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Arkansas
Mental Health System Guidebook

December 2018 MRC2.CORP.X.03164

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This resource is provided for informational purposes only and is not intended as reimbursement or legal advice.

You should seek independent, qualified professional advice to ensure that your organization is in compliance with the complex legal and regulatory requirements governing health care services, and that treatment decisions are made consistent with the applicable standards of care.

Except as otherwise indicated, the information provided is accurate to the best of Otsuka's knowledge as of December 2018. PsychU provides this information for your convenience. In order to obtain the most up-to-date information about a state or its programs, please contact the organization listed within this state's Mental Health System Guidebook.

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Behavioral Health Market Profile Overview

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A. Executive Summary

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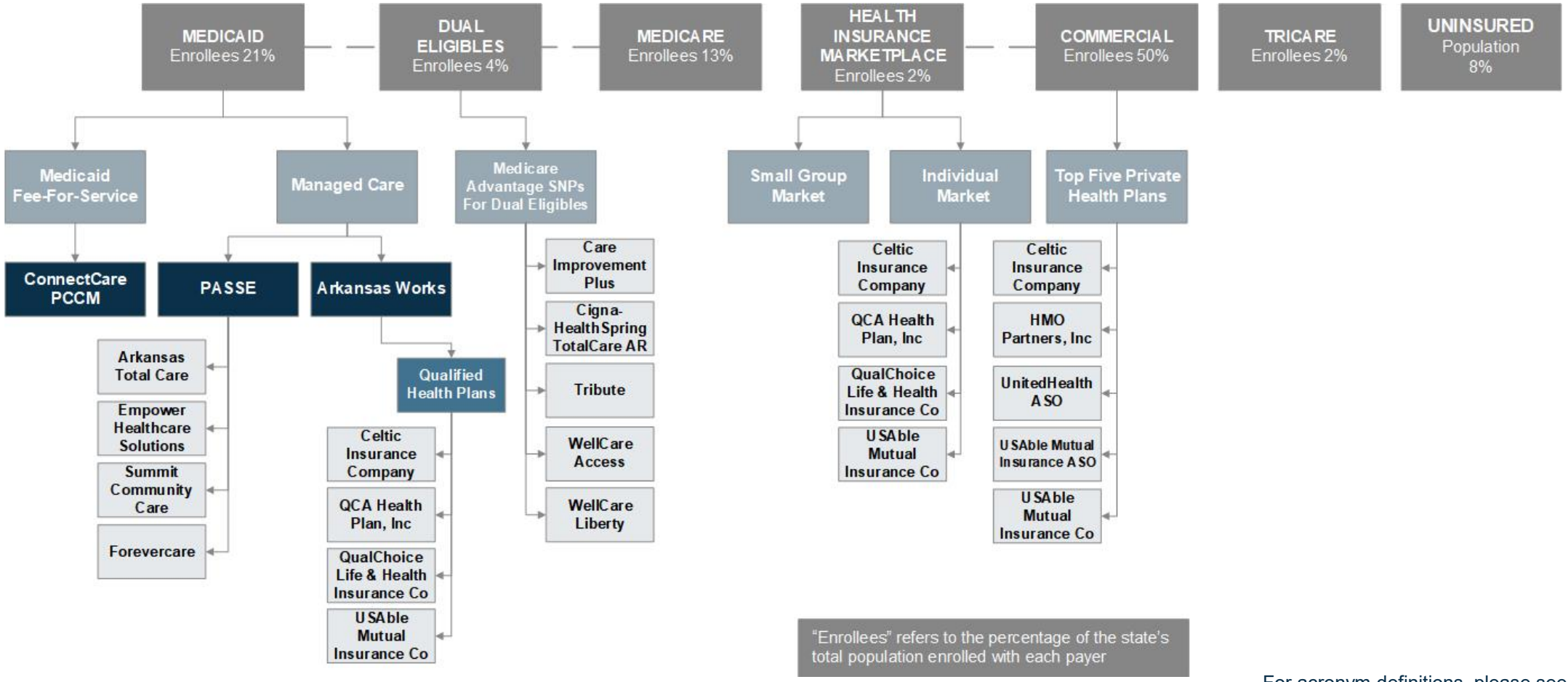
A.1. Arkansas Physical Health Care Coverage Map

Total Arkansas Population- 2,988,248
Estimated SMI Population- 145,064



For acronym definitions, please see Appendices.

A.2. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid Population Distribution	• As of August 2018: 67% in fee-for-service (FFS), 33% in managed care
SMI Population Inclusion In Managed Care	• Arkansas does not specifically preclude individuals with SMI from enrolling in managed care, therefore, the majority of the SMI population is enrolled in managed care • Estimated 30% of population in FFS, 70% in managed care
Dual Eligible Population Inclusion In Managed Care	• Managed care is mandatory for dual eligibles who have a behavioral health diagnosis and are in need of more intensive services, or who have an intellectual and developmental disability (I/DD) • Estimated 70% of population in FFS, 30% in managed care

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	**FFS Population**	**Managed Care Population**
Traditional Behavioral Health	Covered FFS by the state	PASSE: As of March 2019 will be included in the health plan's capitation rate AR Works: Included in the health plan's capitation rate
Specialty Behavioral Health	Covered FFS by the state	PASSE: As of March 2019 will be included in the health plan's capitation rate AR Works: Included in the health plan's capitation rate
Pharmaceuticals	Covered FFS by the state	PASSE: As of March 2019 will be included in the health plan's capitation rate AR Works: Included in the health plan's capitation rate
Long-Term Services & Supports (LTSS)	Covered FFS by the state	Waiver services for individuals with I/DD will be included in the PASSE's capitation rate; all other LTSS will be covered FFS by the state

For acronym definitions, please see Appendices.

A.3. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan	✓	The PASSEs will be responsible for care coordination
Primary Care Case Management (PCCM)	✓	The state's PCCM program is called ConnectCare
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home		None
Patient-Centered Medical Home (PCMH)	✓	The state has a PCMH program with a shared savings component

For acronym definitions, please see Appendices.

A.4. Behavioral Health Safety-Net Delivery System

State Agency Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The Office Of Rural Health & Primary Care within the state Department Of Health is responsible for providing physical health services to the safety-net population

Mental Health Services

- The Division Of Behavioral Health Services within the Department Of Human Services provides mental health services to the safety-net population by funding 12 community mental health centers

Addiction Treatment Services

- The Division Of Behavioral Health Services within the Department Of Human Services provides addiction disorder treatment services to the safety-net population through a network of provider organizations

For acronym definitions, please see Appendices.

A.5. Behavioral Health Safety-Net Delivery System

CMHCs

- The Division Of Behavioral Health Services (DBHS) contracts with 12 community mental health centers (CMHCs) and two specialty CMHCs to provide mental health services to the safety-net population; each CMHC serves as the single point of entry into the public mental health system for adults in its catchment area
- CMHC services include the following:
  - Emergency services
  - Outpatient evaluation and treatment
  - Rehabilitative services
  - Screening and referral for inpatient care
- CMHCs provide services to the Medicaid population along with the uninsured population
- DBHS also delivers addiction disorder treatment services to the underinsured population by contracting with local provider organizations throughout the state; services include—but are not limited to—counseling and residential treatment services

For acronym definitions, please see Appendices.

A.6. Behavioral Health Safety-Net Delivery System

CMHC Catchment Areas

Region	Community Mental Health Center	Counties Served
Area 1	Ouachita Behavioral Health & Wellness	Clark, Garland, Hot Spring, Montgomery, Pike
Area 2	Counseling Associates, Inc	Cleburne, Conway, Faulkner, Johnson, Perry, Pope, Searcy, Stone, Van Buren, Yell
Area 3	Counseling Clinic, Inc	Saline
Area 4	Delta Counseling Associates	Ashley, Bradley, Chicot, Desha, Drew
Area 6	Little Rock Community Mental Health Center, Inc	Area of Pulaski County southwest of the Arkansas River
Area 7	Mid-South Health Systems, Inc	Clay, Craighead, Crittenden, Cross, Fulton, Greene, Independence, Izard Jackson, Lawrence, Lee, Mississippi, Monroe, Phillips, Poinsett, Randolph, Sharp, St. Francis, White, Woodruff
Area 8	Ozark Guidance Center Inc	Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Washington
Area 9	Professional Counseling Associates	Lonoke, Prairie; area of Pulaski County northeast of the Arkansas River
Area 10	South Arkansas Regional Health Center	Calhoun, Columbia, Dallas, Nevada, Ouachita, Union
Area 11	Southeast Arkansas Behavioral Healthcare System, Inc	Arkansas, Cleveland, Grant, Jefferson, Lincoln
Area 12	Western Arkansas Counseling & Mental Health Center, Inc	Hempstead, Howard, Lafayette, Little River, Miller, Sevier
Area 13	Western Arkansas Counseling & Guidance Center	Crawford, Franklin, Logan, Polk, Sebastian, Scott

For acronym definitions, please see Appendices.

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B. Arkansas Health Financing System Overview

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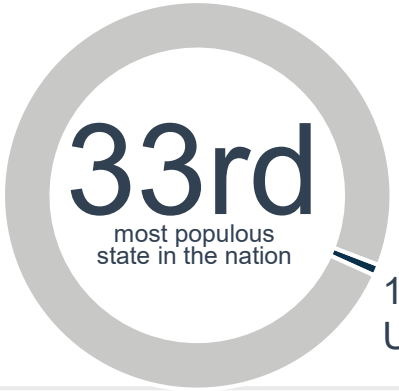
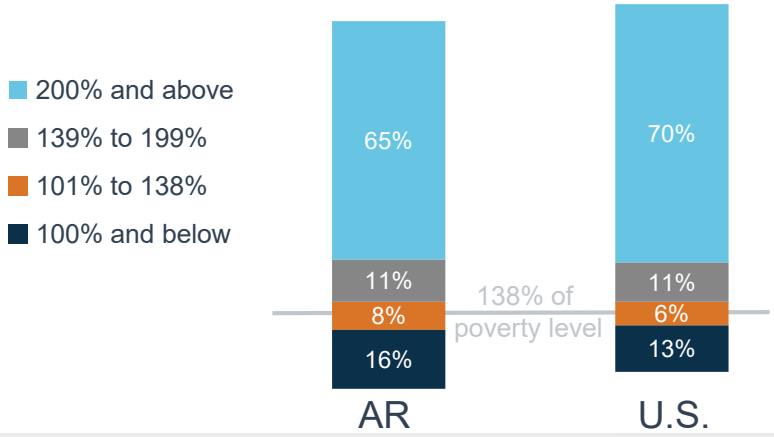
B.1. Population Demographics

Total Arkansas Population- 2,988,248
Estimated SMI Population- 145,064



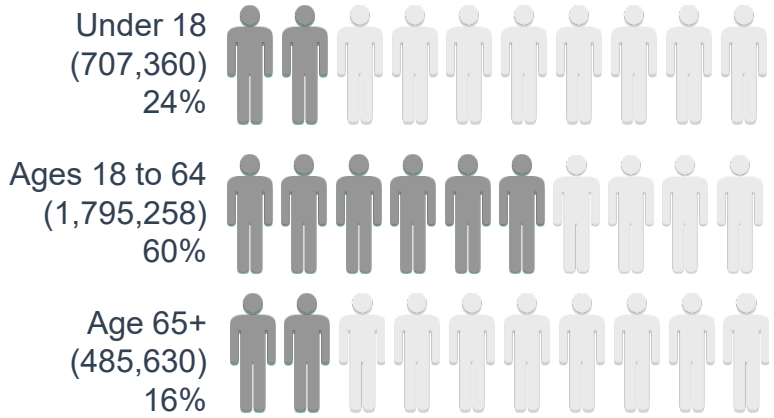
1% of the
U.S. population

Population Distribution By Income To Poverty Threshold Ratio

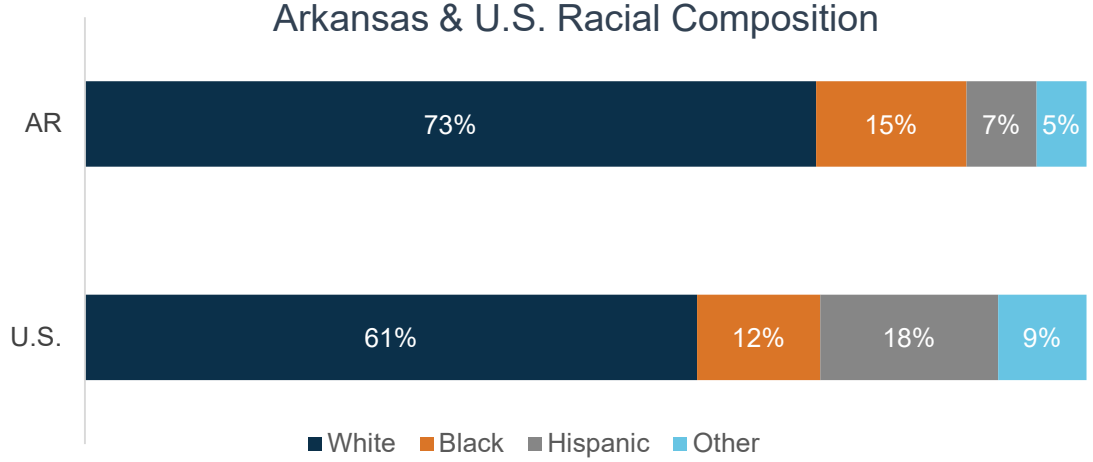


Median Income
Arkansas $44,334
U.S. $57,617

Population Distribution By Age

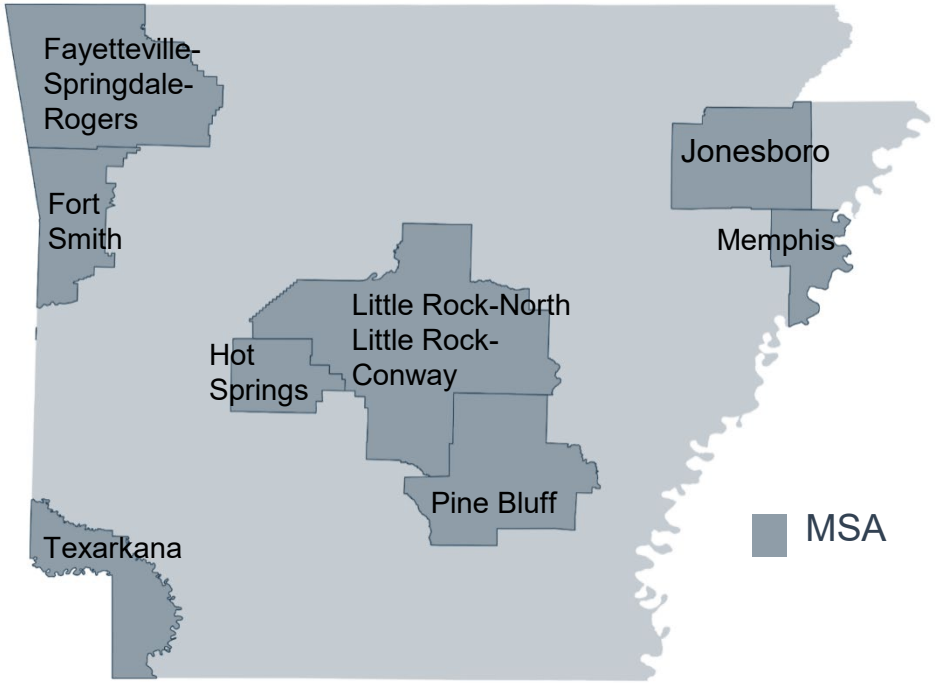


Arkansas & U.S. Racial Composition



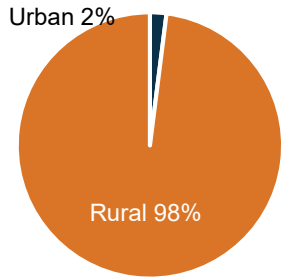
For acronym definitions, please see Appendices.

B.2. Population Centers

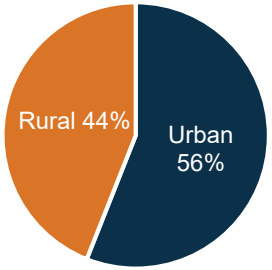


Metropolitan Statistical Areas (MSAs)		
MSA	**Arkansas Residents**	**Percent Of Population**
Total MSA Population	1,851,864	62%
Little Rock-North Little Rock-Conway, AR	734,622	25%
Fayetteville-Springdale-Rogers, AR-MO	502,412	17%
Fort Smith, AR-OK	190,060	6%
Jonesboro, AR	129,858	4%
Hot Springs, AR	97,477	3%
Pine Bluff, AR	91,962	3%
Texarkana, TX-AR	56,238	2%
Memphis, TN-MS-AR	49,235	2%

Distribution Of Land Area



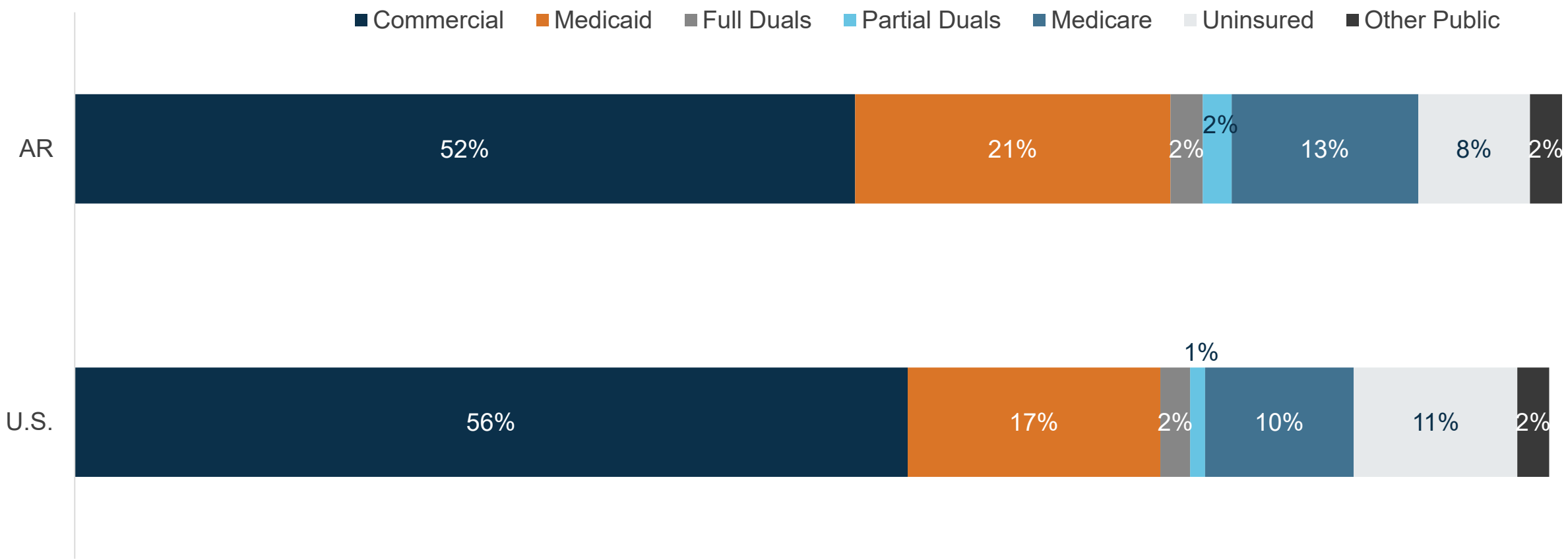
Distribution Of Population



For acronym definitions, please see Appendices.

B.3. Population Distribution By Payer

National Vs. State



For acronym definitions, please see Appendices.

B.4. Largest Arkansas Health Plans
By Enrollment

Plan Name	Plan Type	Enrollment*
Usable Mutual Insurance Company	Commercial Administrative Services Organization (ASO)	1,058,552
Medicaid Fee-For-Service (FFS)	Medicaid	639,145
Medicare FFS	Medicare	446,235
Usable Mutal Insurance Company	Commercial	433,542
UnitedHealth	Commercial ASO	115,610
TRICARE	Other public	86,608
Celtic Insurance Company	Commercial	85,720
HMO Partners	Commercial ASO	68,808
HMO Partners	Commercial	67,738
QCA Health Plan	Commercial ASO	66,367

* Medicaid enrollment as of August 2018; TRICARE as of April 2018; Commercial as of 4th quarter 2017; Medicare enrollment as of September 2017

For acronym definitions, please see Appendices.

B.5. Largest Arkansas Health Plans

By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicare FFS	Medicare	446,235	63,812
Usable Mutual Insurance Company	Commercial ASO	1,058,552	24,347
Medicaid FFS	Medicaid	639,145	12,004
Usable Mutal Insurance Company	Commercial	433,542	9,971
Care Improvement Plus Medicare Advantage	Medicare	37,233	5,324
TRICARE	Other public	86,608	4,850
Humana Gold Plus	Medicare	29,474	4,215
Empower Healthcare Solutions	Medicaid	14,653	4,209
Summit Community Care	Medicaid	9,606	3,585
UnitedHealth	Commercial ASO	115,610	2,659

* Medicaid enrollment as of August 2018; TRICARE as of April 2018; Commercial as of 4th quarter 2017; Medicare enrollment as of September 2017

For acronym definitions, please see Appendices.

B.6. Health Insurance Marketplace

Health Insurance Marketplace	
Type Of Marketplace	Individual: State-based, using federal platform Small group: State-based
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	No small group plans are available through the marketplace; employers must purchase coverage directly from an insurance carrier or through an insurance broker

2018 Individual Market Health Plans
1. Celtic Insurance Company 2. QCA Health Plan, Inc 3. QualChoice Life & Health Insurance Company, Inc 4. USAble Mutual Insurance Company

2018 Small Group Market Health Plans
None

For acronym definitions, please see Appendices.

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C. Medicaid Administration, Governance & Operations

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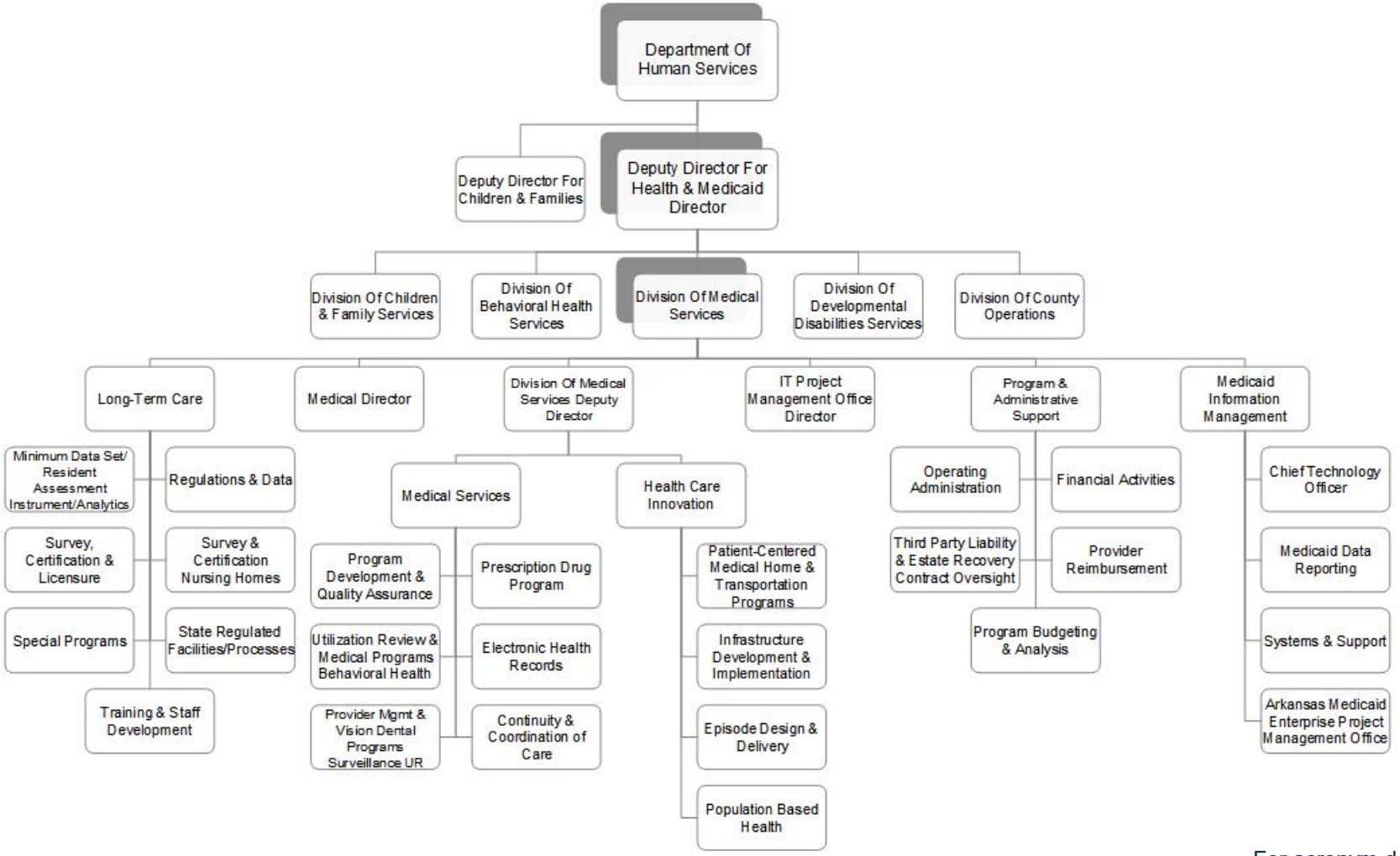
C.1. Medicaid Governance

Organization Chart



For acronym definitions, please see Appendices.

C.2. Medicaid Governance

Key Leadership

Name	Position	Department
Cindy Gillespie	Director	Department Of Human Services (DHS)
Dawn Stehle	Deputy Director, State Medicaid Director	DHS
Tami Harlan	Director	DHS, Division Of Medical Services
William Golden	Medical Director	DHS, Division Of Medical Services
Paula Stone	Deputy Director, Innovations	DHS, Division Of Medical Services
Dennis Smith	Senior Advisor For Medicaid & Healthcare Reform	DHS

For acronym definitions, please see Appendices.

C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of FPL Note: The PPACA requires that 5% of income be disregarded with determining eligibility
Legislation Used To Expand Medicaid	• Acts 1497 and 1498, collectively known as the Health Care Independence Act, passed in 2013 and authorized the state to expand Medicaid through a section 1115 demonstration waiver • Act 1 of the second extraordinary session of 2016, known as the Arkansas Works Act, extended the Medicaid expansion program, which needs ongoing legislative authorization to continue
Number Of Individuals Enrolled In The Expansion Group (December 2016)	326,213
Number Of Enrollees Newly Eligible Due To Expansion	316,483
Benefits Plan For Expansion Population	• The state's alternative benefit plan is more restrictive than the state plan benefit package • The Medicaid expansion population, if medically frail, must be offered the full array of State Plan benefits; medically frail individuals include adults with SMI and chronic substance abuse disorders

For acronym definitions, please see Appendices.

C.4. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early & Periodic Screening, Diagnosis & Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Arkansas's Optional Services

1. Audiological services
2. Chiropractic services
3. Dental services
4. Domiciliary care services
5. Durable medical equipment and medical supplies
6. Hearing aids
7. Hospital services
8. Hyperalimentation services
9. Intermediate care facilities for individuals with intellectual disabilities
10. Nursing facility services under age 21
11. Occupational, physical, and speech therapy services
12. Orthotic appliances
13. Personal care services
14. Podiatrist services
15. Prescription drugs
16. Private duty nursing services
17. Prosthetic devices
18. Rehabilitative services
19. Respiratory care services
20. School-based mental health services
21. Targeted case management
22. Visual care services

For acronym definitions, please see Appendices.

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D. Medicaid Financing & Service Delivery System

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D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	**Medicaid Fee-For-Service (FFS)**	**Medicaid Managed Care**
Enrollment	639,145	312,517
SMI Enrollment	• Arkansas does not specifically preclude individuals with SMI from enrolling in managed care, therefore, the majority of the SMI population is enrolled in managed care • Estimated 30% of population in FFS, 70% in managed care	
Management	FFS & PCCM: Division Of Medical Services	PASSE: Four provider-led health plans AR Works: Qualified health plans on the marketplace
Payment Model	• FFS: FFS • PCCM: FFS and administrative fee to the primary care providers	PASSE: Capitated rate (starting March 2019) AR Works: Capitated rate
Geographic Service Area	Statewide	Statewide

Total Medicaid: 951,662 | Total Medicaid With SMI: 39,543

For acronym definitions, please see Appendices.

D.2. Medicaid Service Delivery System Enrollment
By Eligibility Group

Arkansas has two managed care programs—AR Works and PASSE; the PASSE program does not enroll individuals based on eligibility category, but instead based on service need

- AR Works enrolls the Medicaid expansion population (adults with income up to 138% of the FPL)
- The PASSE program enrolls individuals with behavioral health conditions and individuals with intellectual and developmental disabilities (I/DD)
- All other qualifying individuals are enrolled in FFS

Eligibility Criteria For PASSE	Groups Excluded From PASSE
• Individuals receiving services through DD Waiver • Individuals who are on the DD Waiver waitlist • Individuals who are in private DD intermediate care facilities • Individuals who have a behavioral health diagnosis and have received an independent assessment that determines they need services in tiers 2 or 3	• Residing in a Human Development Center, skilled nursing home, or assisted living • Eligible for spend-down • Enrolled in the ARChoices or Arkansas Independent Choices, and Autism Waiver

For acronym definitions, please see Appendices.

D.3. Medicaid FFS Program
Overview

- FFS enrollment as of August 2018 was 639,145
- The state's primary care case management (PCCM) is called ConnectCare and enrolls approximately 460,000 individuals
  - The ConnectCare program generally includes children, parent and caretaker relatives, and disabled adults
  - ConnectCare also includes individuals who are eligible for Medicare, family planning only beneficiaries, nursing home and intermediate care facility residents, medically needy spend-down beneficiaries, and home- and community-based service (HCBS) waiver beneficiaries
- Under ConnectCare, individuals enroll with a primary care provider (PCP), who acts as a gatekeeper to accessing additional services
  - PCPs receive a case management fee of $3.00 per member per month (PMPM)
  - PCPs can also participate in patient-centered medical homes (PCMHs)

For acronym definitions, please see Appendices.

D.4. Medicaid FFS Program
Behavioral Health Overview

- In July 2018, Arkansas launched a new outpatient behavioral health program that provides three tiers of services
  - The new program eliminates the Rehabilitative Services For Person With Mental Illness, Licensed Mental Health Practitioner program, and the Substance Abuse Treatment Services program
- The three tiers of services include:
  - Counseling – Time-limited behavioral health services in an outpatient-based setting for the purpose of assessing and treating mental health and/or addiction conditions
  - Rehabilitative – Home- and community-based behavioral health services with care coordination for the purpose of treating mental health and/or addiction conditions; services shall be rendered and coordinated through a team-based approach
  - Intensive – The most intensive behavioral health services for the purpose of treating mental health and/or addiction disorder conditions; services shall be rendered and coordinated through a team-based approach
- Rehabilitative and intensive level services require an independent assessment
  - Individuals who qualify for these levels of service must enroll in the PASSE managed care program
- All behavioral health services and pharmacy for the FFS population are delivered FFS

For acronym definitions, please see Appendices.

D.5. Medicaid FFS Program
Behavioral Health Benefits

All enrollees, regardless of tier, have access to inpatient psychiatric, crisis, and acute detoxification services

Counseling Services
1. Individual, group, and family behavioral health counseling
2. Psychoeducation
3. Mental health diagnosis
4. Substance abuse assessment
5. Psychological evaluation
6. Pharmacologic management
7. Psychiatric assessment

Rehabilitative Services
1. Treatment plan
2. Crisis stabilization intervention*
3. Partial hospitalization
4. Behavioral assistance (children only)*
5. Family support partners*
6. Individual and group pharmacologic counseling
7. Intensive outpatient for addiction treatment
8. Life skills development
9. Child and youth support services

Intensive Services
1. Therapeutic communities*
2. Residential community reintegration program*
3. Crisis services*
4. Acute crisis units

For acronym definitions, please see Appendices.

D.6. Medicaid FFS Program

SMI Population

- Arkansas does not specifically preclude individuals with SMI from enrolling in managed care, therefore, the majority of the SMI population is enrolled in managed care
- It is estimated that as of August 2018, 30% of the SMI population was enrolled in FFS

For acronym definitions, please see Appendices.

D.7. Medicaid Managed Care Program
Overview

- Managed care enrollment as of August 2018 was 312,517
- Arkansas has two managed care programs that serve different populations:
  - PASSE (Provider-Led Arkansas Shared Savings Entity) – provides care to individuals with intellectual/developmental disabilities (I/DD) and individuals with behavioral health conditions
    - Currently, the PASSEs receive a per member per month (PMPM) for care coordination; starting March 2019, the PASSEs will receive a capitated rate for all member services
  - Arkansas Works – the state's non-traditional Medicaid expansion program that provides premium assistance to purchase insurance on the health insurance marketplace; it includes cost-sharing and work requirements

For acronym definitions, please see Appendices.

D.8. Medicaid Managed Care Program

PASSE

- PASSEs are provider-led organizations that partner with an organization experienced in an insurance and/or administrative function and began operating in October 2017
  - The state did not issue a competitive procurement request, instead choosing to license willing PASSEs that met the licensing requirements; the state initially certified five statewide PASSEs, however only four are currently in operation
- The PASSEs are responsible for providing care to individuals with I/DD and behavioral health conditions, specifically:
  - Individuals receiving services through DD Waiver
  - Individuals who are on the DD Waiver waitlist
  - Individuals who are in private DD intermediate care facilities
  - Individuals that have a behavioral health diagnosis and have received an independent assessment that determines they need services in tiers 2 (rehabilitative) or 3 (intensive)
- For the first phase of implementation, the PASSEs received a per member per month care coordination fee, while services were reimbursed FFS; in the second phase of implementation starting in March 2019, the PASSEs will receive a global capitation rate for all services provided to enrollees
- Services provided under the PASSE include behavioral health services, physical health services, and home- and community-based waiver services
- All individuals participating in a PASSE receive an annual reassessment, a care coordinator, and a person-centered care plan

For acronym definitions, please see Appendices.

D.9. Medicaid Managed Care Program

Arkansas Works

- Arkansas Works is the state's non-traditional Medicaid expansion program for adults 19-64 with income below 138% of the FPL
- Arkansas Works enrolls individuals in silver-level marketplace qualified health plans covering only the essential health benefits
  - Individuals will have a choice of at least two plans in their area; the state will auto-assign individuals to a plan if they do not make a selection
- Individuals with income above 100% of the FPL are required to pay premiums of up to 2% of household income and are responsible for cost-sharing as defined in the Medicaid state plan
  - There is a two-month grace period for late payments; unpaid premiums will be considered a debt to the state but will not result in disenrollment
  - Cost-sharing and premiums cannot exceed 5% of an individual's household income
  - Individuals with income under 100% of the FPL are not subject to cost-sharing or premiums
- Additionally, individuals are subject to community engagement requirements

For acronym definitions, please see Appendices.

D.10. Medicaid Managed Care Program: Arkansas Works Community Engagement Requirements

- In order to receive coverage through Arkansas works, participants ages 19-49 must work—or engage in other specified activities—for 80 hours per month
  - Examples of individuals exempt from work requirements include those who are medically frail, pregnant or 60-days postpartum, full-time students, exempt from SNAP requirements, caring for an incapacitated person or child, and/or participating in an addiction disorder treatment program
- Examples of activities that meet the engagement requirements include employment, self-employment, community service, on-the-job training, job search, participation in a class on health care, and enrollment in an educational program
- Individuals who do not meet the work requirements for any three months (consecutive or non-consecutive) during the plan year will be dis-enrolled and not able to re-enroll until the next plan year
- Work requirements were phased in by age group
  - Individuals between the ages of 30-49 were phased in between June and September 2018
  - For individuals between the ages of 19 and 29 work requirements began on January 1, 2019
- As of October 2018, there were 69,041 individuals who qualified for the work requirement; 55,388 were exempt from reporting, 1,525 reported at least 80 hours, and 12,128 failed to report 80 hours
  - Thus far, 3,815 individuals have lost coverage for three months due to non-compliance

For acronym definitions, please see Appendices.

D.11. Medicaid Managed Care Program
Behavioral Health Overview

- Under the Arkansas Works program, individuals receive commercial behavioral health and pharmacy benefits through employer-sponsored health plans or marketplace qualified health plans
  - These health plans must include addiction disorder inpatient and outpatient services as required by the state's alternative benefit plan for the Medicaid expansion population
- Beginning on March 1, 2019, the PASSEs will be at-risk for all behavioral health services, including pharmacy benefits; prior to this date, behavioral health services will be delivered FFS
  - Note that all services on the next page are for the date after March 2019; not all services may be currently available

For acronym definitions, please see Appendices.

D.12. Medicaid Managed Care Program

PASSE Behavioral Health Benefits

Counseling Services
1. Individual, group, and family behavioral health counseling
2. Psychoeducation
3. Mental health diagnosis
4. Substance abuse assessment
5. Psychological evaluation
6. Pharmacologic management
7. Psychiatric assessment

Rehabilitative Services
1. Treatment plan
2. Crisis stabilization intervention
3. Partial hospitalization
4. Behavioral assistance (children only)*
5. Adult rehabilitative day service*
6. Peer support*
7. Family support partners*
8. Recovery support partners for addiction*
9. Individual and group pharmacologic counseling*
10. Intensive outpatient for addiction treatment
11. Life skills development*
12. Child and youth support services*
13. Supportive employment*
14. Supportive housing*
15. Outpatient addiction treatment*

Intensive Services
1. Therapeutic communities*
2. Therapeutic host home*
3. Planned and emergency respite*
4. Residential community reintegration program*
5. Crisis services*
6. Acute psychiatric hospitalization
7. Acute crisis units
8. Substance abuse detoxification (observational)*

*Services that will be offered through the state's 1915(i) HCBS state plan amendment, which is currently pending with CMS

For acronym definitions, please see Appendices.

D.13. Medicaid Managed Care Program

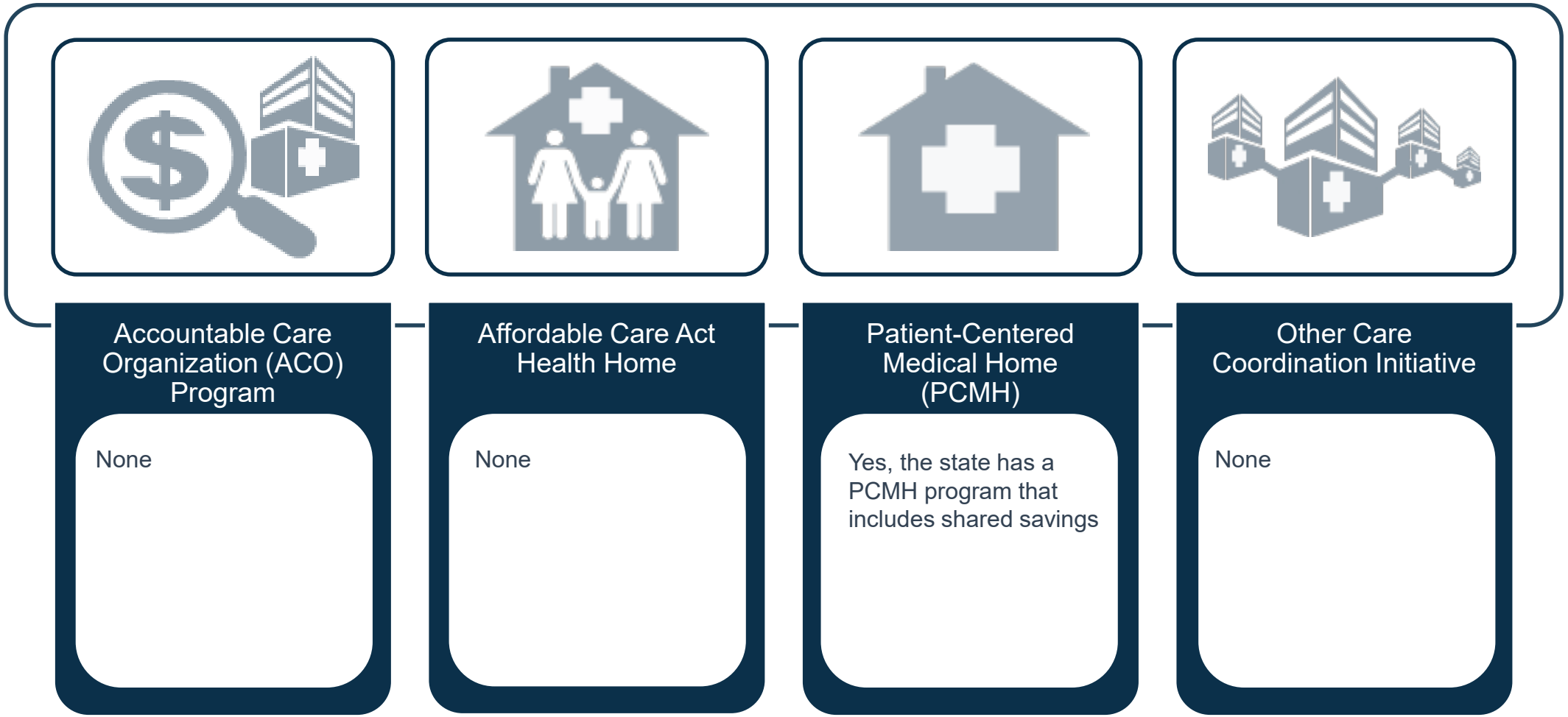
SMI Population

- Arkansas does not specifically preclude individuals with SMI from enrolling in managed care, therefore, the majority of the SMI population is enrolled in managed care
- It is estimated that as of August 2018, 70% of the SMI population was enrolled in managed care
- The Medicaid expansion population, if medically frail, must be offered the full array of State Plan benefits; medically frail individuals include adults with SMI and chronic addiction disorders

For acronym definitions, please see Appendices.

D.14. Medicaid Program

Care Coordination Initiatives



For acronym definitions, please see Appendices.

D.15. Medicaid Program

Patient-Centered Medical Home

- The PCMH initiative is designed to provide additional care coordination to individuals enrolled in the state's PCCM, ConnectCare; the program is also open to other payers
  - The qualified health plans in the health insurance marketplace covering the Arkansas Works population are required to participate in either the state initiative or in a nationally recognized PCMH program
  - The state employees' health program and several self-insured groups and companies also participate
- In order to participate, PCPs must be ConnectCare clinical professionals and have at least 300 Medicaid beneficiaries; participation is optional
  - In 2017, there were 252 practices participating in the program, which covered approximately 356,000 beneficiaries
- PCPs receive a risk-stratified per member per month (PMPM) payment ranging from $1 to $30
- Beginning in 2015, the PCMHs were required to participate in the state's shared savings program; practices with fewer than 5,000 beneficiaries may pool with other practices, join the statewide default pool, or participate in the petit pool
  - In addition to meeting performance benchmarks, PCMHs must either have practice costs lower than the state threshold or have practice costs less than the practice specific benchmark
  - Performance metrics are as follows: Increase in pediatric wellness visits, hemoglobin testing for persons with diabetes, breast cancer screenings, improved ADHD management, and thyroid medication management
- Beginning in 2019, the state will launch PCMH 2.0

For acronym definitions, please see Appendices.

D.16. Medicaid Program

Patient-Centered Medical Home 2.0

- Under the new model, practices with 150 attributed Medicaid beneficiaries may now participate in the program
- Shared performance entity – PCMHs or pools of PCMHs that have at least 1,000 attributed beneficiaries and may receive performance-based incentive payments (PBIP)
- Provider organizations can reach 1,000 participants in multiple ways:
  - Independently – individual practices are responsible for PBIP and quality metrics
  - Participation in the voluntary pool for practices with 150-299 participants – practice performance is aggregated for PBIP and quality metrics
  - Participation in the default pool – practice performance is aggregated for PBIP but not for quality metrics
  - Practices with less than 300 beneficiaries who do not wish to participate in the voluntary pool may participate in the petite pool; practice performance is aggregated for PBIP and quality metrics
- In order to receive the monthly per member per month, PCMHs must meet activities for practice support and must meet the minimal core metric
  - In 2019, the minimum core metric is related to child well visits between the ages of 0-15
- To receive the PBIP incentive payments, provider organizations must be in top 35 percentile for quality metrics

Metric	Practices In 10th Percentile	Top 11th – 35th Percentile
Inpatient rate	$12, times the number of attributed member months	$6, times the number of attributed member months
Emergency department rate	$8, times the number of attributed member months	$4, times the number of attributed member months
Focus metric-adolescent wellness	$5, times the number of attributed member months	$2.50, times the number of attributed member months

For acronym definitions, please see Appendices.

D.17. Medicaid Program

Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Arkansas Works	Authorizes Arkansas's non-traditional Medicaid expansion program, which utilizes commercial benefit health plans available on the health insurance marketplace; enrollment is subject to meeting community engagement requirements	1115	None	10/01/13	12/31/21
Arkansas' Tax Equity & Fiscal Responsibility Act (TEFRA-like)	Provides Medicaid services to disabled children who are eligible for institutional placement; if the family has income above 150% of the FPL, premiums are charged on a sliding scale basis	1115	None	01/01/2003	12/31/2022
Care Coordination (AR-07)	Authorizes the state to enroll individuals with developmental disabilities and behavioral health conditions in the PASSEs for care coordination services	1915 (b)	None	10/01/2017	09/30/2022
Healthy Smiles (AR-08)	Authorizes the state to enroll individuals in managed care for dental services only	1915 (b)	None	01/01/2018	12/31/2022
Arkansas Non Emergency Transportation Change AR-03	Authorizes the state to contract with a single, capitated prepaid ambulatory health plan to provide non-emergency medical transportation	1915 (b)	None	10/01/2017	09/30/2019

For acronym definitions, please see Appendices.

D.18. Medicaid Program

Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2018 Enrollment Cap	Operating Unit	Concurrent Management Authority
AR Choices In Homecare (0195.R05.00)	Individuals age 21-64 with a physical disability and individuals over the age of 65	11,350	Division Of Aging & Adult Services	Yes, 1915 (j) State Plan Amendment
AR Alternative Community Services (0188.R05.00)	Individuals with autism, developmental disabilities, and intellectual disabilities of any age	4,803	Division Of Developmental Disabilities Services	Yes, the 1915(b) Care Coordination Waiver
AR Living Choices Assisted Living	Individuals age 21-64 with a physical disability and individuals over the age of 65	1,300	Division Of Aging & Adult Services	No
AR Autism (0936.R01.00)	Individuals with autism between age 1-7	200	University Of Arkansas At Fayetteville - Partners For Inclusive Communities	No

For acronym definitions, please see Appendices.

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E. State Behavioral Health Administration & Finance System

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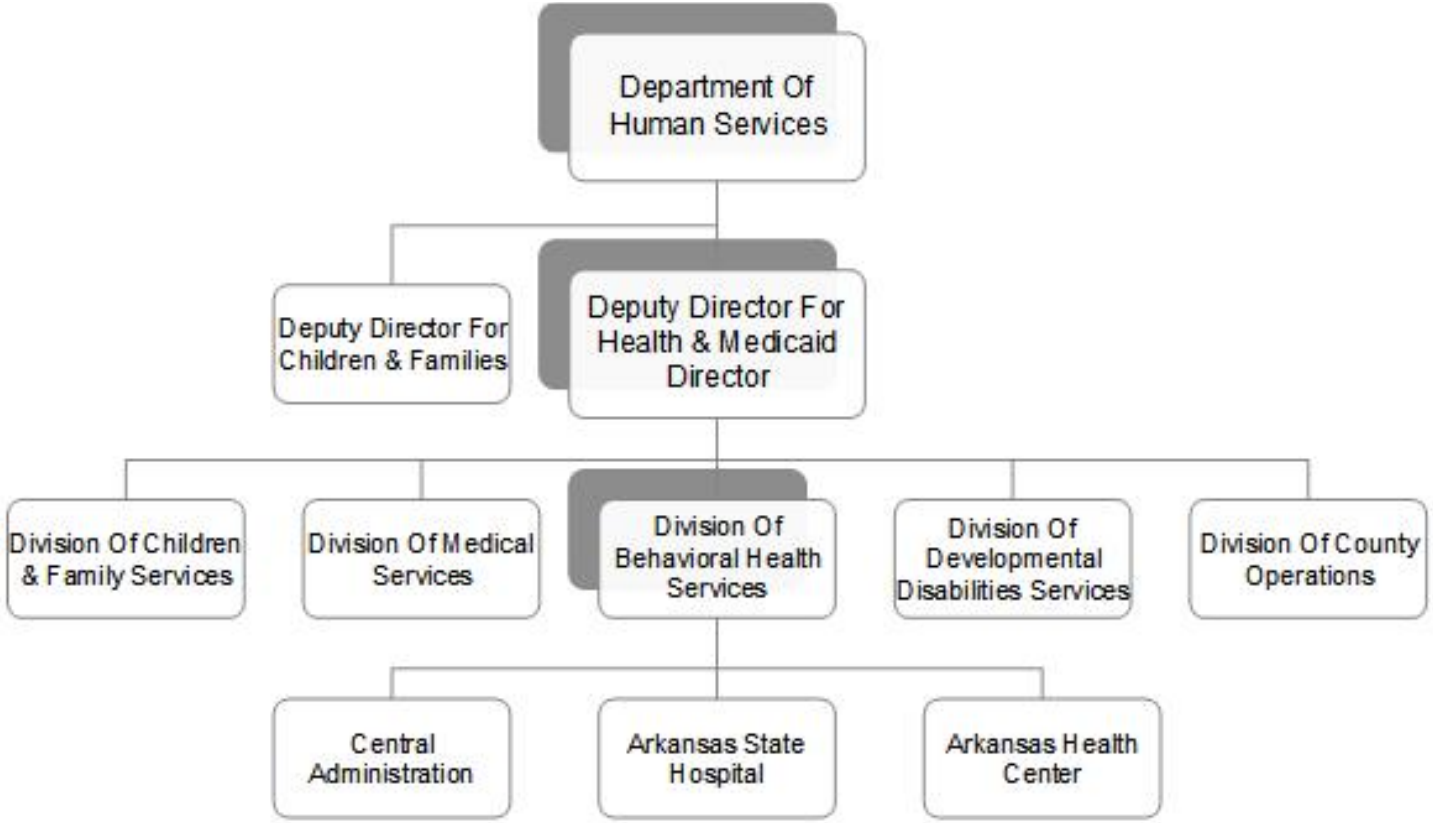
E.1. Division Of Behavioral Health Services

Organization Chart



For acronym definitions, please see Appendices.

E.2. Division Of Behavioral Health Services

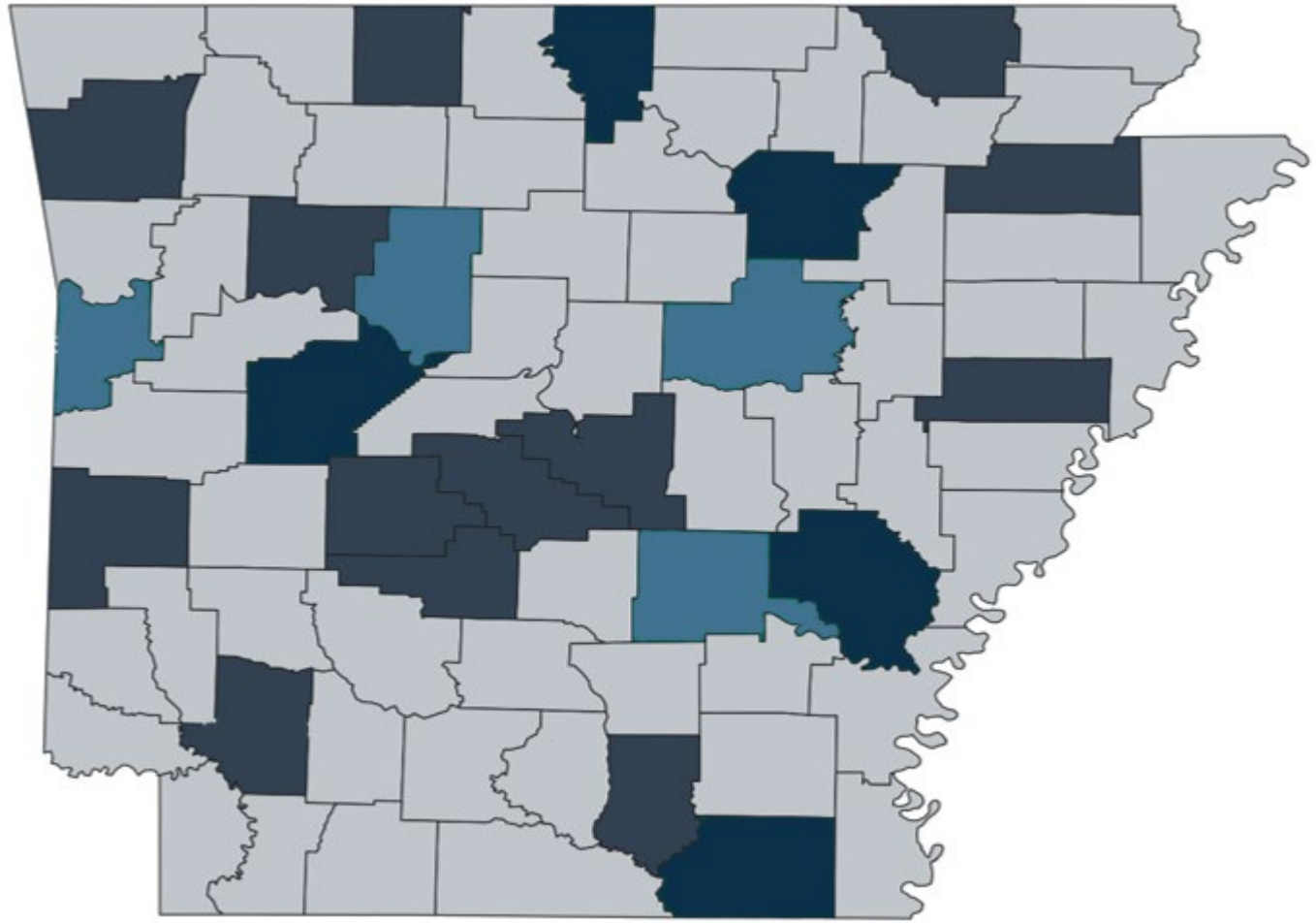
Key Leadership

Name	Position	Department
Cindy Gillespie	Director	Department Of Human Services (DHS)
Dawn Stehle	Deputy Director	DHS
Jay Hill	Interim Director, Facilities	DHS, Division Of Behavioral Health Services
Kirk Lane	State Drug Director	DHS, Division Of Behavioral Health Services
Pam Dodson	Assistant Clinical Director	DHS, Division Of Behavioral Health Services

For acronym definitions, please see Appendices.

E.3. Mental Health & Addiction Hospital Bed Distribution

Mental Health & Addiction Treatment Bed Capacity	
Total number of hospitals with mental health and addiction beds	34
Number of mental health and addiction beds	1,689
Number of mental health and addiction beds per 100,000 population	56.52



For acronym definitions, please see Appendices.

E.4. State Psychiatric Institutions

State Psychiatric Institutions			
Institution	**Location**	**Beds**	**FY 2017 Average Daily Census**
Arkansas Health Center	Benton	310	257
Arkansas State Hospital	Little Rock	234	206
Total		**544**	**463**

For acronym definitions, please see Appendices.

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F. State Behavioral Health Stakeholder Organizations

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F.1. Accountable Care Organizations

Medicare Shared Savings Program
Aledade Arkansas ACO
Aledade Primary Care ACO
Arkansas Accountable Care
Arkansas Health Network
Arkansas High Performance Network ACO
Arkansas High Performance Network Of CAH Accountable Care Organization
Arkansas High Performance Network Of FQHC
Baxter Physician Partners
Central US ACO
Collom & Carney Clinic ACO
Mercy Health ACO
Mercy Springfield ACO
Prime Care Managers
The Physicians Accountable Care Organization (TP-ACO)

Commercial	
ACO	**Commercial Insurer**
Mercy Health ACO	Humana, Aetna, Cigna
Northwest Health System / PremierCare Northwest	Cigna

For acronym definitions, please see Appendices.

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G. Appendices

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Acronym Legend

Acronym	Definition	Acronym	Definition	Acronym	Definition	Acronym	Definition
ACA / PPACA	Affordable Care Act	DHS	Department Of Human Services	MO	Missouri	PPACA	Patient Protection & Affordable Care Act
ACO	Accountable Care Organization	EPSDT	Early & Periodic Screening, Diagnosis & Treatment	MS	Mississippi	QCA	QualChoice Health
ADHD	Attention Deficit Hyperactivity Disorder	FFS	Fee-For-Service	MSA	Metropolitan Statistical Area	SMI	Serious Mental Illness
AR	Arkansas	FPL	Federal Poverty Level	OK	Oklahoma	SNAP	Supplemental Nutrition Assistance Program
ASO	Administrative Services Organization	FQHC	Federally Qualified Health Center	PASSE	Provider-Led Arkansas Shared Savings Entity	SNP	Special Needs Plan
CAH	Critical Access Hospitals	HCBS	Home- & Community-Based Services	PBIP	Performance-Based Incentive Payments	TEFRA	Tax Equity & Fiscal Responsibility Act
CMHC	Community Mental Health Center	HMO	Health Maintenance Organization	PCCM	Primary Care Case Management	TN	Tennessee
CMS	Centers For Medicare & Medicaid Services	I/DD	Intellectual & Developmental Disabilities	PCMH	Patient-Centered Medical Home	TP-ACO	The Physicians Accountable Care Organization
DBHS	Division Of Behavioral Health Services	IMD	Institution For Mental Disease	PCP	Primary Care Provider	TX	Texas
DD	Developmentally Disabled	LTSS	Long-Term Services & Supports	PMPM	Per Member Per Month	UR	Utilization Review

Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of providers—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of consumers. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The organization bears the risk for all claims.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Generally the entity assumes full-risk for the cost of each enrollee's care.
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(I) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.

Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2018, the FPL is $12,140 for an individual and $25,100 for a family of four.
Fee-For-Service	FFS	A system in which provider organizations are reimbursed for each covered service such as an office visit, test, or procedure according to rates set by the payer.
Health Home		A “whole person” care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services.
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online service where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.

Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive residential addiction treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions and/or age.
Managed Care/ Managed Care Organization	MCO	A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore usually contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid State Plan in order to test out new ways to deliver health coverage. Importantly, the waivers must be budget neutral.

Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit people's choice of providers.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Metropolitan Statistical Area	MSA	An urbanized area of 50,000 or more population plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.

Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided. Some states consider PCCM a managed care delivery model, while other states consider it an FFS delivery model.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.

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