaluate performance of MHPP's.

b. MHP Supervision:

i. Communication between an MHP and the MHP's supervisor must include each of the following at least every twelve (12) months:

1. Assessment and referral skills, including the accuracy of assessments;

2. Appropriateness of treatment or service interventions in relation to the client needs;

3. Treatment/intervention effectiveness as reflected by the client meeting individual goals;

4. Issues of ethics, legal aspects of clinical practice, and professional standards;

5. The provision of feedback that enhances the skills of direct service personnel;

6. Clinical documentation issues identified through ongoing compliance review;

7. Cultural competency issues;

8. All areas noted as deficient or needing improvement.

ii. Documented client-specific face-to-face and other necessary communication regarding client care must occur between each MHP's supervisor and the MHP periodically (no less than every ninety (90) calendar days) in accordance with a schedule maintained in the provider's official records.

4. Mental Health Paraprofessionals:

a. Are MHP service extenders;

b. MHPP supervision must conform to the requirements for MHP supervision (*See* § VIII (E)(3)(b)) except that all requirements must be met every six (6) months, and one or more licensed health care professional(s) acting within the scope of his or her practice must have a face-to-face contact with each MHPP for the purpose of clinical supervision at least every fourteen (14) days, must have at least twelve (12) such face-to-face contacts every ninety (90) days, and such additional face-to-face contacts as are necessary in response to a client's unscheduled care needs, response or lack of response to treatment, or change of condition;

c. Providers must establish that MHPP supervision occurred via individualized written certifications created by a licensed mental health professional and filed in the provider's official records on a weekly basis, certifying:

i. That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records) communicated individualized client-specific instructions to the mental health paraprofessional describing the manner and methods for the delivery of paraprofessional services;

ii. That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records, but no less than every 30 days) personally observed the mental health paraprofessional delivering services to a client; that the observations were of sufficient duration to declare whether

paraprofessional services complied with the licensed mental health professional's instructions;

iii. The date, time, and duration of each supervisory communication with and observation of a mental health paraprofessional.

4. **Corporate Compliance Officer:**

a. Manages policy, practice standards and compliance, except compliance that is the responsibility of the medical records librarian;

b. Reports directly to the CEO/ED (except in circumstances where the compliance officer is required to report directly to a director, the board of directors, or an accrediting or oversight agency);

c. Has no direct responsibility for billings or collections;

d. Is the DBHS and Medicaid contact for DBHS certification, Medicaid enrollment, and compliance.

5. **Medical Director:**

a. Oversees RSPMI care planning, coordination, and delivery, and specifically:

i. Diagnoses, treats, and prescribes for behavioral illness;

ii. Is responsible and accountable for all client care, care planning, care coordination, and medication storage;

iii. Assures that physician care is available 24 hours a day, 7 days a week;

iv. May delegate client care to other physicians, subject to documented oversight and approval;

v. Assures that a physician participates in treatment planning and reviews;

vi. If the medical director is not a psychiatrist, a psychiatrist certified by one of the specialties of the American Board of Medical Specialties must service as a consultant to the medical director and to other staff, both medical and non-medical. If the provider serves clients under the age of twenty-one (21), the medical director shall have access to a board certified child psychiatrist, for example, through the Psychiatric Research Institute child/Adolescent Telephone Consultation Service;

vii. Medical director services may be acquired by contract.

b. If the medical director is not a psychiatrist then the medical director shall contact a consulting psychiatrist within twenty-four (24) hours in the following situations:

i. When antipsychotic or stimulant medications are used in dosages higher than recommended in guidelines published by the Arkansas Department of Human Services Division of Medical Services;

ii. When two (2) or more medications from the same pharmacological class are used;

iii. When there is significant clinical deterioration or crisis with enhanced risk of danger to self or others.

c. The consulting psychiatrist(s) shall participate in quarterly quality assurance meetings.

6. **Privacy Officer:** Develops and implements policies to assure compliance with privacy laws, regulations, and rules. Applicants/providers may assign privacy responsibilities to the Corporate Compliance Officer, Grievance Officer, or Medical Records Librarian, but not the CEO/ED.

7. **Quality Control Manager:** Chairs the quality assurance committee and develops and implements quality control and quality improvement activities. Applicants/providers may assign quality control manager responsibilities to the Corporate Compliance Officer or Medical Records Manager, but not the CEO/ED.

8. **Grievance Officer:**

a. Develops and implements the applicant's/provider's employee and client grievance procedures.

b. Effectively communicates grievance procedures to staff, contractors, prospective clients, and clients. Communications to clients who are legally incapacitated shall include communication to the client's responsible party.

c. The grievance officer shall not have any duties that may cause him/her to favor or disfavor any grievant.

9. **Medical Records Librarian:**

a. Must be qualified by education, training, and experience to understand and apply:

i. Medical and behavioral health terminology and usages covering the full range of services offered by the provider;

ii. Medical records forms and formats;

iii. Medical records classification systems and references such as The American Psychiatric Association's Diagnostic and Statistical Manual – IV-TR (DSM-IV-TR) and subsequent editions,

International Classification of Diseases (ICD), Diagnostic Related Groups (DRG's), Physician's Desk Reference (PDR), Current Procedural Terminology (CPT), medical dictionaries, manuals, textbooks, and glossaries.

iv. Legal and regulatory requirements of medical records to assure the record is acceptable as a legal document;

v. Laws and regulations on the confidentiality of medical records (Privacy Act and Freedom of Information Act) and the procedures for informed consent for release of information from the record.

vi. The interrelationship of record services with the rest of the facility's services.

b. Develops and implements:

i. The client information system;

ii. Operating methods and procedures covering all medical records functions.

iii. Insures that the medical record is complete, accurate, and compliant.

10. **Licensed Psychologist, Licensed Psychological Examiner (LPE), or Licensed Psychological Examiner – Independent (LPE-I):**

a. Provides psychological evaluations;

b. Each licensed psychological examiner or licensed psychological examiner-I must have supervision agreements with a doctoral psychologist to provide appropriate supervision or services for any evaluations or procedures that are required under or are outside the psychological examiner’s scope of independent practice. Documentation of such agreements and of all required supervision and other practice arrangements must be included in the psychological examiner’s personnel record;

c. Services may be acquired by contract.

F. Multidisciplinary Team(s): Providers must assign each client a multidisciplinary team that includes professionals and paraprofessionals as necessary to insure care coordination of each client’s RSPMI care and services.

G. Quality Assurance Meetings:

Each provider must hold a quarterly quality assurance meeting.

H. Health Care Professional Notification/Disqualification:

a. Notice of covered health care practitioners:

i. Within twenty (20) days of the effective date of this rule, applicants/providers must notify the Medicaid Program Integrity Unit of the names of covered health care practitioners who are providing RSPMI services.

ii. On or before the tenth day of each month, providers must notify the Medicaid Program Integrity Unit of the names of all covered health care practitioners who are providing RSPMI services and whose names were not previously disclosed.

b. Licensed health care professionals may not furnish RSPMI services during any time the professional's license is subject to adverse license action.

c. Applicants/providers may not employ/engage a covered health care practitioner after learning that the practitioner:

i. Is excluded from Medicare, Medicaid, or both;

ii. Is debarred under Ark. Code Ann. § 19-11-245;

iii. Is excluded under DHS Policy 1088; or

iv. Was subject to a final determination that the provider failed to comply with professionally recognized standards of care, conduct, or both. For purposes of this subsection, "final determination" means a final court or administrative adjudication, or the result of an alternative dispute resolution process such as arbitration or mediation.

I. Applicants/providers must maintain documentation identifying the primary work location of all MHP's and mental health paraprofessionals.

J. Providers must maintain copies of disclosure forms signed by the client, or by the client's parent or guardian before RSPMI services are delivered except in emergencies. Such forms must at a minimum:

1. Disclose that the services to be provided are RSPMI;
2. Explain RSPMI eligibility, SED and SMI criteria;
3. Contain a brief description of RSPMI services;
4. Explain that all RSPMI care must be medically necessary;
5. Disclose that third party (e.g., Medicaid or insurance) RSPMI payments may be denied based on the third party payer's policies or rules;

6. Identify and define any services to be offered or provided in addition to RSPMI care, state whether there will be a charge for such services, and if so, document payment arrangements;

7. Notify that services may be discontinued by the client at any time;

8. Offer to provide copies of RSPMI rules;

9. Provide and explain contact information for making complaints to the provider regarding care delivery, discrimination, or any other dissatisfaction with RSPMI care;

10. Provide and explain contact information for making complaints to state and federal agencies that enforce compliance under § III(F)(1).

K. RSPMI services maintained at each site must include:

1. Psychiatric Evaluation and Medication Management;

2. Intervention Services;

3. Outpatient Services, including individual and family therapy at a minimum;

4. Crisis Services.

L. Providers must tailor all RSPMI care and services to individual client need. If client records contain entries that are materially identical, DBHS and the Division of Medical Services will rebuttably presume that this requirement is not met.

M. RSPMI for individuals under age eighteen (18): Providers must establish and implement policies for family identification and engagement in treatment for persons under age eighteen (18), including strategies for identifying and overcoming barriers to family involvement.

N. Emergency Response Services: Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

1. A 24-hour emergency telephone number;

2. The applicant/provider must:

a. Provide the 24-hour emergency telephone number to all clients;

b. Post the 24-hour emergency number on all public entries to each site;

c. Include the 24-hour emergency phone number on answering machine greetings;

d. Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to client emergencies.

3. Direct access to a MHP within fifteen (15) minutes of an emergency/crisis call and face-to-face crisis assessment within two (2) hours;

4. Response strategies based upon:

a. Time and place of occurrence;
b. Individual's status (client/non-client);
c. Contact source (family, law enforcement, health care provider, etc.).

5. Requirements for a face-to-face response to requests for emergency intervention received from a hospital or law enforcement agency regarding a current client.

6. All face-to-face emergency responses shall be:

a. Available 24 hours a day, 7 days a week;

b. Made by a MHP within two (2) hours of request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the MHP responding to the call).

7. Emergency services training requirements to ensure that emergency service are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency service training in each trainee's personnel file.

8. Requirements for clinical review by the clinical supervisor or emergency services director within 24 hours of each after-hours emergency intervention with such additional reporting as may be required by the provider's policy.

9. Requirements for documentation of all crisis calls, responses, collaborations, and outcomes;

10. Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral health care funded through the community mental health centers and the provider is not a community mental health center with access to these funds, the provider must:

a. Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and

b. Contact the appropriate community mental health center (CMHC) for consult and to request the CMHC to access local acute care funds for those over 21.

O. Each applicant/provider must establish and maintain procedures, competence, and capacity:

1. For assessment and individualized care planning and delivery;
2. For discharge planning integral to treatment;
3. For mobile care;
4. To assure that each MHP makes timely clinical disposition decisions;
5. To make timely referrals to other services;
6. To refer for inpatient services or less restrictive alternative;
7. To identify clients who need direct access to clinical staff, and to promptly provide such access.

P. Each applicant/provider must establish, maintain, and document a quality improvement program, to include:

1. Evidence based practices;

2. Use of the Youth Outcome Questionnaire (YOQ) for all clients over age four (4) and under age 21, except that the YOQ is not required for persons age eighteen (18) through twenty-one (21) who are certified to be seriously mentally ill.

3. Requirements for informing all clients and clients' responsible parties of the client's rights while accessing services.

4. Regular (at least quarterly) quality assurance meetings that include:

    a. Clinical Record Reviews: medical record reviews of a minimum number of randomly selected charts. The minimum number is the lesser of a statistically valid sample yielding 95% confidence with a 5% margin of error; or 10% of all charts open at any time during the past three (3) months;

    b. Program and services reviews that:

        i. Assess and document whether care and services meet client needs;

        ii. Identify unmet behavioral health needs;

        iii. Establish and implement plans to address unmet needs.

Q. Technical Training and Consultation: Applicants may attend a "technical training for provider applicants" in-service training that will be conducted at least quarterly. The training explains the DBHS RSPMI certification application process and includes a review of RSPMI requirements. *See* Appendix # 4 for training agenda.

IX. HOME OFFICE

A. Each provider must maintain and identify a home office in the State of Arkansas;

B. The home office may be located at a site or may be solely an administrative office not requiring site certification;

C. The home office is solely responsible for governance and administration of all of the provider's Arkansas sites;

D. Home office governance and administration must be documented in a coordinated management plan;

E. The home office shall establish policies for maintaining client records, including policies designating where the original records are stored.

X. SITE REQUIREMENTS

A. All sites must be located in the State of Arkansas;

B. Accreditation documentation must specifically include each site.

XI. SITE RELOCATION, OPENING, AND CLOSING (Note: temporary service disruptions caused by inclement weather or power outages are not "closings.")

A. Planned Closings:

1. Upon deciding to close a site either temporarily or permanently, the provider immediately must provide written notice to clients, DBHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization.

2. Notice of site closure must state the site closure date;

3. If site closure is permanent, the site certification expires at 12:00 a.m. the day following the closure date stated in the notice;

4. If site closing is temporary, and is for reasons unrelated to adverse governmental action, DBHS may suspend the site certification for up to one (1) year if the provider maintains possession and control of the site. If the site is not operating and in compliance within the time specified in the site certification suspension, the site certification expires at 12:00 a.m. the day after the site certification suspension ends.

B. Unplanned Closings:

1. If a provider must involuntarily close a site due to, for example, fire, natural disaster, or adverse governmental action, the provider must immediately notify clients and families, DBHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization of the closure and the reason(s) for the closure.

2. Site certification expires in accordance with any pending regulatory action, or, if no regulatory action is pending, at 12:00 a.m. the day following permanent closure.

C. All Closings:

1. Providers must assure and document continuity of care for all clients who receive RSPMI at the site;

2. Notice of Closure and Continuing Care Options:

a. Providers must assure and document that clients and families receive actual notice of the closure, the closure date, and any information and instructions necessary for the client to obtain transition services;

b. After documenting that actual notice to a specific client was impossible despite the exercise of due diligence, providers may satisfy the client notice requirement by mailing a notice containing the information described in subsection (a), above, to the last known address provided by the client; and

c. Before closing, providers must post a public notice at each site entry. The public notice must include the name and contact information for all RSPMI providers within a fifty (50) mile radius of the site.

3. An acceptable transition plan is described below:

Transition Plan:
1. Identify and list all certified sites within a 50 mile radius. Include telephone numbers and physical addresses on the list. **2. Provide clients/families with the referral information and have them sign a transfer of records form/release of information to enable records to be transferred to the provider of their choice.** **3. Transfer records to the designated provider.**

4. Designate a records retrieval process as specified in Section I of the Arkansas Medicaid RSPMI Provider Policy Manual § 142.300.

5. Submit a reporting of transfer to DBHS (Attn: Policy & Certification Office) including a list of client names and the disposition of each referral. See example below:

Name	**Referred to:**	**Records Transfer Status:**	**RX Needs Met By:**
Johnny	**OP Provider Name**	**to be delivered 4/30/20XX**	**Provided 1 month RX**
Mary	**Private Provider Name**	**Delivered 4/28/20XX**	**No Meds**
Judy	**Declined Referral**	**XX**	

6. DBHS may require additional information regarding documentation of client transfers to insure that client needs are addressed and met.

A site closing Form is available at: www.arkansas.gov/dhs/dmhs *See* appendix # 9

D. New Sites: Providers may apply for a new site by completing the new site Form available at www.arkansas.gov/dhs/dmhs

See appendix # 10 DBHS Form # 5 – (Adding Site)

E. Site Transfer:

1. At least forty-five (45) calendar days before a proposed transfer of an accredited site, the provider must apply to DBHS to transfer site certification. The application must include documentation that:

a. The provider notified the accrediting entity, and the accrediting entity has extended or will extend accreditation to the second site; or

b. The accrediting entity has established an accreditation timeframe.

2. The provider must notify clients and families, DBHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization at least thirty (30) calendar days before the transfer;

3. DBHS does not require an on-site survey, nor does the Division of Medical Services require a new Medicaid provider number. The moving or transferring site form is available at: www.arkansas.gov/dhs/dmhs

See appendix # 9 – DBHS Form # 4 (Closing and Moving Sites)

F. Site Relocation: The provider must follow the rules for closing the original site, and the rules for opening a new site.

XII. PROVIDER RE-CERTIFICATION

A. The term of DBHS site certification is concurrent with the provider's national accreditation cycle, except that site certification extends six months past the accreditation expiration month if there is no interruption in the accreditation. (The six-month extension is to give the RSPMI provider time to receive a final report from the accrediting organization, which the provider must immediately forward to DBHS.)

B. Providers must furnish DBHS a copy of:

1. Correspondence related to the provider's request for re-accreditation:

a. Providers shall send DBHS copies of correspondence from the accrediting agency within five (5) business days of receipt;

b. Providers shall furnish DBHS copies of correspondence to the accrediting organization concurrently with sending originals to the accrediting organization.

2. An application for provider and site recertification:

a. DBHS must receive provider and site recertification applications at least fifteen (15) business days before the DBHS RSPMI certification expiration date;

b. The Re-Certification form with required documentation is available at www.arkansas.gov/dhs/dmhs

See Appendix # 11 DBHS Form 3 (Re-certification)

C. If DBHS has not recertified the provider and site(s) before the certification expiration date, certification is void beginning 12:00 a.m. the next day.

XIII. MAINTAINING DBHS RSPMI CERTIFICATION

A. Providers must:

1. Maintain compliance;

2. Assure that DBHS certification information is current, and to that end must notify DBHS within thirty (30) calendar days of any change affecting the accuracy of the provider's certification records;

3. Furnish DBHS all correspondence in any form (e.g., letter, facsimile, email) to and from the accrediting organization to DBHS within thirty (30) calendar days of the date the correspondence was sent or received except:

a. As stated in § XII;

b. Correspondence related to any change of accreditation status, which providers must send to DBHS within three (3) calendar days of the date the correspondence was sent or received.

c. Correspondence related to changes in service delivery, site location, or organizational structure, which providers must send to DBHS within ten (10) calendar days of the date the correspondence was sent or received.

4. Display the RSPMI certificate for each site at a prominent public location within the site

B. Annual Reports:

1. Providers must furnish annual reports to DBHS before July 1 of each year that the provider has been in operation for the preceding twelve (12) months. Community Mental Health Centers and specialty clinics may meet this requirement by submitting the Annual Plan/Basic Services Plan to DBHS.

2. Annual report shall be prepared by completing forms provided by DBHS. The annual report form is available at www.arkansas.gov/dhs/dmhs and at Appendix # 12 DBHS Form # 6

XIV. NONCOMPLIANCE

A. Failure to comply with this rule may result in one or more of the following:

1. Submission and implementation of an acceptable corrective action plan as a condition of retaining RSPMI certification;

2. Suspension of RSPMI certification for either a fixed period or until the provider meets all conditions specified in the suspension notice;

3. Termination of RSPMI certification.

XV. APPEAL PROCESS

A. If DBHS denies, suspends, or revokes any DBHS RSPMI certification (takes adverse action), the affected proposed provider or provider may appeal the DBHS adverse action. Notice of adverse action shall comply with Ark. Code Ann. §§ 20-77-1701-1705, and §§1708-1713. Appeals must be submitted in writing to the DBHS Director. The provider has thirty (30) calendar days from the date of the notice of adverse action to appeal. An appeal request received within thirty-five (35) calendar days of the date of the notice will be deemed timely. The appeal must state with particularity the error or errors asserted to have been made by DBHS in denying certification, and cite the legal authority for each

assertion of error. The provider may elect to continue Medicaid billing under the RSPMI program during the appeals process. If the appeal is denied, the provider must return all monies received for RSPMI services provided during the appeals process.

B. Within thirty (30) calendar days after receiving an appeal the DBHS Director shall: (1) designate a person who did not participate in reviewing the application or in the appealed-from adverse decision to hear the appeal; (2) set a date for the appeal hearing; (3) notify the appellant in writing of the date, time, and place of the hearing. The hearing shall be set within sixty (60) calendar days of the date DBHS receives the request for appeal, unless a party to the appeal requests and receives a continuance for good cause.

C. DBHS shall tape record each hearing.

D. The hearing official shall issue the decision within forty-five (45) calendar days of the date that the hearing record is completed and closed. The hearing official shall issue the decision in a written document that contains findings of fact, conclusions of law, and the decision. The findings, conclusions, and decision shall be mailed to the appellant except that if the appellant is represented by counsel, a copy of the findings, conclusions, and decision shall also be mailed to the appellant’s counsel. The decision is the final agency determination under the Administrative Procedure Act.

E. Delays caused by the appealing party shall not count against any deadline. Failure to issue a decision within the time required is not a decision on the merits and shall not alter the rights or status of any party to the appeal, except that any party may pursue legal process to compel the hearing official to render a decision.

F. Except to the extent that they are inconsistent with this policy, the appeal procedures in the Arkansas Medicaid RSPMI Provider Manual are incorporated by reference and shall control.

AGENCY NUMBER: 710

Certification Manual
For
Rehabilitative Services for Persons with Mental Illness

Appendix

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1 EXCLUSIONARY RULE

2 OWNERSHIP & CONVICTION DISCLOSURE FORM

3 DISCLOSURE OF SIGNIFICANT BUSINESS TRANSACTIONS

4 TECHNICAL TRAINING AGENDA FOR PROVIDER APPLICANTS & RSPMI OPERATION TECHNICAL ASSISTANCE TRAINING AGENDA

5 EXAMPLE OF DBHSFORM 1 (Initial Provider Application)

6 EXAMPLE OF DBHS FORM 2 (Initial Provider Application)

7 EXAMPLE OF SITE SURVEY FORM

8 EXAMPLE OF RSPMI CERTIFICATION CERTIFICATE

9 EXAMPLE OF DBHS FORM 4 (Closing & Moving Sites)

10 EXAMPLE OF DBHS FORM 5 (Adding Sites)

11 EXAMPLE OF DBHS FORM 3 (Re-Certification)

12 EXAMPLE OF DBHS FORM 6 (Annual Update)

Created:

Appendix #1

1088.0.0 **DHS PARTICIPANT EXCLUSION RULE**

1088.1.0 **Purpose**

1088.1.1 DHS shall conduct business only with responsible participants. Participants will be excluded from participation in DHS programs not as penalty, but rather to protect public funds, the integrity of publicly funded programs, and public confidence in those programs. It is also the intent of this policy to prevent excluded participants from substituting others, usually immediate family members, as surrogates to continue the practices that caused DHS to exclude the participant.

1088.1.2 Participant exclusion is a serious action that shall be used only in the State's best interests and for the protection of the public and DHS. DHS shall impose exclusion only in accordance with this rule.

1088.2.0 **Substantive Rules**

1088.2.1 **Definitions:**

A. Administrative Adjudication - an adjudication conforming to the Administrative Procedure Act, codified as Ark. Code Ann. §25-15-201 *et seq*. Administrative adjudications must be limited to the extent necessary to avoid compromising any ongoing criminal investigation.

B. Appropriation - the authority granted by the Arkansas General Assembly to expend public funds for specified purposes.

C. Automatic Exclusion - exclusion imposed following and based upon a final adjudication of one or more acts or omissions described in 1088.2.3. Participants automatically excluded cannot have an administrative adjudication of the facts or law determined by the final adjudication.

D. Civil Judgment - the disposition of a civil action by any court of competent jurisdiction, whether entered by verdict, decision, settlement, stipulation, or otherwise creating a civil liability for a wrongful act.

E. Collateral Exclusion - exclusion from one program based upon a previous final exclusion from another program as provided in 1088.2.5.A and B.

F. Common Ownership - when an entity, entities, an individual or individuals possess 5% or more ownership or equity in the participant.

G. Control - where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of a participant.

H. DHS - the Arkansas Department of Human Services, including all divisions, offices, and units thereof.

I. Director - the DHS Director or the Director's designee.

J. Due Process - a full and fair opportunity to be heard, including the right to call and cross examine witnesses, as part of a civil, criminal, or administrative adjudication.

K. Final Determination – Unless provided otherwise in federal law or regulation, a final determination exists when, with respect to a determination upon which the exclusion is based, the deadline to appeal that determination has passed or all appeals have been exhausted.

L. Immediate Family Member - spouse; natural or adoptive parent, child, or sibling; step-parent, child, or sibling; father, mother, brother, sister, son or daughter-in-law; grandparent or grandchild.

M. Nonconforming Commodities or Services - goods or services not in accordance with the obligations under the contract.

N. Participant - a person or entity that is a party or is seeking to become a party to a contract, grant or agreement with DHS to furnish commodities or services to, on behalf of, or as a grantee or sub-grantee or recipient of DHS.

O. Preponderance of the Evidence - proof of any nature that, when compared with that opposing it, leads to the conclusion that the fact in issue is more probably true than not.

P. Related Party - a person or an entity associated or affiliated with, or which shares common ownership, control, or common board members, or which has control of or is controlled by the participant.

Q. Temporary Exclusion - exclusion pending an investigation and adjudication (if the participant timely requests adjudication) imposed upon a finding that there is a reasonable basis to believe that one or more grounds for exclusion as specified in this rule exist.

1088.2.2 **Application**

This rule applies to all contracts, grants, and agreements between DHS and participants involving the expenditure of appropriated funds. The rights, obligations, and remedies created and imposed by this rule are in addition to any other laws and rules pertaining to contracts and grants.

1088.2.3 **Causes for Exclusion**

DHS shall automatically exclude a participant if the participant is the subject of final determination that the participant has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or *nolo contendere*, to any crime related to:

A. Obtaining, attempting to obtain, or performing a public or private contract or subcontract

B. Embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty

C. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony

D. Federal antitrust statutes

E. The submission of bids or proposals

F. Any physical or sexual abuse or neglect when the offense is a felony

1088.2.4 DHS shall exclude participants for any of the following acts or omissions that are of a character regarded by the Director to be so serious as to justify exclusion:

A. Refusal or knowing failure, without good cause, to comply with applicable requirements (including requirements contained or incorporated in statutes, rules, contracts, or purchase orders) or within the time provided in the contract or grant

B. Failure to perform or unsatisfactory performance, provided that the failure to perform or unsatisfactory performance beyond the control of the contractor or grantee shall not be considered to be a basis for exclusion

C. Failure to post any surety bond, or to provide similar guarantees acceptable to DHS required under any contract or grant

D. Substitution of commodities or services without prior written approval of DHS

E. Failure to cure nonconforming commodities or services within the lesser of a reasonable time, or the time specified in the contract or in a corrective action plan

F. Refusal to accept a contract or grant awarded in accordance with the request for proposal or invitation for bid

G. Making material misrepresentations or failing to make representations when required or when a reasonable person would naturally have been expected to affirm or deny the existence of a material fact

H. Collusion or collaboration with any bidder, proposer, or applicant in the submission of any proposal, bid, or grant application for the purpose of lessening or reducing competition

I. Failure to submit to or to supply an audit as required by federal or state law or rule

J. Failure or refusal, after request by DHS, to supply records related to the contract, proposal, bid, or application

K. Any act or omission that causes or materially contributes to placement of a lien upon the assets of the State

L. Conviction related to the use of illegal drugs, controlled substances, or other drug-related offenses when the offense is a misdemeanor

M. Any physical or sexual abuse or neglect when the offense is a misdemeanor

N. Submitting, without good cause, a bill or claim for payment exceeding the amount to which the participant is entitled

O. Failure to make repayment arrangements acceptable to the Department to repay any funds owed the Department, or failure to strictly adhere to the terms of any agreed-to repayment arrangements.

P. Failure to comply with professional standards of care or conduct applicable to the service provided.

Q. Failure to comply with standards or requirements relating to any license, permit, certification, other publicly granted authority, or accreditation needed to provide any service funded in whole or in part with public funds.

R. Failure to fully and accurately make any disclosures required by contract, federal or state law or rule.

S. Transaction of business in knowing contravention of an exclusion imposed under this rule.

1088.2.5 **Mandatory Exclusion:**

A. DHS shall exclude a participant that is presently subject to debarment, suspension, or other exclusion by any unit of the federal government or any unit of a state government, if the debarment, suspension, or exclusion was imposed after an opportunity for due process, and if federal law does not expressly prohibit collateral exclusion under the circumstances. Exclusion shall be concurrent with the period of debarment, suspension, or exclusion imposed by the federal or state government.

B. DHS shall exclude a participant upon learning that within the past year the participant was terminated for cause by any unit of the federal government or any unit of a state government, provided that the debarment or exclusion was imposed after an opportunity for due process, and provided that federal law does not expressly prohibit collateral exclusion under the circumstances. The term of exclusion shall be determined under section 1088.2.9.

1088.2.6 **Persons and Entities Excluded:** In addition to excluded participants, exclusion applies to:

A. All the participant's related parties, and the heirs and assigns of the participants and related parties.

B. The participant's immediate family members in order to prevent continued wrongdoing via a surrogate. Generally, immediate family members will be excluded from participation in any entity to which the excluded participant was a related party, any successor entity, or a start-up entity in the same or a similar program.

1088.2.7 Effect of Exclusion: Excluded participants may not receive appropriated funds except to the extent such funds are for proper charges approved before the date of exclusion. Payments are limited to the amount by which the proper charges exceed the amount of any indebtedness to DHS.

1088.2.8 DHS shall maintain a list of excluded participants. Upon being listed as an excluded participant, the participant cannot continue as a party to any DHS contract or grant, and is ineligible to submit proposals, bids, or applications to DHS for the term of the exclusion.

1088.2.9 **Term of Exclusion:** The term of the exclusion shall be set after consideration of the nature and seriousness of the wrongful act or omission warranting exclusion, the length of time since any wrongful act or omission warranting exclusion, and the goals and purposes underlying this rule. The term of exclusion must be stated in the exclusion determination. Exclusion shall be for not less than one year and at least until all appropriated funds, costs, and penalties owed to DHS by the participant are paid in full and the participant meets all contract or grant requirements as well as all applicable requirements in federal rules and laws. Exclusion of immediate family members and related parties shall run concurrently not to exceed five years.

1088.3.0 **Procedural Rules**

1088.3.1 DHS must prove the act or omission upon which the exclusion is based by a preponderance of the evidence. The participant must prove the elements of any defense by a preponderance of the evidence.

1088.3.2 Administrative due process shall be accomplished via existing DHS processes for appeals by participants.

1088.3.3 If a participant is entitled to an administrative hearing, the hearing must be held within a reasonable time after temporary exclusion, and before any exclusion other than a temporary exclusion.

DEPARTMENT CONTACT

Office of Finance and Administration
Policy and Administrative Program Management
P.O. Box 1437 – Slot W403
Little Rock, Arkansas 72203-1437
Telephone: (501) 682-6476

Ownership and Conviction Disclosure

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Ownership and Conviction Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full and accurate disclosure of ownership and financial interests is required. Failure to submit full and accurate requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, attach the information at the end of the provider application before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. (Example: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported).

Ownership or control interest: a person or corporation that: (1) has an ownership interest totaling 5 percent or more in a disclosing entity; (2) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (3) has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity; (4) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (5) is an officer or director of a disclosing entity that is organized as a corporation; or (6) is a partner in a disclosing entity that is organized as a partnership.

Ownership Interest: equity in the capital, stock, or profits of the disclosing entity. To determine the percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. (Example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 6% and must be reported. If B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported).

Managing employee: a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/ persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

Ownership and Conviction Disclosure

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, address and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or control interest of 5% or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. [This applies to all Medicaid providers.]

Individuals – for each individual listed, provide date of birth and social security number

Name	Address	% of interest	DOB	SS#

Corporations/Limited Liability Companies/Partnerships/Other legal Entities or Organizations – for each legal entity or organization listed, provide the tax identification number and submit a copy of the legal entity or organization's IRS form SS4 and the approval letter with this application.

Name	Address	% of interest	Tax ID #

Are any of the above mentioned persons related to each other as a spouse, parent, child, or sibling? Yes________ No________ If yes, print name and provide relationship.

Name	Relationship

Do any of the persons, legal entities or organizations with an ownership or control interest have any ownership or control interest of 5% or more in any other entity doing business with the Arkansas Medicaid Program? Yes_______ No_______ If yes, print name and give other provider name and percentage of interest.

Name	Other Provider	% of Interest

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Ownership and Conviction Disclosure

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, address, date of birth, and social security number for any person who is a managing employee of the named entity:

Name	Address	DOB	SS#

List any person who has a direct or indirect ownership or control interest in the named entity, or is an agent, or managing employee of the named entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs in any state:

Name	Offense

List names of persons or entities with direct/indirect ownership or control interest in the named entity, or is an agent or managing employee of the named entity who, as listed in DHS Policy 1088 (Participant Exclusion Rule), has been found guilty, or pled guilty or nolo contendere, to any crime related to: (1) obtaining, attempting to obtain, or performing a public or private contract or subcontract, (2) embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, (3) dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony, (4) federal antitrust statutes, (5) the submission of bids or proposals, (6) any physical or sexual abuse or neglect when the offense is a felony.

Name	Offense

Ownership and Conviction Disclosure

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name: (Print or Type) ___________________________________

Title: (Print or Type) ____________________________________

Signature: ______________________________________ Date: ___________________

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Disclosure of Significant Business Transactions

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Significant Business Transactions Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full, complete and accurate disclosure of ownership and financial interests is required. Failure to submit requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, please attach the information at the end of the application for new enrollments, or attached to the form for updated information from existing providers, before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program.

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

DMS-675 (9/08) Page 5 of 6

Disclosure of Significant Business Transactions

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Submit full, accurate and complete disclosure concerning the following information:
Ownership of any subcontractor with whom the named entity has had business transactions totaling more than $25,000 during the last 12 months (12 month period ending as of the date on this application).

____

____

____

Any significant business transaction between the named entity and any wholly owned supplier in the last 5 years (5 year period ending as of the date of this application).

____

____

____

Any significant business transaction between the named entity and any subcontractor in the last 5 years (5 year period ending as of the date of this application).

____

____

____

Beginning on the effective date of enrollment in the Arkansas Medicaid Program, full, accurate and complete disclosure shall be submitted concerning any significant business transaction that occurs between the named entity and any subcontractor or wholly owned supplier. This information shall be submitted within 35 days of the date the transaction takes place.

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name: (Print or Type) ____________________________________

Title: (Print or Type) _____________________________________

Signature: ______________________________________ Date: ___________________

TECHNICAL TRAINING FOR PROVIDER APPLICANTS

Beginning the RSPMI Application Process

1. Training sessions will be held at set times (at least quarterly) and all interested applicants may register to attend
2. Training sessions will be co-hosted by DBHS and DMS
3. Training topics and materials:
   i. Accreditation Requirements
   ii. Certification Process & Program Requirements
   iii. Expectations for Standards of Care
   iv. Licensing Requirements i.e. Child Care Licensing Standards, RCF Licensing Standards, Health Department Standards, Professional Licenses, Paraprofessional Certification
   v. Corporate Compliance Issues & Ethics
   vi. Overview of Medicaid Enrollment process and claims processing (referral information for connecting with EDS)
   vii. Overview of Utilization Management process (referral information for connecting with appropriate UM contractors)
   viii. Introduction to Policy (how to use the Medicaid manual and other source documents)

RSPMI OPERATION TECHNICAL ASSISTANCE TRAINING AGENDA

Beginning the RSPMI Process

I. Completion of the Disclosure Form

II. Medicaid Enrollment Process & Claims Processing (Referral Information for Connecting with EDS)

III. Utilization Management Process (Referral Information for Connecting Maintenance of DBHS Certification)

IV. Policy (how to use the Medicaid manual and other source documents)

V. Licensing requirements and referrals for Child Care Licensing Standards, RCF Licensing Standards, Health Department Standards, Professional Licenses, Paraprofessional Certification, etc.

VI. Expectations for standards of care (Best Practices and System of Care information)

VII. Corporate Compliance & Ethics

VIII. Maintenance of DBHS Certification

IX. OADAP License and Certification Information

** Training agendas may be adjusted according to program and regulation needs within DHS or for community/audience needs.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
QUALIFICATION FORM FOR RSPMI PROVIDER CERTIFICATION BY THE DIVISION OF BEHAVIORAL HEALTH SERVICES

To be completed upon initial application for DBHS RSPMI Certification.

Name of Agency: ____

Chief Executive Officer (or equivalent): ______________________________________

Corporate Compliance Officer (or equivalent):__________________________________

Administrative Address: ____

County: ____________________

Telephone: ______________________________ Fax: ____________________

E-mail: ____

Website: ____

1. The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

   ____ Joint Commission on Accreditation of Healthcare Organizations (J-CO)
   ____ Commission on Accreditation for Rehabilitation Facilities (CARF)
   ____ Council on Accreditation (COA)

2. Date(s) of most recent survey: __________________________

3. Accreditation Period: ____________________ through ____________________

4. The accredited provider is located within the State of Arkansas.

   ______ Yes ______ No

As the Chief Executive Officer (or equivalent) of the agency named above, I verify that all information contained in this form and in all attachments is correct and complete.

____ __________________

Signature of Chief Executive Officer (or equivalent) Date

____

Name of Chief Executive Officer (or equivalent) typed or printed

Created:

DBHS Form 1 Appendix #5

Qualification Form for RSPMI Provider Certification

All of the following information must be attached to the Qualification Form for RSPMI Certification (DBHS Form 1). Applications must be submitted in full.

1. Latest accreditation survey results. (The entire survey report covering outpatient mental health services must be included.)

2. Copies of all correspondence and e mails (e mails may be copied to the DBHS office) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient mental health services.

3. A signed agreement that DBHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery. (See DBHS Form 1 Attachment #1)

4. All Evidence of Compliance, Measures of Success, Performance Improvement Plans, and any Corrective Action Plans submitted to the accreditation organization pertaining to outpatient mental health services.

5. Annual RSPMI Services and Resource Summary Report with all attachments as designated in the RSPMI Services and Resource Summary Form (DBHS Form 2).

DBHS WILL SCHEDULE AN ONSITE SURVEY WITHIN TWENTY (20) CALENDAR DAYS OF APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164

Please send a cover letter and all application materials to be certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
OFFICE OF POLICY AND CERTIFICATION

Accreditation Organization Release of Information Consent

I, ___________________________, hereby consent to the exchange of information between
CEO (or equivalent)

____ and
Accrediting Agency

The Division of Behavioral Health Services, Policy and Certification Office, for the specific purpose of obtaining or sharing information relevant to RSPMI Provider Certification.

I consent to information regarding my agency's national accreditation or state certifications being released by facsimile (FAX) __________ Yes ___________ No.

I understand that the information I authorize for release may include sensitive information. I understand that a facsimile of this consent is considered as valid as if it were the original.

____ ____________________
Signature of CEO (or equivalent) Date

____ ____________________
Signature of Witness Date

Created:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
RSPMI SERVICES AND RESOURCE SUMMARY

State Fiscal Year XXXX: 7/01/20XX Through 6/30/20XX

Name of Agency: ____

Chief Executive Officer (or equivalent): ______________________________________

Corporate Compliance Officer (or equivalent): _________________________________

Administrative Address: ____

Telephone: ______________________ Fax: ______________

E-mail:____

Provider Type: ________ Private Non-Profit ________ Private For Profit __________ Public Entity

Other (Specify): ____

Chief Executive Officer (or equivalent) **Certification:** By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

Chief Executive Officer (or equivalent): ______________________________ Date: __________

PERSONNEL RESOURCES (as of the date this report is submitted)	**SFY XXXX**
1. Psychiatrists	
2. M.D. Non-psychiatrists	
3. Psychologists	
4. Psychological Examiners	
5. Psychological Examiners, Independent	
6. Licensed Certified Social Workers	
7. Licensed Master Social Workers	
8. Registered Nurses	
9. Licensed Professional Counselors	
10. MHP in Related Profession (LAC, LMFT)	
11. Mental Health Professionals (sum of lines 1-10)	
12. Mental Health Paraprofessionals	
13. All other staff not included above	
14. Sum of lines 11, 12, and 13	
PROGRAM RESOURCES (round to nearest whole number)	
15. Number of counties in service area	
16. Number of counties in service area in which agency operates a service site	
17. Total number of service sites operated by Agency	
18. Number of sites at which a psychosocial rehabilitative day program is operated	
19. Total daily capacity of all psychosocial rehabilitative day programs combined	
20. Total projected daily average attendance at all psychosocial day sites combined	
21. Number of School Based Mental Health Programs run by agency	
22. Total projected daily average of clients in all school based sites combined	
23. Total projected number of clients served in the out patient clinic	

Created:

24. Please list other mental health services provided by the organization and provide capacity information, as appropriate (i.e. residential beds, crisis beds, inpatient beds, housing, therapeutic foster care, etc.)		
24.A.		
24.B.		
24.C		
24.D		
If more room is needed, please list on a separate page and attach to this report.		
FINANCIAL RESOURCES – PROJECTED MEDICAID/MEDICARE INCOME (Projected for current fiscal year – July 1 through June 30)	**SFY XXXX**	**SFY XXXX**
25. Total Medicaid revenues		
26. Total Medicare revenues		
CONTACT INFORMATION		
27. Contact person regarding this report		
28. Telephone number of contact person for this report		
29. E-mail address of contact person for this report		

PERSONNEL QUALIFICATIONS & RESOURCES

1. Attach organizational chart for agency making certification application. (Include names of staff for each position)

2. Describe the agency's governing body, to include the make up of the Board of Directors, and the rules/policies regarding oversight of the executive and administrative staff. Include the coordinated management plan for all operations.

3. Attach policy and procedures related to Code of Ethics and Client Grievance Procedures.

4. Identify one Clinical Director for the entire agency. Include name, credentials, resume and contact information.

5. Attach licenses or certifications and resumes of all administrators, medical director and consulting psychiatrist if medical director is not a psychiatrist.

6. Attach all contracts with consulting professionals.

7. Explain how psychological testing services are delivered. Include names, licenses and any contracts or signed agreements related to psychological services.

8. Attach all existing contracts the agency has with any other providers or agencies (including schools) to provide RSPMI services.

9. Attach one job description for Licensed Mental Health Professionals and one for Certified Mental Health Para Professional personnel.

10. Attach policy for supervision of all direct care staff and the plan for staff training and supervision of those staff whose licensure or certification require professional supervision.

PHYSICAL PLANT(S)

1. Attach a list of all service delivery sites including each site's address (street, city & county), telephone number, fax number, the name of the designated contact person for each site and that person's email address, the geographic area served by each site and the RSPMI services available at each site.

2. Submit website if available.

3. Attach a photograph of each service delivery site. Include outside entrance to building, staff offices and waiting area.

4. Describe any projected plan for expansion of the physical plant post RSPMI certification. Please include time frames for the expansions.

SERVICE DELIVERY PLAN CURRENTLY IN PLACE FOR EACH SITE

In a narrative report, describe the agency's plan for the provision of services including all requested information in compliance with the current RSPMI Certification Policy and RSPMI Medicaid Manual. Please utilize the following format:

I. Type of services available at each site, hours of operation and type of clients served (i.e. children, adults, Seriously Mentally Ill, Seriously Emotionally Disturbed, Juvenile Justice population, school based sites etc.)

II. The number of clients the agency is currently serving. Include the age ranges and total numbers of children (3y/o – 12y/o), adolescents (13 y/o – 17y/o) and adults (18y/o – 21y/o). Also, include the average length of treatment for clients served by the agency.

III. Identify the names and locations of schools where the agency provides services. Include the number of children/adolescents served in each school and specific services that are provided in each school (i.e. individual therapy, group therapy, day treatment case management). If the agency does not currently provide services in school, please identify any plans to do so in the future and the projected number of students anticipated to be treated.

IV. Description of agency's crisis services plan that is available at each site including policy and procedures for provision of crisis services 24 hours a day; 7 days a week.

V. Describe any plans for expansion or reduction in services, as described above, for the current fiscal year.

VI. Treatment Process:

A. Briefly describe the following:
(This item must include a description of the resources and procedures used to ensure the timely delivery of services and the policy addressing family involvement in treatment.)
1. How a client accesses treatment/services
2. Intake/diagnostic process (Include a sample of assessment instrument(s)
3. Treatment planning and review process (Include a sample of Treatment Plan and Treatment Plan Review)

B. Describe the agency's process for assessing, and criteria used to determine, which clients would benefit from case management services provided by mental health paraprofessionals. Briefly state the Center's definition of case management and how paraprofessionals will be utilized in service delivery including coordination/supervision with clinical staff.

C. Briefly explain how the agency utilizes and interfaces with other community resources to provide services for the recipient to reinforce the agency's efforts to support the System of Care.

VII. Substance Abuse Services: Describe in detail substance abuse services provided by the agency, including services for co-occurring disorders.

VIII. Submit plans and activities to overcome cultural and linguistic barriers to treatment.

IX. Quality Assurance & Improvement Efforts:

A. Submit the policy and procedures for the agency's quality assurance committee. Include committee make up, schedule for meetings and procedural activities.

B. Describe at least three significant quality improvement efforts the agency has initiated or plans to undertake during the coming fiscal year. Describe the outcomes expected and the methods by which these outcomes will be monitored.

This RSPMI Service Resource Summary and Plan of Services should cover the current fiscal year. If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send this form with your application to be certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

Created:

Appendix #7

PROVIDER SITE SURVEY FOR DBHS RSPMI CERTIFICATION REPORT

DHS/DBHS Reviewer(s): ____

#	Service Site Name/Location/Telephone/Fax/Site Coordinator	Date(s) of IOF
1		
2		

Chief Executive Officer (or equivalent): ______________________________________

Medical Director: ____

Clinical Supervisor: ____

Corporate Compliance Officer: ____

<u>1: Clinical Record Management</u>

1. Name of Medical Records Librarian: _____________________________________
2. Description of Medical Records Security
3. Review of Clinical Charts and Forms

<u>2: Client Services</u>

1. The services provided as well as the provider's service plans
2. Review of Client Rights
3. Activities to overcome cultural and linguistic barriers to treatment.
4. Review of Grievance Procedures Name of Grievance Officer: __________________________
5. Review of Emergency Services Policy Postings and Notification of Emergency Information

<u>3: Physical Plant</u>

1. Posting of Accreditation
2. General Appearance
3. Life Safety
4. Privacy and Confidentiality/ Name of Privacy Officer: ________________________________
5. Medication Storage
6. Handicap Accessibility

<u>4: Date of RSPMI Services Availability & Programs Overview</u>

1. Outpatient Services—individual and family therapy at a minimum
2. Intervention services—on-site and off-site at a minimum
3. Medication Management
4. Crisis Services
5. Psychological Evaluation
6. Rehab Day

<u>5: Staff Requirements (Personnel Record Documentation)</u>

1. Policy for Staff Supervision
2. Documentation of Supervision Required by Licensure
3. Contract of Medical Director and Psychiatrist providing oversight
4. Policy for Quality Assurance Committee/Schedule of Activities and Quality Assurance Coordinator
5. Schedule and Process for Clinical Reviews

6. Process for justifying documentation with billing & compliance with Medicaid Regulations
7. Current Staff Composite
8. Documentation and Schedule for training of paraprofessionals
9. Procedure for utilizing paraprofessionals

CLIENT INTERVIEWS:

Summary

Recommendations:

Created:

Appendix #8
Example of Certification Certificate

Arkansas Department of Human Services

Division of Behavioral Health Services

Presents this certification for

Rehabilitative Services for Persons with Mental Illness

to

Behavioral Health Services Provider

123 Main Street in Anytown, Arkansas

This Certification extends through April XX, 20XX.

The mission of the Division of Behavioral Health Services is to improve the quality of life for Arkansans by providing recovery-based, consumer driven behavioral health care utilizing evidence-based practices.

Director
Policy and Certification

Director
Division of Behavioral Health Services

Created:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
NOTIFICATION FORM FOR CLOSING OR MOVING OF AN RSPMI PROVIDER SITE

Moving a site constitutes a closing of one site and a move of the program(s), move of existing staff and move of existing client base to another location. If a provider relocates a currently certified site within a fifty (50) mile radius the accrediting agency, DBHS and Medicaid must be notified thirty (30) days prior to that relocation. Neither an on-site survey nor a new Medicaid number is required in order to extend certification to the moved location.

Name of Agency:

____

Chief Executive Officer (or equivalent): ________________________

Corporate Compliance Officer (or equivalent): ________________________

Administrative Address: ____________________________________

____

Telephone: ____________________ Fax: ____________________

E-mail: ______________________________

This is notification that the following site(s) have:

________ moved ______closed

<u>CLOSING</u> Date of Closing: ____________________

ADDRESS:

____

____

____

____

<u>MOVING</u> Date of Move: ____________________

PREVIOUS ADDRESS (Include: street, city, county, telephone & fax) NEW ADDRESS

PREVIOUS ADDRESS	NEW ADDRESS
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please attach all documentation to and from your accrediting organization regarding the above information. Certification will not be granted to the new site address until all information from the accrediting organization indicates that the new site address is accredited.

Chief Executive Officer (or equivalent) **Certification**: By my signature I verify that all information contained in this form and in all attachments is correct and complete.

____________________________________ ________________

Signature of Chief Executive Officer (or equivalent) Date

____

Name of Chief Executive Officer (or equivalent) typed or printed

Created:

Page Two
Notification Form for Closing/Moving

1. In addition to this form, please provide any information that is specific to the site/s for which certification is being requested that is different from those agency sites already certified by DBHS.

2. Include a photograph of outside entrance to building, staff offices, and waiting area for all new site locations.

If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send this form with required documentation to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

Created:

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES
RSPMI SERVICES AND RESOURCE SUMMARY

ADDITIONAL SITES SINCE LAST CERTIFICATION

State Fiscal Year 20XX: 7/01/20XX Through 6/30/20XX

Name of Agency:

____

Chief Executive Officer (or equivalent):

____

Corporate Compliance Officer (or equivalent):

____

Administrative Address:

____
____
____
____

Telephone: ____________________________ **Fax:** ____________________________

E-mail: ____

NEW SITE PHYSICAL ADDRESS: **DATE SITE OPENED:**__________________

____
____
____
____

Telephone:________________________ **Fax Number:** ____________________

E-mail:____________________________________

Chief Executive Officer (or equivalent) Certification: By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

____ ____________________
Name of Chief Executive Officer (or equivalent) typed or printed Date

____
Signature of Chief Executive Officer (or equivalent)

Created:

PERSONNEL RESOURCES FOR NEW SITE ONLY (as of the date this report is submitted)	SFYXX	
1. Psychiatrists		
2. M.D. Non-psychiatrists		
3. Psychologists		
4. Psychological Examiners		
5. Psychological Examiners, Independent		
6. Licensed Certified Social Workers		
7. Licensed Master Social Workers		
8. Registered Nurses		
9. Licensed Professional Counselors		
10. MHP in Related Profession (LAC, LMFT)		
11. Mental Health Professionals (sum of lines 1-10)		
12. Mental Health Paraprofessionals		
13. All other staff not included above		
14. Sum of lines 11, 12, and 13		
PROGRAM RESOURCES FOR NEW SITE ONLY (round to nearest whole number)		
15. Number of counties in service area		
16. Number of counties in service area in which agency operates a service site		
17. Total number of service sites operated by agency		
18. Number of sites at which a psychosocial rehabilitative day program is operated		
19. Total daily capacity of all psychosocial rehabilitative day programs combined		
20. Total projected daily average attendance at all psychosocial day sites combined		
21. Number of school based sites that service site projects to operate		
22. Total projected daily average of clients in all school based sites combined		
23. Total projected number of clients served in the out patient clinic		
24. Please list other mental health services provided by the organization and provide capacity information, as appropriate (i.e. residential beds, crisis beds, inpatient beds, housing, therapeutic foster care, etc.)		
25. A		
26. B		
27. C		
28. D		
If more room is needed, please list on a separate page and attach to this report.		
FINANCIAL RESOURCES PROJECTED MEDICAID/MEDICARE INCOME FOR NEW SITE ONLY	SFYXX	SFYXX
29. Total Medicaid revenues		
30. Total Medicare revenues		
CONTACT INFORMATION		
33. Contact person regarding this report		
34. Telephone number of contact person for this report		
35. E-mail address of contact person for this report		

PERSONNEL QUALIFICATIONS & RESOURCES

1. Attach administrative structure for the new site/s for which extension of certification is being requested.

2. Attach licenses or certifications and resumes of all administrators of the new site. Include the medical director or consulting psychiatrist information if different from the main office site.

3. Attach any contracts with consulting professionals specific to the new site only if additional to the original certification.

PHSYICAL PLANT

1. Attach a list of all new service delivery sites including each site's address (street, city & county), telephone number, fax number, the name of the designated contact person, for each site and that person's email address, the geographic area served by each site and the RSPMI services available at each site.

Created:

2. Attach a photograph of each service delivery site for which you are requesting a certification extension. Include outside entrance to building, staff offices, and waiting area.

SERVICE DELIVERY PLAN THAT IS CURRENTLY IN PLACE FOR EACH NEW SITE

In a narrative report, describe the agency's plan for the provision of services including all requested information in compliance with the current RSPMI Certification Policy and RSPMI Medicaid Manual. Please utilize the format below:

1. Type of services available at additional site/s, hours of operation and type of clients served (i.e. children, adults, Seriously Mentally Ill, Seriously Emotionally Disturbed, Juvenile Justice population, etc.)

2. Provide any information that is specific to the site/s for which certification is being requested that is different from those agency sites already certified by DBHS.

3. Description of agency's crisis services plan that is available at the new site including the policy and procedures for provision of crisis services 24 hours a day 7 days a week.

4. Briefly explain how the new site will utilize and interface with other community resources to provide services for the recipient to reinforce the agency's efforts to support the System of Care.

5. Describe how the new site will be integrated into the Quality Improvement Program of the agency.

ACCREDITATION INFORMATION

I. Attach documentation notifying your accrediting organization of the site/s addition/s and the accrediting organization's acknowledgement of the accreditation extension. Certification extension **WILL NOT BE GRANTED** until you have the accrediting organization's documentation.

II. Include dates of current accreditation cycle.

This RSPMI Service Resource Summary and Plan of Services should cover the current fiscal year. If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send this form along with your application to be certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
QUALIFICATION FORM FOR RSPMI PROVIDER RE-CERTIFICATION BY THE DIVISION OF BEHAVIORAL HEALTH SERVICES

To be submitted to renew DBHS certification after receiving re-accreditation from the national accrediting agency at the time of the new accreditation cycle.

Name of Agency:

____

Chief Executive Officer (or equivalent): ____________________________________

Corporate Compliance Officer (or equivalent): _______________________________

Administrative Address: ____

Telephone: ______________________________ Fax: __________________

E-mail: ____

1. The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

____ Joint Commission (J-CO)

____ Commission on Accreditation for Rehabilitation Facilities (CARF)

____ Council on Accreditation (COA)

2. Date of most recent survey: __________________________

3. National Accreditation Period: ____________________ through _________________

4. The accredited provider is located within the state of Arkansas.

______ Yes ______ No

Chief Executive Officer (or equivalent) Certification: By my signature I certify that all information contained in this form and in all attachments are correct and complete.

____ _____________

Signature of Chief Executive Officer (or equivalent) Date

____

Name of Chief Executive Officer (or equivalent) typed or printed

Created:

Qualification Form for RSPMI Provider Re-Certification

All of the following information must be attached to the Qualification DBHS Form 3 for RSPMI Re-Certification. Applications must be submitted in full. Partial submissions will not be accepted.

1. Latest accreditation survey results. (The entire survey report with a listing of all provider service sites providing outpatient mental health services must be included.)

2. Copies of all correspondence and e-mails (e-mails may be copied to the DBHS office) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient behavioral health services.

3. A signed agreement that DBHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery.

4. All Evidence of Compliance, Measures of Success, Quality Improvement Plans, and any Corrective Action Plans that were required and submitted to the accrediting organization pertaining to outpatient behavioral health services related to the latest accreditation survey.

5. Identify any significant changes (since last certification period) in program resources (i.e. number of sites operated by agency, changes in administrative staff, and number of school-based Mental Health Programs). Please attach additional pages if needed.

____
____
____
____
____
____

6. Identify any significant changes (since last certification period) in personnel qualifications and resources (i.e. changes in code of ethics and client grievance policy, changes in how psychological testing services are delivered and changes in the plan for staff training and supervision). Please attach additional pages if needed.

____
____
____
____
____
____

7. Identify any significant changes (since last certification period) in the physical plant(s). (i.e. changes in address and phone numbers of service delivery sites, any structural/cosmetic changes). Please attach additional pages if needed.

____
____
____
____
____
____

Created:

8. Describe any significant changes (since last certification period) in the service delivery plan (i.e. types of services available at each site, changes in the crisis services plan and any plans for expansion or reduction in services). Please attach additional pages if needed.

If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send a cover letter and all application materials to be re-certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES
RSPMI ANNUAL REPORTING FORM

State Fiscal Year 20XX: 7/01/XX through 6/30/XX

Name of Agency:

____

Chief Executive Officer (or equivalent):

____

Corporate Compliance Officer (or equivalent):

____

Address:

____

____

Phone Number :________________________ Fax Number: ______________________

E-Mail:

Provider Type: Private Non-Profit ________ Private For Profit __________ Public Entity _________

Other (Specify): ____

Chief Executive Officer Certification (or equivalent): By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

____ ______________________

Signature of Chief Executive Officer (or equivalent) Date

____

Name of Chief Executive Officer (or equivalent) typed or printed

THIS REPORT RELATES TO AGENCY WIDE INFORMATION

1. Please include all annual reporting requirements from the accrediting organization. This includes Annual Conformance to Quality Report, Maintenance of Accreditation or Periodic Performance Review. Please include all correspondence to and from the accrediting organization related to annual reporting requirements.

2. **RSPMI services provided at the agency (Please check all that apply):**

Individual Therapy
Family Therapy
Group Therapy
Rehabilitative Day Treatment
Adults U-21

Crisis Services
Acute Day Treatment
Adults U-21
Residential Programs
Adults U-21

Medication Management
Psychological Evaluation

MHPP Case Management
School Based

Created:

After School Programs School Linked
Other
(Please Explain):

____

3. Provider's plans and activities to overcome cultural and linguistic barriers to treatment. (Please include a brief statement regarding on-going efforts to serve clients from diverse backgrounds as well as those clients that may have physical disabilities.)

4. **Staff Composition (Please fill out the following chart)**

THIS INFORMATION RELATES TO AGENCY WIDE INFORMATION PERSONNEL RESOURCES

(As of the date this report is submitted, report the number of employees. Also, indicate whether the employee is salary (W-9) or contract (10-99).)

See following page for example of filling out Staff Composition Chart.

	TOTAL	W-9 or 10-99
1. Psychiatrists		
2. M.D. Non-psychiatrists		
3. Psychologists		
4. Psychological Examiners		
5. Psychological Examiners, Independent		
6. Licensed Certified Social Workers		
7. Licensed Master Social Workers		
8. Registered Nurses		
9. Licensed Professional Counselors		
10. MHP in Related Profession (LAC, LMFT)		
11. Mental Health Professionals (sum of lines 1-10)		
12. Mental Health Paraprofessionals		
13. All other staff not included above		
14. Sum of lines 11, 12, and 13		

Created:

See following example as a guideline for filling out Staff Composition Chart. For a provider that has 3 psychiatrists, 6 licensed certified social workers, and 1 psychologist, the chart would look like:

	TOTAL	W-9 or 10-99
1. Psychiatrists	3	1 (W-9) 2(10-99)
2. M.D. Non-psychiatrists	2	2(10-99)
3. Psychologists	1	1(10-99)
4. Psychological Examiners	4	4(W-9)
5. Psychological Examiners, Independent	2	1(W-9) 1(10-99)
6. Licensed Certified Social Workers	6	6(W-9)
7. Licensed Master Social Workers	2	2(W-9)
8. Registered Nurses	2	1(W-9) 1(10-99)
9. Licensed Professional Counselors	6	4(W-9) 2(10-99)
10. MHP in Related Profession (LAC, LMFT)	2	1(W-9) 1(10-99)
11. Mental Health Professionals (sum of lines 1-10)	30	20(W-9) 10(10-99)
12. Mental Health Paraprofessionals	15	12(W-9) 3(10-99)
13. All other staff not included above	20	N/A
14. Sum of lines 11, 12, and 13	65	32(W-9) 13(10-99)

5. **Interagency involvement** (Please identify all existing formal or informal contracts the agency has with other providers or agencies to provide RSPMI services. Briefly explain how the agency utilizes and interfaces with other community resources to provide services for the recipient to reinforce the agency's efforts to support Recovery Model and System of Care philosophies.)

6. **Agency wide quality improvement and outcomes activities** (Please include agency organizational chart and the outcomes of identified quality improvement efforts to improve client care/outcomes.)

PLEASE SUBMIT THIS FORM AND INFORMATION TO:

Division of Behavioral Health
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

Created:

FOR DBHS INTERNAL USE ONLY:

1) Services Provided Yes ___ No ___
Status: Complete

2) Cultural/Linguistic Barriers Yes ___ No ___
Status: Complete

3) Staff Composition Yes ___ No ___
Status: Complete

4) Interagency Involvement Yes ___ No ___
Status: Complete

5) Quality Improvement Yes ___ No ___
Status: Complete

6) ACQR MOA PPR Yes___ No ___

Comments:

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Created: