

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES and DIVISION OF PROVIDER SERVICES AND QUALITY ASSURANCE

SUBJECT: Psychiatric Residential Treatment Facility Services for Under Age 21 (20 CAR pts. 417, 627, 651)

DESCRIPTION:

Statement of Necessity

This rule is necessary pursuant to Act 636 of 2025. Currently, no licensure manual or Medicaid provider manual exists for Psychiatric Residential Treatment Facility (PRTF) providers. The Department of Human Services (DHS) finds certain minimum standards are necessary for providers to deliver services to enrolled beneficiaries who are admitted into a PRTF. This rule helps ensure the health and safety of beneficiaries who are admitted into a Psychiatric Residential Treatment Facility.

Rule Summary

DHS creates two new manuals for Psychiatric Residential Treatment Facility (PRTF) Providers. The first is a licensure manual that sets the minimum standards for providers delivering services to enrolled beneficiaries who are admitted into a PRTF. The second is a companion Medicaid Provider Manual, “Psychiatric Residential Treatment Facility Services for Under Age 21”. These new manuals necessitate removal of duplicative standards currently found within the “Inpatient Psychiatric Services for Under Age 21” provider manual.

PUBLIC COMMENT: A public hearing was held on this rule on July 9, 2025. The public comment period expired on July 21, 2025. The agency made changes to the rule based on public comment and released the rule for a second public comment period. A second public hearing was held on August 27, 2025. The second public comment period expired on September 6, 2025.

Due to its length, the public comment summary is attached separately.

Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following questions and received the following responses:

1. Act 636, § 1 requires prior approval from the Health Services Permit Agency for any renovation project that exceeds \$250,000 for an existing psychiatric residential treatment facility. Is this “prior approval” equivalent to a “permit” under 20 CAR § 417-202(a)(4)? If so, why does the rule not address renovations over \$250,000?

RESPONSE: It applies to both. See definition 22 New Construction where we define New Construction as construction OR renovation after January 1.

2. The list of minimum license posting requirements in 20 CAR § 417-202(f)(1) mirrors the list in Act 636, § 10 [codified at § 20-46-403], with one exception. The Act includes “The status of the license, whether regular, provisional, or probationary;” while the rule

does not. Is there a reason this language was omitted from the rule? **RESPONSE:** This was an agency decision. Once the permanent rules are in place we do not plan to issue anything other than a regular license.

3. 20 CAR § 417-202(j) provides that no PRT Facility may be sold or transferred without prior approval from the Office of Long-Term Care. Is there specific statutory authority for a violation of this provision constituting a Class D felony, as provided in 20 CAR § 417-202(k)? **RESPONSE:** [The agency amended the rules to remove the provision at issue.]

4. 20 CAR § 417-304(d)(1)(B) sets a minimum staffing ratio of 1:8 from 10:00 p.m. to 6:00 a.m. or 11:00 p.m. to 7:00 a.m., depending on age and need. Where does the 1:8 minimum ratio come from? **RESPONSE:** This was an agency decision that mimics ratios in Intermediate Care Facilities and aligned the ratios the PRTF providers were previously under, Minimum Licensing Standards for Child Welfare Agencies, which was 1:8 during sleeping hours.

5. 20 CAR § 417-405(l) provides that a PRT Facility shall not admit, after July 1, 2025, a child who is under 10 years of age. Where does this provision come from? **RESPONSE:** This was an agency decision. There are more appropriate services in place for children ages 5-9.

6. 20 CAR § 417-406 contains a list of requirements for an individual plan of care that mirrors the list found in 42 C.F.R. § 441.155(b), with one exception. The CFR includes “prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;” (42 C.F.R. § 441.155(b)(4)) while the DHS rule does not. Is there a reason this language was omitted from the rule? **RESPONSE:** [The agency amended the rule to include the language at issue.]

7. 20 CAR § 417-408 requires retention of complete medical records for two years after the resident reaches the age of majority. 42 C.F.R. § 483.70(h)(4)(iii) requires long-term care facilities to keep medical records for three years after a resident reaches majority. Does this CFR provision apply to PRT Facilities? If so, why is the retention period in the state rule shorter than that prescribed by federal regulation? **RESPONSE:** [The agency amended the rule to address this issue.]

8. 20 CAR § 417-411 requires notification of a resident’s “parent or legal guardian” in certain situations. Arkansas Code § 20-10-107 requires notification of “the resident’s guardian or other responsible party” in these situations. Why is the language in the rule different than the language in statute? **RESPONSE:** [The agency amended the rule to address this issue.]

9. 20 CAR § 417-411 states that reportable serious occurrences include, among other things, “a serious injury to a Resident as defined in 42 C.F.R. § 483.352” and “any significant impairment of the resident as determined by qualified medical personnel.” 42 C.F.R. § 483.352 defines “serious injury” as “any significant impairment of the physical

condition of the resident as determined by qualified medical personnel” and includes a non-exhaustive list of examples. In light of this fact, why are both the reference to the CFR definition and the language regarding significant impairment included in the DHS rule? **RESPONSE:** This was discussed at length between DHS staff and the PRTF providers. We were attempting to avoid confusion on reportable events and included significant impairment in the definition of serious occurrences.

10. 20 CAR § 417-417, regarding medication storage, states that “Food and drinks shall not be stored in the same refrigerator.” Does this mean that food and drinks may not be stored together, or does this mean that food and drinks may not be stored in a medication refrigerator? **RESPONSE:** [The agency amended the rule to address this issue.]

11. 20 CAR § 417-501(e) states, “Restraint may not be used simultaneously.” I see that this language comes from 42 C.F.R. § 483.356(a)(4), which states “Restraint and seclusion must not be used simultaneously.” Given that the DHS rules categorically prohibit the use of seclusion, what is subsection (e) prohibiting? **RESPONSE:** [The agency amended the rule to address this issue.]

12. Given that 20 CAR § 417-501(a)(3) prohibits the use of seclusion, why does 20 CAR § 417-501(o) reference a “restraint or seclusion order”? **RESPONSE:** [The agency amended the rule to address this issue.]

13. Given that 20 CAR § 417-501(a)(3) prohibits the use of seclusion, why does 20 CAR § 417-505(a)(5) reference preventing “the future use of restraint or seclusion”? **RESPONSE:** Since seclusion is allowed under federal regulation we wanted to closely align with that federal regulation but also state seclusion will not be allowed.

14. 20 CAR § 417-704 sets the minimum size for a single room at 50 square feet. 42 C.F.R. § 483.90(e)(1)(ii) requires single resident rooms in long-term care facilities to measure at least 100 square feet. Does the CFR provision apply to PRT Facilities? If so, why does this rule set the minimum size for a single room at 50 square feet? If not, where does the 50 ft² minimum come from? **RESPONSE:** This was an agency decision. All buildings providing PRTF services were designed in accordance with Minimum Licensing Standards for Child Welfare Agencies. The 50 square feet was the requirement at time of build. To now require 100 square feet would not be feasible and would cause all the buildings to undergo major renovations.

15. What is the source for the minimum and maximum temperatures referenced in 20 CAR § 417-711? **RESPONSE:** This was an agency decision based on a lengthy conversation with the PRTF providers. Under the former rules, Minimum Licensing Standards for Child Welfare Agencies, they were required to maintain temperature between 65 and 85 degrees.

FINANCIAL IMPACT: The agency indicated that this rule has no financial impact.

LEGAL AUTHORIZATION: The Department of Human Services shall promulgate rules to implement Title 20, Chapter 46, Subchapter 4 of the Arkansas Code, regarding psychiatric residential treatment facilities. *See Ark. Code Ann. § 20-46-404(b), as created by Act 636 of 2025.* These rules “shall include components that ensure quality of care, health and safety of residents and psychiatric residential treatment facility staff, and compliance with all educational requirements.” *Id.*

This rule implements Act 636 of 2025. The Act, sponsored by Representative Frances Cavanaugh, moved licensing and regulation of psychiatric residential treatment facilities from the Child Welfare Agency Review Board to the Department of Human Services and set standards for the licensing and regulation of psychiatric residential treatment facilities.



Office of Policy and Rules

P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437

P: 501.320.6383 F: 501.404.4619

August 7, 2025

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Psychiatric Residential Treatment Facility Services for Under Age 21

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Deputy Chief

Attachments

**QUESTIONNAIRE FOR FILING PROPOSED RULES WITH
THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT Department of Human Services
BOARD/COMMISSION _____
BOARD/COMMISSION DIRECTOR _____
CONTACT PERSON Mac Golden
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203-1437
PHONE NO. (501) 320-6383 EMAIL Mac.E.Golden@dhs.arkansas.gov
NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING _____
Paula Stone, Martina Smith, and Melissa Weatherton
PRESENTER EMAIL(S) Paula.Stone@dhs.arkansas.gov; Martina.Smith@dhs.arkansas.gov; Melissa.V

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

1. What is the official title of this rule?
Psychiatric Residential Treatment Facility Services for Under Age 21
2. What is the subject of the proposed rule? 20 CAR Parts 417 (new), 651 (new), 627
3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☒

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☐

4. Is this rule being filed for permanent promulgation? Yes ☒ No ☐

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☒ No ☐

If yes, what was the effective date of the emergency rule? 06/20/2025

On what date does the emergency rule expire? 10/17/2025

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes ☐ No ☒

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes ☒ No ☐

If yes, please provide the state statute and/or rule citation.

Act 636 of 2025

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes ☐ No ☒

If yes, please list the rules being repealed.

If no, please explain.

Exception from the Governor

8. Is this a new rule? Yes ☒ No ☐

Does this repeal an existing rule? Yes ☐ No ☒

If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes ☒ No ☐

If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

[Arkansas Code §§20-76-201, 20 77-107, and 25-10-129](#)

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes ☒ No ☐

If yes, please provide the year of the act(s) and act number(s).

[Act 636 of 2025](#)

11. What is the reason for this proposed rule? Why is it necessary?

[DHS creates two new manuals for Psychiatric Residential Treatment Facility \(PRTF\) Providers to set the minimum standards for providers delivering services to enrolled beneficiaries who are admitted into a PRTF.](#)

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

[ar.gov/dhs-proposed-rules](https://www.ark.gov/dhs-proposed-rules)

13. Will a public hearing be held on this proposed rule? Yes ☒ No ☐

If yes, please complete the following:

Date: 08/27/2025

Time: 10:00 am

Place: Zoom: <https://us02web.zoom.us/j/88020769741>

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. 09/06/2025

15. What is the proposed effective date for this rule? 10/27/2025

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

[Unknown.](#)

19. Is the rule expected to be controversial? Yes ☐ No ☒

If yes, please explain.

NOTICE OF RULEMAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20 77-107, and 25-10-129. The proposed effective date of the rule is October 27, 2025, and it has no fiscal impact.

This rule is pursuant to Act 636 of 2025. DHS creates two new manuals for Psychiatric Residential Treatment Facility (PRTF) Providers. The first is a licensure manual that sets the minimum standards for community providers delivering services to enrolled beneficiaries who are admitted into a PRTF. The second is a companion Medicaid Provider Manual, “Psychiatric Residential Treatment Facility Services for Under Age 21”. These new manuals necessitate removal of duplicative standards currently found within the “Inpatient Psychiatric Services for Under Age 21” provider manual.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than September 6, 2025. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter’s name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. 4502292178

Melissa Weatherton, Director
Medicaid Specialty Populations

From: [Legal Ads](#)
To: [Jack Tiner](#)
Cc: [Mac Golden](#); [Lakeya Gipson](#); [Elaine Stafford](#)
Subject: Re: Full Run AD (R307)
Date: Wednesday, August 6, 2025 8:20:12 AM
Attachments: [image001.png](#)
[image002.png](#)

[EXTERNAL SENDER]

Thanks. Notice is scheduled for Fri 8/8, Sat 8/9, and Sun 8/10.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>
Sent: Tuesday, August 5, 2025 3:36:41 PM
Subject: Full Run AD (R307)

Please Reply to this email using REPLY ALL.

Please run the attached ad in the Arkansas Democrat-Gazette on the following days:

- Friday August 8, 2025
- Saturday August 9, 2025
- Sunday August 10, 2025

A public hearing by remote access only will be held through a Zoom webinar. The public comment period will end on September 6, 2025. I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**
OPR, ATTN: Lakeya Gipson
P.O. Box 1437, Slot S295
Little Rock, AR 72203-8068

(Lakeya.Gipson@dhs.arkansas.gov)

Thanks.



OFFICE OF POLICY AND RULES

DHS/DMS MEDICAL ASSISTANCE MANAGER

P: 501.251.6535

F: 501.404.4619

700 Main St., Slot S295

Little Rock, AR 72203

Jack.Tiner@dhs.arkansas.gov

humanservices.arkansas.gov



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From: [Jack Tiner](#)
To: register@sos.arkansas.gov
Cc: [Mac Golden](#); [Jack Tiner](#); [Brett Hays](#); [Amanda Cox](#); [JAMIE EWING](#); [Lakeya Gipson](#)
Subject: DHS--Proposed Filing--Psychiatric Residential Treatment Facility Services for Under Age 21 (R307)
Date: Thursday, August 7, 2025 3:49:33 PM
Attachments: [image001.png](#)
[image002.png](#)
[SoS-Proposed Filing Packet-PRTF-R307-2nd Notice.pdf](#)

Please find attached the proposed filing for rule titled: Psychiatric Residential Treatment Facility Services for Under Age 21.

This rule was previously filed under an emergency promulgation. The Secretary of State's file # for the emergency is 016.00.25-001E. If appropriate, please post with that.

Thank you.



[OFFICE OF POLICY AND RULES](#)

Rules & Regulations Coordinator

P: 501.251.6535

F: 501.404.4619

700 Main St., Slot S295

Little Rock, AR 72203

Jack.Tiner@dhs.arkansas.gov

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FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services

BOARD/COMMISSION Office of Substance Abuse and Mental Health (OSAMH)

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Psychiatric Residential Treatment Facility Services for Under Age 21

1. Does this proposed, amended, or repealed rule have a financial impact?
Yes ☐ No ☒
2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
Yes ☒ No ☐
3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

If no, please explain:

(a) how the additional benefits of the more costly rule justify its additional cost;

(b) the reason for adoption of the more costly rule;

(c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

(d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:
 - (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

 Total _____

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

 Total _____

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

Current Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

 Total \$ 0.00 _____

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

 Total \$ 0.00 _____

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year

\$ 0.00 _____

Next Fiscal Year

\$ 0.00 _____

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

\$ 0.00 _____

Next Fiscal Year

\$ 0.00 _____

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
 - (a) the rule is achieving the statutory objectives;
 - (b) the benefits of the rule continue to justify its costs; and
 - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Summary and Statement of Necessity

Psychiatric Residential Treatment Facility Services for Under Age 21

Statement of Necessity

This rule is necessary pursuant to Act 636 of 2025. Currently, no licensure manual or Medicaid provider manual exists for Psychiatric Residential Treatment Facility (PRTF) providers. The Department of Human Services (DHS) finds certain minimum standards are necessary for providers to deliver services to enrolled beneficiaries who are admitted into a PRTF. This rule helps ensure the health and safety of beneficiaries who are admitted into a Psychiatric Residential Treatment Facility.

Rule Summary

DHS creates two new manuals for Psychiatric Residential Treatment Facility (PRTF) Providers. The first is a licensure manual that sets the minimum standards for providers delivering services to enrolled beneficiaries who are admitted into a PRTF. The second is a companion Medicaid Provider Manual, “Psychiatric Residential Treatment Facility Services for Under Age 21”. These new manuals necessitate removal of duplicative standards currently found within the “Inpatient Psychiatric Services for Under Age 21” provider manual.

Stricken language would be deleted from and underlined language would be added to the Code of Arkansas Rules.

Proposed Rulemaking

Title

Psychiatric Residential Treatment Facility Services for Under 21

Promulgated by:

Office of Long Term Care

Title 20, Chapter X. Office of Long-Term Care, Division of Provider Services and Quality Assurance, Department of Human Services

Part 417. Psychiatric Residential Treatment Facility Providers

Codification Notes. This part, as promulgated prior to codification into the Code of Arkansas Rules of 2025, provided as follows:

101.Authority.

These standards are promulgated under the authority of Arkansas Code § 20-76-201 et seq. and Arkansas Code § 20-10-101 et seq.

Subpart 1. General

(1) 20 CAR § 417-101. Purpose.

The purpose of this part is to:

- (1) Serve as the minimum standards for community providers delivering services to enrolled beneficiaries who are admitted into a Psychiatric Residential Treatment Facility; and
- (2) Ensure the health and safety of beneficiaries who are admitted into a Psychiatric Residential Treatment Facility.

Authority: Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

DRAFT

20 CAR § 417-102. Definitions.

As used in this part:

(1) "Abuse" means any of the acts or omissions defined under Arkansas Code § 12-18-103.

(2) "Accreditation" means official notification given to the provider of compliance to standards established by The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, for Psychiatric Residential Treatment Facilities.

(3) "Active Treatment" means implementation of a professionally developed and supervised individual plan of care that is developed no later than seven (7) days after admission and designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

(4) "Administrator" means a person licensed as a Psychiatric Residential Treatment Facility Administrator, by the Office of Long-Term Care who administers, manages, supervises, or is in general administrative charge of a Psychiatric Residential Treatment Facility.

(5) "Centers for Medicare & Medicaid Services" means the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services.

(6) "C.F.R" means the United States Code of Federal Regulations.

(7) "Controlled Substance" means a drug, substance or immediate precursor in Schedules I through V of Article 11 of the Controlled Substances Act.

(8) "CPR" means cardiopulmonary resuscitation.

(9) "Department" means the Arkansas Department of Human Services.

(10) "Drug Administration" means an act restricted to nursing personnel as defined in Nurses Practice Act 432 or 1971, in which a single dose of a prescribed drug or biological is given to a patient. This activity includes the removal of the dose from a previously dispensed, properly labeled container, verifying it with the prescriber's orders, giving the individual dose to the proper patient, and recording the time and dose given.

DRAFT

(11) "Drug used as a restraint" means any drug that:

(A) Is administered to manage a Resident's behavior in a way that reduces the safety risk to the Resident or others;

(B) Has the temporary effect of restricting the Resident's freedom of movement; and

(C) Is not a standard treatment for the Resident's medical or psychiatric condition.

(12) "Emergency" means a situation, physical condition, or one (1) or more practices, methods or operations which threatens the health, security, safety or welfare of Residents.

(13) "Emergency safety intervention" means the use of physical or chemical restraint as an immediate response to an emergency safety situation which is defined as an unanticipated behavior from a resident that places the resident or others at serious threat of violence or injury if no intervention occurs. Interventions shall not be preventative in nature. Emergency safety intervention shall only be used as the last resort after all lesser restrictive alternatives are exhausted.

(14) "Existing Facilities" means Psychiatric Residential Treatment Facilities which were in operation, and previously licensed by the Child Welfare Agency Review Board for the purpose of operating as a psychiatric residential treatment facility or beds that were fully constructed and could be used for the purpose of operating a psychiatric residential treatment facility as of January 1, 2025

(15) "Facility" means Psychiatric Residential Treatment Facility which is required to be licensed pursuant to Arkansas Code § 20-10-224.

(16) "Governing Body" or "management team" means the individuals or group in whom the ultimate authority and legal responsibility is vested for conduct of the Psychiatric Residential Treatment Facility.

(17) "Guardian" means a court appointed person who, by law, is responsible for a Resident's affairs.

(18) "HIPAA" means the Health Insurance Portability and Accountability Act.

(19) "Incidents" include, but are not limited to: Resident injuries, abuse, neglect, maltreatment, accidents, unusual deaths or deaths from violence, suicide attempts, and significant changes in Resident condition, location, or property.

(20) "Mechanical restraint" means any device attached or adjacent to the Resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

(21) "Neglect" means as defined under Arkansas Code § 12-18-103.

(22) "New Construction" means those Psychiatric Residential Treatment Facilities which are constructed or renovated for the purpose of a Psychiatric Residential Treatment Facility after January 1, 2025, and require prior approval from the Health Services Permit.

(23) "Personal restraint" means the application of physical force without the use of any device, for the purposes of restraining the free movement of a Resident's body. The term personal restraint does not include briefly holding without undue force a Resident in order to calm or comfort him or her or holding a Resident's hand to safely escort a Resident from one (1) area to another.

(24) "PRN" means "as needed" or "as circumstances arise" (from the Latin, *pro re nata*) and is used when referring to medication administration or patient care.

(25) "Psychiatric Residential Treatment Facility" means a standalone, non-hospital facility with a provider agreement with the Arkansas Medicaid Program to provide inpatient service benefits to individuals who are under twenty-one (21) years of age, and that:

(A) Is accredited by The Joint Commission or any other accrediting organization with comparable standards recognized by this state;

(B) Attests to meeting the conditions of participation found at 42 C.F.R. § 483, Subpart G (2001) and;

(C) Attests that all of the residents in the facility meet the certification of need for services requirements as identified under 42 C.F.R. § 441, Subpart D (2019).

(26) "Responsible Party" means the person who is accountable for the Resident's affairs but who has not been appointed by the court.

(27) "Restraint" means any device or instrument used to limit, restrict, or hold patients under control, not including safety vests or other instruments such as bed rails used for the safety and positioning of patients. Personal safety devices and postural support

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devices that restrict movement are considered restraints. Restraint means a “personal restraint,” “mechanical restraint,” or “drug used as a restraint” as defined in this section.

(28) “Seclusion” means the involuntary confinement of a Resident alone in a room or an area from which the Resident is physically prevented from leaving.

(29) “Sending state” means the state where the out-of-state Resident’s guardian or responsible party resides.

(30) “Serious injury” means physical harm or a physical injury that caused any significant impairment of the physical condition of the Resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

(31) “Serious physical harm” means physical injury that creates a substantial risk of death or that causes protracted disfigurement, protracted impairment of health, or loss or protracted impairment of the function of any bodily member or organ.

(32) “Sexual abuse” means the same as defined under Arkansas Code § 12-18-103.

(33) “Sexual act” means where a resident is coerced or manipulated to participate in any form of sexual activity for which the resident did not give affirmative permission.

(34) “Staff for Ratio” means those individuals with responsibility for managing a Resident’s health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis. This includes, but is not limited to, a licensed nurse, physician, licensed therapist, or other healthcare professionals licensed, registered, or certified to practice in the State of Arkansas, as well as paraprofessionals who meet requirements. All staff must comply with all staffing sections in the manual.

(35) “Suicide attempt” means self-inflicted harm in an attempt to end an individual’s own life; potentially self-injurious act with the wish to die; an act of self-harm that is intended to result in death but does not.

(36) "Time out" means the restriction of a Resident for a period of time to a designated area from which the Resident is not physically prevented from leaving, for the purpose of providing the Resident an opportunity to regain self-control.

(37) "Transfer" means the movement of the Resident from one (1) Psychiatric Residential Treatment Facility to another Psychiatric Residential Treatment Facility.

(38) "Violation" means:

(A) Class A violations create a condition or occurrence relating to the operation and maintenance of a Psychiatric Residential Treatment Facility resulting in death or serious physical harm to a Resident or creating a substantial probability that death or serious physical harm to a Resident will result therefrom;

(B) Class B violations create a condition or occurrence relating to the operation and maintenance of a Psychiatric Residential Treatment Facility which directly threatens the health, safety, or welfare of a Resident;

(C) Class C violations shall relate to administrative and reporting requirements that do not directly threaten the health, safety, or welfare of a Resident; or

(D) Class D violations shall relate to the timely submittal of statistical and financial reports to the Office of Long-Term Care. The failure to timely submit a statistical or financial report shall be considered a separate Class D classified violation during any month or part thereof of non-compliance. In addition to any civil money penalty which may be imposed, the director is authorized after the first month of a Class D violation to withhold any further reimbursement to the Psychiatric Residential Treatment Facility until the statistical and financial report is received by the Office of Long-Term Care.

20 CAR § 417-103. State Regulations.

Psychiatric Residential Treatment Facilities that are operated, conducted, managed, or maintained in this state are subject to the provisions of Arkansas Codes §§ 20-10-101 — 20-10-2510.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

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Subpart 2. Licensure

20 CAR § 417-201. Licensure.

(a)(1) Psychiatric Residential Treatment Facilities shall be operated, conducted, or maintained in Arkansas by obtaining a license pursuant to the provisions in this section.

(2) All Psychiatric Residential Treatment Facilities shall be licensed by the Office of Long-Term Care which is the sole licensing authority for Psychiatric Residential Treatment Facilities in the State of Arkansas.

(3) It shall be unlawful to operate a Psychiatric Residential Treatment Facility without possessing a current, valid license issued by the Office of Long-Term Care and each Psychiatric Residential Treatment Facility shall be separately licensed.

(b) A Psychiatric Residential Treatment Facility license shall:

(1) Be issued only to the person or entity named in the license application;

(2) Be valid only for the Psychiatric Residential Treatment Facility to which it is issued and only for the specific geographic address of that Psychiatric Residential Treatment Facility;

(3) Expire on the expiration date listed on the license, unless renewed, according to the Office of Long-Term Care's Psychiatric Residential Treatment Facility licensing renewal timeframes; and

(4) Not be subject to sale, assignment, donation, or other transfer, without prior approval by the Health Service Permit Agency and the Office of Long-Term Care.

(c) No branches, satellite locations or offsite campuses shall be authorized for a Psychiatric Residential Treatment Facility.

(d) The licensed Psychiatric Residential Treatment Facility shall abide by and adhere to any state law, rules, policy, procedure, applicable Medicaid manual, or memoranda pertaining to such Psychiatric Residential Treatment Facilities including but not limited to:

(1) Individual plan of care, 42 C.F.R. § 441.155 (1996);

(2) Team developing individual plan of care, 42 C.F.R. § 441.156 (1978);

(3) Purpose, 42 C.F.R. § 456.600 (1996);

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(4) Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21, 42 C.F.R. § 483, Subpart G (2001);

(5) Basis and scope, 42 C.F.R. § 483.350 (2001);

(6) Definitions, 42 C.F.R. § 483.352 (2001);

____ (7) General requirements for psychiatric residential treatment facilities, 42 C.F.R. § 483.354 (2001);

(8) Protection of residents, 42 C.F.R. § 483.356 (2001);

(9) Orders for the use of restraint or seclusion, 42 C.F.R. § 483.358 (2001);

(10) Consultation with treatment team physician, 42 C.F.R. § 483.360 (2001);

(11) Monitoring of the resident in and immediately after restraint, 42 C.F.R. § 483.362 (2001);

(12) Monitoring of the resident in and immediately after seclusion, 42 C.F.R. § 483.364 (2001);

(13) Notification of parent(s) or legal guardian(s), 42 C.F.R. § 483.366 (2001);

(14) Application of time out 42 C.F.R. § 483.368 (2001);

(15) Postintervention debriefings 42 C.F.R. § 483.370 (2001);

____ (16) Medical treatment for injuries resulting from an emergency safety intervention, 42 C.F.R. § 483.372 (2001);

(17) Facility reporting, 42 C.F.R. § 483.374 (2001);

(18) Education and training, 42 C.F.R. § 483.376 (2001);

____ (19) Inspections of Care in Intermediate Care Facilities and Institutions for Mental Diseases, 42 C.F.R. § 456, Subpart I (1978);

(20) Basis and purpose, 42 C.F.R. § 483.400 (1991);

(21) Relationship to other HHS regulations, 42 C.F.R. § 483.405 (1991);

(22) Condition of participation: Governing body and management, 42 C.F.R. § 483.410 (1991);

(23) Condition of participation: Client protections, 42 C.F.R. § 483.420 (1991);

(24) Condition of participation: Facility staffing, 42 C.F.R. § 483.430 (1991);

(25) Condition of participation: Active treatment services, 42 C.F.R. § 483.440 (1991);

(26) Condition of participation: Client behavior and facility practices, 42 C.F.R. § 483.450 (1991);

(27) Condition of participation: Health care services, 42 C.F.R. § 483.460 (2021);

(28) Condition of participation: Physical environment, 42 C.F.R. § 483.470 (1991);

(29) Condition of participation: Emergency preparedness, 42 C.F.R. § 483.475 (2019);

and

(30) Condition of participation: Dietetic services, 42 C.F.R. § 483.480 (1991).

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR § 417-202. Licensing application process.

(a) It is unlawful for any person, partnership, group, corporation, association, or other entity or identifiable group of entities having a coordinated ownership with controlling interest to operate or assist in the operation of a Psychiatric Residential Treatment Facility that has not been licensed by the Office of Long-Term Care.

(b) (1) Prior to obtaining a license, Psychiatric Residential Treatment Facilities shall obtain a permit from the Health Services Permit Agency to operate in Arkansas.

(2) The bed capacity allowed by the permit issued by the Health Services Permit Agency includes both in-state and out-of-state Residents.

(3) As of January 1, 2025, all increases or decreases in the total number of Psychiatric Residential Treatment Facilities authorized beds, must be approved by the Arkansas Legislative Council prior to receiving a permit from the Health Services Permit Agency, or license from the Office of Long-Term Care.

(4) Any expansions of bed capacity or new construction exceeding \$250,000, by an existing licensee shall require a license from the Office of Long-Term Care and a permit from the Health Services Permit Agency.

(5) A license issued by the Office of Long-Term Care is effective unless revoked, suspended, or terminated by the Office of Long-Term Care.

(c) After the requisite permit has been approved by the Health Services Permit Agency, an application for licensing as a Psychiatric Residential Treatment Facility shall be completed, as prescribed by the Office of Long-Term Care.

(d) All applicants shall submit a completed licensing application packet to the Office of Long-Term Care, which shall include:

(1) A completed Psychiatric Residential Treatment Facility licensure application and the non-refundable licensing fee as established by statute; and

(2) The annual fee, calculated by multiplying ten dollars (\$10.00) by the total approved licensed Resident beds in the Psychiatric Residential Treatment Facility, or maximum approved licensed Resident population.

(e) After the licensing application has been approved by the Office of Long-Term Care, notification of the approval shall be sent to the applicant.

(f) If the Office of Long-Term Care issues a license to operate a Psychiatric Residential Treatment Facility, the license shall:

(1) Be posted and displayed in a conspicuous place in the Psychiatric Residential Treatment Facility and must state at a minimum the:

(A) Full legal name of the person, partnership, group, corporation, organization, association, or other entity or identifiable group of entities having a coordinated ownership with controlling interest holding the license, including the business name, if different;

(B) Address of the Psychiatric Residential Treatment Facility;

(C) Effective date and expiration date of the license;

(D) Type of Psychiatric Residential Treatment Facility the licensee is authorized to operate;

(E) Ages and maximum number of children that may receive services from the Psychiatric Residential Treatment Facility; and

(F) Special conditions or limitations of the license.

(g) In addition to any other basis provided by law or rule, the Arkansas Department of Human Services shall terminate the license of a Facility that has not been in operation for a consecutive twelve-month period.

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(h) The Office of Long-Term Care may revoke, suspend, or terminate a license upon any basis provided by law or rule, including, without limitation, failure to be in operation, or in substantial compliance to the specific laws and rules which govern Psychiatric Residential Treatment Facilities, for a consecutive six-month period.

(i) It is unlawful for any person to falsify an application for licensure, to knowingly circumvent the authority of this manual, to knowingly violate the orders issued by the Office of Long-Term Care, or to advertise for inpatient psychiatric residential treatment when not licensed to provide those services.

(j) No Psychiatric Residential Treatment Facility may be sold or transferred without prior approval from the Office of Long-Term Care.

Authority. Arkansas Code §§ 20-10-224, 20-76-201 et seq., and 25-10-129.

20 CAR § 417-203. Penalties.

(a) Any person, partnership, association, or corporation, establishing, conducting, managing, or operating any institution within the guidelines set forth herein, without first obtaining a license, or who violates any provision of these lawfully promulgated regulations shall be subject to all remedies outlined in these regulations.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR § 417-204. Permit application process.

(a) An application for a Psychiatric Residential Treatment Facility permit shall be completed—as prescribed by the Health Services Permit Agency--and as outlined in Arkansas Code § 20-8-101 et seq.

(b) An applicant shall submit proof of permit prior to completing the Office of Long-Term Care licensure application.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR § 417-205. Psychiatric Residential Treatment Facility

Administrator.

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(a) It shall be unlawful for any person to act or serve in the capacity of a Psychiatric Residential Treatment Facility Administrator in this state unless the person has been licensed as outlined in this section.

(b)(1) An application for licensing as a Psychiatric Residential Treatment Facility Administrator shall be completed under oath and as prescribed by the Office of Long-Term Care.

(2) Applications must be accompanied by the applicant's criminal background check, child maltreatment registry check, adult maltreatment registry check, and a sex offender registry check result.

(c) Administrators shall:

(1) Be a person who is at least twenty-one (21) years of age; and

(2) Have a Baccalaureate (preferred Master's degree, or Doctorate in a human services field) in child development, psychology, sociology, social work, guidance and counseling, education, administration, or business, or a related field with at least two (2) years of experience in a health-related field within the past five (5) years; or

(3) Have at least fifteen (15) years of executive level Psychiatric Residential Treatment Facility experience.

(d) Applicants shall be physically and mentally capable of performing the full-time duties of a Psychiatric Residential Treatment Facility Administrator, pursuant to Arkansas Code § 20-10-403.

(e) If the Psychiatric Residential Treatment Facility Administrator application is approved, the applicant has nine (9) months from the date of approval to become licensed.

(f)(1) Applicants for a Psychiatric Residential Treatment Facility Administrator license must pass a written examination, designed and administered by the Office of Long-Term Care, with the goal of showing competence in Psychiatric Residential Treatment Facility administration.

(2) Scores of seventy (70) will be required to pass the Office of Long-Term Care examination.

(g) (1) Applicants who do not pass the Office of Long-Term Care's examination shall be entitled to be re-examined one (1) additional time, at their own expense.

(2) After two (2) such successive failures, an applicant must:

(A) Retake the approved Office of Long-Term Care training course; and

(B) Reapply before re-examination.

(h) Psychiatric Residential Treatment Facility Administrators shall be required to renew their licenses, as follows:

(1) Every active administrator license shall be renewed annually and, on or before January 1, by submitting a renewal application to the Arkansas Department of Human Services and by furnishing written documentation that the licensee has attended and accumulated a specific number of continuing education clock hours as established by the department.

(2) If the renewal application and satisfactory documentation of compliance with continuing education requirements is not postmarked or received by the department on or before January 1, the licensee shall be ineligible to perform the duties of the Psychiatric Residential Treatment Facility administrator, and the license shall be deemed suspended effective January 2nd;

(3) A request for renewal postmarked or received by the department after January 1 shall not be considered unless the licensee complies with all of the requirements imposed by law or rule; and

(4) Any long-term care facility administrator license not renewed, on or before March 1, shall expire effective March 2.

(i) Pursuant to Arkansas Code § 17-4-101 et seq., military personnel, veterans, and their spouses, may have additional pathways to licensure intended to "eliminate barriers impeding employment [...] following a move across state lines."

(j) The department may refuse to issue or renew a Psychiatric Residential Treatment Facility Administrator's license—or may revoke or suspend the license of a Psychiatric Residential Treatment Facility Administrator—if the Office of Long-Term Care discovers that the applicant/licensee does not qualify for licensure, or has violated

Arkansas Code or the Office of Long-Term Care rules relating to the proper and effective administration and management of a Psychiatric Residential Treatment Facility.

(k) The Office of Long-Term Care may deny a Psychiatric Residential Treatment Facility Administrator applicant if they fail to comply with this section.

(l) Disciplinary proceedings: The Office of Long-Term Care may refuse to issue or renew a Psychiatric Residential Treatment Facility Administrator's license or may take other disciplinary action against a Psychiatric Residential Treatment Facility Administrator, who fails to perform their duties adequately, as outlined below.

(m) Inadequate performance that may lead to disciplinary actions include, but are not limited to, the following areas:

(1) During the time that the Psychiatric Residential Treatment Facility Administrator is acting in their capacity as Administrator, the Psychiatric Residential Treatment Facility subjected to:

(A) Involuntary closure and transfer of a Resident;

(B) Appointment of a temporary manager or receiver;

(C) Determination of immediate jeopardy to the health and safety of any Resident;

(D) Civil money penalties based on annual or complaint surveys;

(E) Termination from the Medicaid program;

(F) An extended, or partial extended, survey resulting in a determination of substandard quality of care;

(G) Denial of payments for new admissions, or denial of all payments; and

(H) Conviction or finding against the Psychiatric Residential Treatment Facility Administrator of certain misconduct, concerning any Psychiatric Residential Treatment Facility or Resident, past or current, listed below:

(i) Fraud in the operation of any facility;

(ii) Misappropriation or embezzlement of funds from any facility or Resident;

(iii) Abuse or neglect of any Resident;

(iv) Purposeful failure to report abuse or neglect of any Resident;

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(v) Misappropriation of any Resident's property;

(vi) Criminal offense conviction(s) related to the abuse of adults or children;

(vii) Failure to protect any Resident's rights; and

(viii) Criminal offense(s) under Arkansas Code § 17-3-102, or any additional state law, relating to occupational licensure.

(I) Disciplinary action may include, but is not limited to:

(i) Letter of concern or reprimand;

(ii) Directed in-service training or Corrective Action Plan;

(iii) Probation; and

(iv) Suspension of license or revocation of Psychiatric Residential Treatment Facility Administrator license.

(n)(1) Penalties: It shall be unlawful for any person to act or serve in the capacity of a Psychiatric Residential Treatment Facility Administrator in this state unless such person has been licensed to do so.

(2) Any person who violates this requirement shall be guilty of a Class A misdemeanor and upon conviction thereof shall be subject to:

(A) Fine of not less than one hundred dollars (\$100) nor more than one thousand dollars (\$1,000);

(B) Imprisonment for not less than ten (10) days nor more than ninety (90) days; or

(C) Both fine and imprisonment.

(o) Licensure Requirement: No person shall administer, manage, supervise, or be in general administrative charge of a Psychiatric Residential Treatment Facility unless they are a licensed Psychiatric Residential Treatment Facility Administrator in active status.

(p) No Psychiatric Residential Treatment Facility within the state shall operate except under the supervision of a licensed Psychiatric Residential Treatment Facility Administrator.

(g) No Administrator shall manage more than one (1) Psychiatric Residential Treatment Facility.

(r)(1) The Psychiatric Residential Treatment Facility Administrator, or their designee, must be on call at all times.

(2) The Psychiatric Residential Treatment Facility Administrator must also ensure that a manager or supervisor is on site at all times.

(3) The manager, supervisor, or acting Psychiatric Residential Treatment Facility Administrator, shall be designated, in writing, to act in the absence of the Administrator, for example, listing of the lines of successional authority, by position and title.

(s) On an annual basis, actively licensed Psychiatric Residential Treatment Facility Administrators must:

(1) Participate in twelve (12) clock hours of continuing education at approved workshops.

(2) Continuing education hours must be applied to the licensure year in which they were obtained and cannot be carried over to the following year.

(3) Workshops and seminars must be approved by the Office of Long-Term Care.

(4) Psychiatric Residential Treatment Facility Administrators, who are initially licensed after July 2, will not be required to complete continuing education hours for the renewal period immediately following.

(t) Appeals: Disciplinary actions by the Office of Long-Term Care that result in suspension or revocation of a Psychiatric Residential Treatment Facility Administrator's license may be appealed for hearing before the department at:

Office of Appeals and Hearings

P.O. Box 1437 – Slot S101

Little Rock, AR 72203-1437

Phone: 501-682-8622

Fax: 501-682-6605

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(u) If individuals have questions about becoming a licensed provider, they may email the Office of Long-Term at OLTC.LicensureCertification@dhs.arkansas.gov.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR § 417-206. Licensing surveys and inspections of care.

(a) A Psychiatric Residential Treatment Facility is regulated under the following:

(1) For Arkansas Residents, the Arkansas Medicaid Manual—Psychiatric Residential Treatment Facility Services for under Age 21;

(2) Applicable Medicaid or Payor Manuals from the Resident’s sending state;

(3) The Office of Long-Term Care’s Psychiatric Residential Treatment Facility Licensure Manual (this manual);

(4) All applicable federal regulations including those cited herein; and

(5) Arkansas State Statutes.

(b) The Office of Long-Term Care, the Office of the Attorney General, Centers for Medicare & Medicaid Services, other legal authority, contractor, or any combination thereof, may investigate complaints of alleged violation of licensing standards against all residential facilities and may participate in investigations of alleged child maltreatment.

(c)(1) The Office of Long-Term Care, the Office of the Attorney General, Centers for Medicare & Medicaid Services, other legal authority, contractor, or any combination thereof, may monitor and conduct such surveys, audits, records reviews, desk reviews, complaint inquiries, and investigations of an applicant, licensee, and Psychiatric Residential Treatment Facility as necessary to carry out the Office of Long Term Care’s authority and responsibilities under these licensure rules and provisions applicable under Public Health and Welfare, Arkansas Code §§ 20-2-101 — 20-86-113.

(2) This includes, but is not limited to, inspecting the following: all areas used in the care, protection, or support of Residents, including the kitchen or food preparation areas, laundry areas, and storage areas; all Resident records, including

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Residents' financial records, medical records, and any other records maintained by the Psychiatric Residential Treatment Facility; all employee records; administration or operation records; and any other records necessary for an investigation or survey.

(d)(1) The Psychiatric Residential Treatment Facility shall submit to, and cooperate with, unannounced inspection surveys and complaint investigations in order to receive or maintain a license.

(2) Said inspection or complaint investigation shall be unscheduled, and at the discretion of the Office of Long-Term Care, the Office of the Attorney General, Centers for Medicare and Medicaid Services, other legal authority, contractor, or any combination therefore, and may be conducted outside regular working hours.

(e) The frequency of inspections shall be at the discretion of the Office of Long-Term Care and may be based on the Psychiatric Residential Treatment Facility's compliance history.

(f)(1) Any owner/operator/Administrator, employee, contractor or volunteer in a Psychiatric Residential Treatment Facility shall immediately notify the Child Abuse Hotline if they have reasonable cause to suspect that a child has been subjected to child maltreatment, died as a result of child maltreatment, or if they observe a child being subjected to conditions or circumstances that would reasonably result in child maltreatment.

(2) The Psychiatric Residential Treatment Facility shall maintain a log or file of all calls to the child abuse hotline.

(3) The Psychiatric Residential Treatment Facility shall notify the Office of Long-Term Care by the next business day when a report of child maltreatment is accepted by the Child Abuse Hotline against the owner/operator/Administrator, employee, contractor, volunteer, child, or other person in a child welfare agency.

(4) The Psychiatric Residential Treatment Facility and all staff shall cooperate fully with investigators during a child maltreatment investigation.

(5) The Psychiatric Residential Treatment Facility shall take steps to prevent harm or retaliation against the child while an allegation of child maltreatment is being investigated.

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(6) Any person with a true finding of child maltreatment shall be reviewed by the owner or Administrator of the Psychiatric Residential Treatment Facility, in consultation with the Office of Long-Term Care, or its designee, to determine corrective action. Corrective action may include, but is not limited to, counseling, training, probationary employment, non-selection for employment, or termination.

(7) Any employee who has been sanctioned by any licensing or certifying entity, for any reason pertaining to child safety, shall be reviewed by the owner or Administrator of the Psychiatric Residential Treatment Facility, in consultation with the Office of Long-Term Care, or its designee, to determine corrective action.

(8) Corrective action may include, but is not limited to, counseling, training, probationary employment, non-selection for employment, or termination.

(9) The Psychiatric Residential Treatment Facility shall notify the Office of Long-Term Care by the next business day of serious injuries requiring emergency medical treatment, agency vehicle accidents, arrests, elopements, suicide attempts, or deaths, and maintain documentation of the incident and notification.

(10) The Psychiatric Residential Treatment Facility shall maintain reports on all incidents that cause injury, property damage, or disruption to routine operations or services.

(g) The Office of Long-Term Care, the Office of the Attorney General, Centers for Medicare & Medicaid Services, other legal authority, contractor, or combination thereof, have the authority to conduct interviews with the licensee, Residents, Residents' guardians/legal representatives, Psychiatric Residential Treatment Facility Administrator, members of the Governing Body, the medical director, the director of nursing, assistant directors of nursing, and other Psychiatric Residential Treatment Facility employees and contractors associated with the Psychiatric Residential Treatment Facility.

(h) Each applicant and each licensee, Psychiatric Residential Treatment Facility employees, and contractors shall cooperate with, and shall not hinder, or obstruct, the Office of Long-Term Care's inspections, records reviews, audits, inquiries, or investigations, as described in the section.

(i) The Psychiatric Residential Treatment Facility shall provide access to any equipment, meeting space, and private room as necessary to conduct interviews or tasks associated with conducting the survey or investigation.

(j) The Office of Long-Term Care, or its' contractor, shall conduct annual On-Site Inspections of Care for Psychiatric Residential Treatment Facility providers.

(k) All Psychiatric Residential Treatment Facilities will receive an Inspection of Care, consistent with 42 C.F.R. §§ 483.354, and 456.600 – 456.614 (2001).

(l) The Inspection of Care must include:

(1) Personal contact and observation of each Resident in the Psychiatric Residential Treatment Facility; and

(2) Review of each Resident's medical record.

(m) The inspection team must determine in its inspection whether:

(1) The services available in the Psychiatric Residential Treatment Facility are adequate to:

(A) Meet the health needs of each Resident;

(B) Promote the maximum physical, mental, and psychosocial functioning;

(2) If is necessary and desirable for the Resident to remain in the Psychiatric Residential Treatment Facility;

(3) If is feasible to meet the Resident's health needs; and

(4) Each Resident in a Psychiatric Residential Treatment Facility is receiving active and appropriate treatment.

(n) The provider shall make the following available upon the Inspection of Care Team's arrival at the site:

(1) Medical records of all Residents;

(2) One (1) or more knowledgeable administrative staff to assist the team;

(3) The opportunity to assess direct Resident care in a manner least disruptive to the actual provision of care;

(4) Staff personnel records, complete with hire dates, dates of credentialing and copies of current licenses, credentials, criminal background checks, and similar or related records;

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_____ (5) Written policies, procedures, and quality assurance committee minutes;

_____ (6) Clinical Administrative, Clinical Services, Quality Assurance, Quality Improvement, Utilization Review and Credentialing documentation;

_____ (7) Program descriptions, manuals, schedules, staffing plans, and evaluation studies; and

_____ (8) If identified as necessary and, as requested, additional documents required by a provider's individual licensing board, child maltreatment checks, and adult maltreatment checks.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR § 417-207. Written notice of enforcement action and plan of correction.

_____ (a) After a survey or inspection, the Office of Long-Term Care will provide the Psychiatric Residential Treatment Facility with a written notice for each program, which shall state:

_____ (1) A factual description of the conditions that constitute a violation of the standard;

_____ (2) The specific law or standard violated; and

_____ (A) The written notice shall also indicate the classification of violation, if applicable, pursuant to Arkansas Code §§ 20-10-205 – -20-10-206.

_____ (3) A reasonable time frame within which the violation shall be corrected.

_____ (b) Upon receiving the Statement of Deficiencies, Psychiatric Residential Treatment Facilities must provide a written Corrective Action Plan within ten (10) business days of receipt of the written notification of Statement of Deficiencies, also called a CMS-2567, or "Statement of Deficiencies and Plan of Correction," pursuant to Arkansas Code § 20-10-1902. The Office of Long-Term Care shall determine whether the proposed

Corrective Action Plan, including any proposed dates by which correction will be made, is acceptable.

(c)(1) The Psychiatric Residential Treatment Facility must post the Statement of Deficiencies and the Psychiatric Residential Treatment Facility's response, and the outcome of the response from the latest survey, in a public area utilized by Resident or their responsible parties and visitors.

(2) The last twelve (12) months of deficiency notices and Psychiatric Residential Treatment Facility responses and outcomes of responses, for all surveys, shall be provided to their guardians/responsible parties, upon request.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR § 417-208. Remedies.

(a)(1) The purpose of remedies are to ensure prompt compliance with program requirements.

(2) When the Office of Long-Term Care chooses to apply one (1) or more remedies specified herein, the remedies are applied on the basis of non-compliance found during surveys or investigations, of any nature, conducted by the Office of Long-Term Care, or its' contractor, or for failure to comply with applicable laws or regulations.

(b)(1) The Office of Long-Term Care may apply one (1) or more remedies for each deficiency constituting non-compliance, or for all deficiencies constituting non-compliance in aggregate.

(2) Examples of these remedies may include the following:

(A) Civil Money Penalties;

(B) Moratorium on new admissions;

(C) Directed in-service training;

(D) Directed Corrective Action Plan;

(E) Additional state monitoring;

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(F) Temporary Psychiatric Residential Treatment Facility Administrator;
(G) Termination of license and closure of Psychiatric Residential Treatment Facility;
(H) Transfer of Arkansas resident;
(I) Transfer of out-of-state Resident back to sending state;
(J) Decertification of any Resident determined not to meet medical necessity criteria for Psychiatric Residential Treatment Facility services;
(K) Decertification of any provider determined to be non-compliant with the Office of Long-Term Care provider certification rules, Medicaid manual, federal regulations, or Arkansas State statutes;
(L) Formulation of an emergency transition plan for Residents;
(M) Recoupment for services that are not medically necessary, or that fail to meet professionally recognized standards for health care;
(N) Termination from participation in the Medicaid Program;
(O) Suspension of participation in the Medicaid Program; or
(P) Exclusion under current Arkansas Department of Human Services Policy 1088, titled Arkansas Department of Human Services Participant Exclusion Rule.
(c) Unless otherwise provided by law or other applicable regulations, remedies continue until:
(1) The Psychiatric Residential Treatment Facility has corrected the cited deficiencies that resulted in the imposition of the remedy, or remedies, as determined by the Office of Long-Term Care, based upon a revisit, or after an examination of credible written evidence that can be verified without an on-site visit, or both; or
(2) The Office of Long-Term Care terminates the Psychiatric Residential Treatment Facility's license.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR § 417-209. Mandatory closure notification.

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(a) Except as provided in these licensing regulations, a license shall be immediately null and void if a Psychiatric Residential Treatment Facility becomes non-operational.

(b) A cessation of business is deemed to be effective the date on which the Psychiatric Residential Treatment Facility stopped offering or providing services to the community.

(c) Upon the cessation of business, the provider shall immediately return the original license to the Office of Long-Term Care.

(d) Cessation of business is deemed to be a voluntary action on the part of the provider.

(e) The provider does not have a right to appeal a cessation of business.

(f) Prior to the effective date of the closure or cessation of business, the Psychiatric Residential Treatment Facility shall:

(1) Give thirty (30) days advance written notice to:

(A) The Office of Long-Term Care;

(B) The prescribing physicians; and

(C) The parent or legal guardian or legal representative of each Resident;
and

(2) Provide for an orderly discharge and transition of all Residents in the Psychiatric Residential Treatment Facility.

(g)(1) In addition to the advance notice of voluntary closure, the Psychiatric Residential Treatment Facility shall submit a written plan for the disposition of Residents' medical records for approval by the Office of Long-Term Care.

(2) The plan shall include the following:

(A) Effective date of the voluntary closure;

(B) Provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's Residents' medical records;

(C) An appointed custodian(s) who shall provide the following:

(i) Access to records and copies of records to the Resident's parent or legal guardian, upon presentation of proper authorization(s); and

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(ii) Physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and
(iii) Public Notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least fifteen (15) days prior to the effective date of closure.
(h) If a Psychiatric Residential Treatment Facility fails to follow these procedures, the owners, managers, officers, directors, and Administrators may be prohibited from opening, managing, directing, operating, or owning a Psychiatric Residential Treatment Facility for a two-year period.

Authority. Arkansas Code §§, 20-76-201 et seq., and 25-10-129.

20 CAR § 417-210. Informal dispute resolution.

(a)(1) When a Psychiatric Residential Treatment Facility does not agree with deficiencies cited on a Statement of Deficiencies, the Psychiatric Residential Treatment Facility may request an Informal Dispute Resolution hearing of the deficiencies in lieu of, or in addition to, a formal appeal.

(2) The Informal Dispute Resolution process is governed by Arkansas Code § 20-10-1901 et seq.

(b)(1) A written request for an Informal Dispute Resolution must be made to the Arkansas Department of Health within ten (10) calendar days of the receipt of the Statement of Deficiencies.

(2) The request must:

(A) List all deficiencies the Psychiatric Residential Treatment Facility wishes to challenge; and

(B) Contain a statement whether the Psychiatric Residential Treatment Facility wishes the Informal Dispute Resolution hearing to be conducted by telephone conference, by record review, or by an in person meeting in which the parties appear before the impartial decision maker.

(c) The request for an Informal Dispute Resolution does not alter or postpone the requirement for submission of an acceptable Corrective Action Plan.

(d) Refutations of allegations or implementation of remedies, similarly, does not substitute for an appeal, or alter/postpone the need to submit an acceptable Corrective Action Plan.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR § 417-211. Appeals.

(a) Any applicant or licensee who considers themselves injured in their person, business, or property by final administrative adjudication shall be entitled to judicial review thereof as provided by law.

(b) All petitions for judicial review shall be in accordance with the Arkansas Administrative Procedure Act as codified at Arkansas Code § 25-15-201 et seq.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

Subpart 3. Administration

20 CAR 417-301. Purpose and organizational structure.

(a) The purpose of the Psychiatric Residential Treatment Facility shall be clearly defined in a statement filed with the Office of Long-Term Care. The statement must include the:

- (1) Program philosophy;
- (2) Program goals and objectives;
- (3) Ages, gender, and characteristics of Residents accepted for care;
- (4) Geographical area(s) served;
- (5) Types of services provided;
- (6) Description of admission policies; and
- (7) Needs, problems, situations, or patterns best addressed by the provider's program.

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(b) House Rules: The provider shall have a clearly written list of rules governing conduct for Residents in care and shall document that these rules are made available to each staff member, Resident, and where appropriate, the Resident's parent or legal guardian.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-302. Management.

(a) The Governing Body or management team shall adopt effective Resident care policies and administrative policies and by-laws governing the operation of the Psychiatric Residential Treatment Facility in accordance with legal requirements.

(b) The Governing Body or management team, or the owner, or the person or persons designated by the owner as the governing authority shall be the supreme authority responsible for the management control of the Psychiatric Residential Treatment Facility. The Governing Body or management team is ultimately accountable for the safety of Residents and staff and the quality of care, treatment, and services provided.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-303. Required policies around staffing.

(a) The Psychiatric Residential Treatment Facility shall have personnel policies which include, but are not limited to, defining staff roles, essential job functions, qualifications, and lines of authority.

(b) The Psychiatric Residential Treatment Facility shall have:

(1) A written plan for recruitment, screening, orientation, ongoing training, development, supervision, and performance evaluation of staff members whether directly employed or contracted;

(2) Written personnel policies and written job descriptions for each staff position;

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(3) Written employee grievance procedures;

(4) Written policies that ensure that accurate and current information is maintained regarding all staff members of the Psychiatric Residential Treatment Facility, to include, at least: address, phone number, and personal, work, and training background; and

(5)(A) Written policies that ensure that, when a Psychiatric Residential Treatment Facility outsources services normally provided by the Psychiatric Residential Treatment Facility, there must be a written/contractual agreement with the source/contractor that describes how and exact services to be provided, when the services are to be provided, and that the services are only to be provided by qualified individuals.

(i) Example services may include but are not limited to staffing, training, recreation, food service, professional consultant, maintenance, or transportation.

(B) The source shall comply with this regulation in regard to Resident care, services, and rights.

(c) The Psychiatric Residential Treatment Facility shall have written policies, contracts, and practices to assure:

(1) The availability of adequate psychiatric services to meet the following requirements:

(A) Provide medical oversight of all of the clinical aspects of care, and provide twenty-four (24) hours per day, and seven (7) days per week, psychiatric on-call coverage;

(B) Assess each Resident's medication and treatment needs including administration of medication; prescribe medications or otherwise assure the case management and consultation services are provided to obtain prescriptions, and prescribe therapeutic modalities to achieve the resident's individual treatment plan's goals; and

(C) Participate in the Psychiatric Residential Treatment Facility's individual plan of care team and quality assessment and improvement process.

(2) Sufficient supervision of all Residents twenty-four (24) hours per day.

(d)(1) There shall be a single organized professional staff that has the overall responsibility for the quality of all clinical care provided to Residents, and for the ethical conduct and professional practices of its staff, as well as for accounting to the Governing Body or management team.

(2) The manner in which the professional staff is organized shall be consistent with the Psychiatric Residential Treatment Facility's documented staff organization and policies and shall pertain to the setting where the Psychiatric Residential Treatment Facility is located.

(3) The organization of the professional staff and its policies shall be approved by the Psychiatric Residential Treatment Facility's Governing Body or management team.

(e) The staff of a Psychiatric Residential Treatment Facility shall have the appropriate qualifications to provide the services required by its Residents' comprehensive plans of care. Each member of the direct care staff may not practice beyond the scope of his or her license, certification, or training.

(f) A Psychiatric Residential Treatment Facility must conduct criminal background checks for all staff as required by Arkansas Code §§ 20-38-101 — 20-38-113, and applicable minimum licensing standards.

(1) A Psychiatric Residential Treatment Facility must conduct an Arkansas Child Maltreatment Central Registry check on each employee prior to hiring and at least every two (2) years thereafter.

(2) A Psychiatric Residential Treatment Facility must conduct an Arkansas Adult and Long-Term Care Facility Resident Maltreatment Central Registry check on each employee prior to hiring and at least every two (2) years thereafter.

(3) A Psychiatric Residential Treatment Facility must conduct a five (5) panel drug screen that tests for the use of illegal drugs on each employee prior to hiring for employees hired after November 1, 2025, and at least every two (2) years after hiring.

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For employees hired prior to November 1, 2025, a PRTF will have 120 days from November 1, 2025, to administer the initial drug screen.

(4) A Psychiatric Residential Treatment Facility must conduct an Arkansas Sex Offender Central Registry search on each employee prior to hiring and at least every two (2) years thereafter.

(g) Personnel Records:

(1) The Psychiatric Residential Treatment Facility shall maintain on file a written or electronic personnel record for each employee working at the Psychiatric Residential Treatment Facility, which shall be kept for at least five (5) years following an employee's separation from employment. The personnel record shall include:

(A) An application, resumé, or staff information sheet that documents qualifications for the position;

(B) Any health records required by the Psychiatric Residential Treatment Facility;

(C) Annual performance evaluations and any reports and notes relating to the individual's employment with the Psychiatric Residential Treatment Facility;

(D) Documentation of the successful completion of orientation, training, and demonstrations of competency, the dates of completion and the names of the persons certifying the completion of the orientation, training, and demonstrations of competency;

(E) Date of employment; and

(F) Date and reason for leaving employment.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-304. Staffing ratios and required personnel.

(a) The Psychiatric Residential Treatment Facility shall have:

(1) A physician currently licensed by the Arkansas State Medical Board who has experience in the practice of adolescent psychiatry;

(2) A Director of Nursing or Nurse Manager currently licensed in Arkansas as a Registered Nurse;

(3) A Clinical Director who has at least a master's degree in a human services field and is currently licensed in Arkansas as a mental health professional as recognized by Arkansas Medicaid;

(4) One (1) or more therapists having at least a master's degree in a human services field and who is currently licensed as a mental health professional as recognized by Arkansas Medicaid; and

(5) A therapist assigned to each child who is responsible for assessments, treatment planning, and casework services.

(b) Staff shall be at least twenty-one (21) years of age and have a high school diploma or equivalent.

(c) The Psychiatric Residential Treatment Facility shall meet minimum licensure requirements for staffing, staff qualifications, and staffing ratios.

(d) The Psychiatric Residential Treatment Facility shall:

(1) Maintain the following minimum staffing ratios:

(A) One (1) staff person per four (4) Residents, for a minimum ratio of (1:4), from 6:00 a.m. to 10:00 p.m., or 7:00 a.m. to 11:00 p.m.; and

(B) One (1) staff person per eight (8) Residents, for a minimum ratio of (1:8), from 10:00 p.m. to 6:00 a.m., or 11:00 p.m. to 7:00 a.m., depending on age and need.

(2) The staff, for purposes of this ratio, shall be

(A) Staff dedicated to provide direct care in that particular milieu.

(B) Awake at all times.

(C) Provide and document a visual check on each child at least every (15) minutes but no greater than twenty (20) minutes during the 1:8 ratio.

(D) Provide supervision and treatment on each child during the 1:4 ratio.

(3) The Psychiatric Residential Treatment Facility shall maintain a daily census report to include the child's name and room or building assignment.

(e) A Psychiatric Residential Treatment Facility shall modify staffing patterns to fit their increased needs.

(f) Staffing ratios listed above are a minimum standard. The Psychiatric Residential Treatment Facility shall have written policies and procedures that:

(1) Demonstrate how the staffing pattern will be adjusted when necessary to meet the individual needs and acuity of youth as those fluctuate over time;

(2) Document how the Psychiatric Residential Treatment Facility continuously monitors the appropriateness of its staffing pattern to ensure the safety of both the Residents and the staff;

(3) Shall include specific methods used by the Psychiatric Residential Treatment Facility to monitor metrics such as restraints and seclusions and other adverse incidents, and documentation of how the Psychiatric Residential Treatment Facility uses this monitoring to make ongoing decisions about staffing patterns;

(4) Document how the Psychiatric Residential Treatment Facility continuously monitors the appropriateness of its staffing pattern to ensure that Residents receive appropriate, individualized care, treatment and therapeutic interactions; and

(5) The documentation in this subsection shall include specific methods used by the Psychiatric Residential Treatment Facility to monitor metrics such as clinical progress and outcomes, and documentation of how the Psychiatric Residential Treatment Facility uses this monitoring to make ongoing decisions about staffing patterns.

(g)(1) Beds exceeding licensure and permit will be authorized only in cases of emergency.

(2) An emergency exists when it can be demonstrated that the Resident's health or safety would be placed in immediate jeopardy if relocation were not accomplished.

(3) A fire, natural disaster such as a flood or tornado, or other catastrophic event that necessitates Resident relocation will be considered an emergency.

(4) The Office of Long-Term Care must be contacted for prior authorization of the overbed, and all authorizations must be in writing.

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Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

Subpart 4. Administrative Policies and Records

20 CAR 417-401. Policy management.

(a)(1) Every Psychiatric Residential Treatment Facility shall have policies that are clearly written and current.

(2) All policies shall be available for review by all facility staff and Arkansas Department of Human Services personnel.

(3) All policies shall be available for review upon request by a Resident or a Resident's parent or legal guardian. Policies regarding physical and chemical restraints must be provided to the Resident's parent or legal guardian.

(b) All policies shall be reviewed annually by the Governing Body or management team.

(c) The Psychiatric Residential Treatment Facility shall have policies governing:

(1) Admission and discharge;

(2) Personnel;

(3) Grievance procedures;

(4) Behavior management;

(5) Use of restraint;

(6) Mandatory reporting of abuse or neglect;

(7) Administering medication;

(8) Confidentiality of records;

(9) Release of medical information;

(10) Participation of Residents in activities related to fundraising and publicity;

(11) Participation of Residents in research projects;

(12) The photographing and audio or audio-visual recording of Residents and clarification of the facility's prohibited use of social media to ensure that all staff, either

contracted or directly employed, receive training relative to the restrictive use of social media;

(13) Hazards risk assessment and emergency/disaster procedures, pursuant to 42 C.F.R. § 441.184 (2019), including the provision that when the Psychiatric Residential Treatment Facility has an interruption in services or a change in the licensed location due to an emergency situation, the Psychiatric Residential Treatment Facility shall notify the Office of Long-Term Care no later than the next stated business day;

(14) Reportable incidents, sentinel events, and critical incidents; and

(15) Factors that determine room assignments, including, but not limited to, age and diagnoses.

(d)(1) Pursuant to Arkansas Code § 5-13-202(a)(4)(E), the administration of a facility shall post a notice that attacking a healthcare professional, including a nurse, is a felony.

(2)(A) Said notice shall be posted:

(i) At entrances to a healthcare facility, emergency department, clinic, or long-term care facility that are used by patients, residents, and visitors; and

(ii) In patient or resident waiting areas of a healthcare facility, emergency department, clinic, or long-term care facility.

(B) The text of the notice shall read: "We respect you. Please respect our staff. Attacking a healthcare worker is a FELONY*. *Arkansas Code § 5-13-202."

Authority. Arkansas Code §§, 20-76-201 et seq., and 25-10-129.

20 CAR 417-402. Requirements and recording of staff training.

(a)(1) The Psychiatric Residential Treatment Facility must document in the staff personnel records that the required training and demonstration of competency were successfully completed.

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(2) Documentation must include the date the training was completed, number of hours, the name of the source, the name of persons certifying the completion of training, and the topic or title of the training.

(b) All training programs and materials used by the Psychiatric Residential Treatment Facility must be available for review by the state's Office of Long-Term Care, the Office of Substance Abuse and Mental Health, and the Division of Medical Services, and by the federal Centers for Medicare & Medicaid Services.

(c) Individuals who are qualified by education, training, and experience must provide staff training.

(d) All trainings must be a mixture of in-person and online interactive modules that require competency testing.

(e) Training shall be conducted immediately upon hire and annually thereafter and must be completed in order for staff to be included in staffing ratio requirements and shall include, without limitation:

(1) Confidentiality including the restricted use of social media and HIPAA;

(2) Resident grievance process;

(3) Fire and disaster plans;

(4) Suicide awareness and protocol;

(5) Crisis de-escalation and the management of aggressive behavior including acceptable and prohibited responses;

(6) Seclusions and restraints;

(7) Trauma-informed care;

(8) Knowledge of appropriate relationships with clients;

(9) Record Keeping: observing beneficiary, reporting or recording observations;

(10) Knowledge of behavioral health illnesses;

(11) Group interaction;

(12) Childhood development;

(13) Agency policies and procedures;

(14) Child Maltreatment Mandated Reporter rule; and

(15) First Aid and CPR;

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(f) If offering a Sexualized Rehabilitation Program, all staff shall have at least ten (10) hours of sexualized rehabilitation specific training.

(g) No staff shall be allowed to participate in any type of physical or chemical restraint until properly trained to do so. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations that could lead to an emergency safety intervention. The Facility shall ensure that staff are trained and demonstrate competency and this shall be documented in the staff personnel records, including date the training was completed and name of the person(s) certifying completion of training.

(h) The Psychiatric Residential Treatment Facility must require and record staff to have ongoing research based education, training, and demonstrated knowledge of:

(1) Techniques to identify staff and Resident behaviors, events, and environmental factors that may trigger emergency safety situations;

(2) The use of non-physical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations; and

(3) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in Residents who are restrained or in seclusion.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-403. Resident record maintenance.

(a) The Psychiatric Residential Treatment Facility shall maintain an individual record on all Residents admitted in accordance with accepted professional standards and practices.

(b) The Psychiatric Residential Treatment Facility must have sufficient staff to provide records that are completely and accurately documented, readily accessible, and systematically organized.

(c) The Psychiatric Residential Treatment Facility shall ensure the confidentiality and security of resident records, including information in a computerized medical record system, in accordance with the HIPAA Privacy Regulations and Arkansas state law.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-404. Contents of resident records.

(a) The Psychiatric Residential Treatment Facility shall initiate and maintain an onsite and organized record for each Resident.

(b) The record shall contain sufficient documented information to:

(1) Identify the Resident, and the agency and the associated staff responsible for that Resident;

(2) Support the diagnosis, secure the appropriate care/services as needed;
and

(3) Justify the care/services provided to include:

(A) The course of action taken and results;

(B) The symptoms or other indications of sickness or injury;

(C) Changes in physical, mental, or behavioral condition, or any combination thereof;

(D) The response or reaction to care, medication, and diet provided; the results of the baseline data captured at the time of admission with a standardized tool designed to measure outcomes; data captured at the time of discharge and any data collected between admission and discharge; and

(E) Promote continuity of care among providers, consistent with acceptable standards of practice.

(c) All entries shall be written legibly in ink, typed, or electronic media, and signed and dated.

(d) Specific entries and documentation shall include at a minimum:

(1) Personal data sheet to include the following information, when obtainable:

(A) Resident name;

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_____ (B) Address;
_____ (C) Date of birth;
_____ (D) Gender;
_____ (E) Race;
_____ (F) Parent or legal guardian's name;
_____ (G) Medicaid ID or PASSE ID;
_____ (H) Provisional diagnosis;
_____ (I) Days of care;
_____ (J) Social Security number;
_____ (K) Name, address, and telephone number of person(s) to be notified in
the event of an emergency;
_____ (L) Name and address of referral source;
_____ (M) Name of attending physician;
_____ (N) Date and hour of admission; and
_____ (O) Consultations by physicians or other authorized healthcare providers.
(2) Consents and acknowledgements: The provider shall obtain and maintain
in the Resident record all consents including:
_____ (A) Authority to place the child;
_____ (B) Consent for medical care;
_____ (C) Consent for administration of psychotropic medication;
_____ (D) Acknowledgement of restraint policy;
_____ (E) Consent(s) for restraint; and
_____ (F) Any additional consents as required by state or federal law, guidance,
rules, or regulations.
_____ (3) Consultations by physicians or other authorized healthcare providers.
_____ (4)(A) Orders and recommendations for all medication, care, services,
procedures, and diet from physicians or other authorized healthcare providers, which
shall be completed prior to, or within forty-eight (48) hours after admission, and
thereafter as warranted.

(B) Verbal orders received shall be documented and include the date and time of receipt of the order, description of the order, and identification of the individual receiving the order.

(C) Medication Administration Record or similar document for recording of medications, treatments, and other pertinent data and procedures followed if an error is made.

(D) All treatment service documentation and progress notes must include, at a minimum, the following:

(i) An intake/intake assessment and diagnosis;

(ii) Ongoing assessment and diagnosis;

(iii) An individualized treatment plan;

(iv) Staff ratio associated with the Resident if on heightened ratio requirements;

(v) Psychiatric services;

(vi) Mental health therapy services;

(vii) Milieu therapy;

(viii) Recreational and therapeutic activities;

(ix) Family involvement;

(x) Visitation records; and

(xi) Discharge planning.

(E) Provisions for routine and emergency medical care, to include the name and telephone number of the Resident's physician, plan for payment, and plan for securing medications.

(F) Special information, such as proof of legal guardianship status, allergies, power of attorney, or responsible party.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-405. Admission policies.

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(a) The Psychiatric Residential Treatment Facility shall not admit any child for whom the Psychiatric Residential Treatment Facility cannot provide adequate care.

(b) The Psychiatric Residential Treatment Facility shall not admit any out-of-state child without a written agreement from the payor, and responsible party if different, regarding return to the child's sending state upon scheduled or unscheduled discharge.

(c) A Psychiatric Residential Treatment Facility licensed under Arkansas Code § 9-28-401 et seq., and holding a permit from the Health Services Permit Agency shall not admit a child for psychiatric residential treatment unless the child is:

(1) An Arkansas Resident;

(2) A child of a parent who is an Arkansas Resident;

(3) A child placed by or on behalf of another state's child welfare agency;

(4) A child for whom the Psychiatric Residential Treatment Facility is being paid by another state's Medicaid program;

(5) A child of an active-duty member or veteran of the uniformed services as defined in Arkansas Code § 6-4-302; or

(6) A Non-Resident child victim of human trafficking when the regulated Psychiatric Residential Treatment Facility maintains responsibility for the return of the child to the out-of-state custodian.

(d) Each child shall have a:

(1) Medical exam no more than one (1) year before admission; or

(2) Documented appointment date for an exam within one (1) week after admission.

(e) Each child shall have:

(1) Proof of current immunizations;

(2) A letter of exemption in accordance with the Department of Health; or

(3) A scheduled appointment within one (1) week after admission.

(f) The Psychiatric Residential Treatment Facility shall obtain written verification of the placing agent's authority to place the child at the time of admission.

(g) The Psychiatric Residential Treatment Facility shall obtain written authority for medical care for the child from the placing agent at the time of admission.

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(h) The Psychiatric Residential Treatment Facility shall comply with the Interstate Compact on the Placement of Children, Arkansas Code § 9-29-201 et seq., when admitting children from outside Arkansas, if applicable.

(i) The Resident shall be discharged no later than their twenty-first birthday.

(j) Per 42 C.F.R. §§ 441.152 – 441.153 (1996), admission into a Psychiatric Residential Treatment Facility requires the following:

(1) An independent team that:

(A) Includes a physician;

(B) If the child is on Arkansas Medicaid, the physician is the PASSE medical director;

(C) If the child is from out-of-state, the physician is employed by the payor;

(D) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and

(E) Has knowledge of the Resident's situation.

(2) The independent team will certify that:

(A) Ambulatory care services available in the community do not meet the treatment needs of the Resident;

(B) Proper treatment of the Resident's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(C) The services can reasonably be expected to improve the Resident's condition or prevent further regression so that the services will no longer be needed.

(k) Pursuant to 42 C.F.R. § 483.440 (1991):

(1) Residents who are admitted by the Psychiatric Residential Treatment Facility must be in need of and receiving active treatment services.

(2) Admission decisions must be based on a preliminary evaluation of the Resident that is conducted or updated by the Psychiatric Residential Treatment Facility or by outside sources.

(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, psychiatric, social,

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health and nutritional status to determine if the Psychiatric Residential Treatment Facility can provide for the individual's needs and if the individual is likely to benefit from placement in the Psychiatric Residential Treatment Facility.

(l) The Psychiatric Residential Treatment Facility shall not admit, after July 1, 2025, a child who is under ten (10) years of age.

(m) At the time of admission, the following information shall be documented in the child's record:

(1) Name, signature, and role or relationship of the person who relinquished the child into care;

(2) A brief description of the symptoms of a psychiatric diagnosis that require admission;

(3) The date and time of the admission;

(4) A brief description of the child's history, if known, including behavioral history, mental health treatment and response;

(5) Any known medical history and known current health conditions;

(6) All medications currently prescribed for the child, if known and available;
and

(7) The child's current mental health diagnosis and symptoms, other behaviors related to the mental health diagnosis or known other co-occurring conditions.

(n) Intake information shall be completed on each child in the Facility's care within ten (10) working days after admission.

(o) The intake shall include:

(1) Demographic information on the child and parent or legal guardian,
including:

(A) Name;

(B) Address;

(C) Birth date;

(D) Gender;

(E) Race; and

(F) Religious preference;

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(2) A factual description of the symptoms and behaviors related to the mental health condition;

(3) A brief social history of the family;

(4) The child's current legal status or custody;

(5) Any history of previous placements outside the family;

(6) All previous mental health treatment and provider of treatment services;
and

(7) An assessment to establish the child's baseline that will be used to determine treatment outcomes throughout the stay; the assessment must be a standardized tool used to determine outcome measures.

(p)(1) When refusing admission to a Resident, the Psychiatric Residential Treatment Facility shall provide a written statement to the referral source with the reason for the refusal.

(2) Written statements refusing admission shall be provided to the designated representative(s) of the Office of Long-Term Care upon request.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-406. Individual plan of care.

Psychiatric Residential Treatment Facilities must provide services to a Resident according to an individual plan of care that:

(1) Is based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the Resident's situation and reflects the need for inpatient psychiatric care;

(2) Is developed by a team of professionals in consultation with the Resident, parent or legal guardian, or other individuals in whose care the Resident will be released after discharge;

(3) Describes clear and concise treatment objectives;

(4) Ensures continuity of care with the Resident's family, school and educational requirements, and community upon discharge;

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- (5) Determines that services being provided are or were required on an inpatient basis;
- (6) Prescribes an integrated program of therapies, activities, and experiences designed to meet the treatment objectives; and
- (7) Recommends changes in the individual plan of care as indicated by the Resident's overall adjustment as an inpatient.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-407. Certification of Need and Continuation of Benefits During Appeals and State Fair Hearing.

(a) A Team specified in 42 CFR 441.154 must certify that:

- (1) Ambulatory care resources available in the community do not meet the treatment needs of the Resident;
- (2) Proper treatment of the recipients' psychiatric condition requires services on an inpatient basis under the direction of a physician;
- (3) The services can reasonably be expected to improve the Resident's condition or prevent further regression so that the services will no longer be needed; and
- (4) All other Certification of Need requirements in 42 CFR 441.150 through 441.156.

(b) Residents with Medicaid Managed Care Organization payors.

- (1) If a resident receives notice of an adverse benefit determination and timely requests an appeal and continuation of benefits in accordance with 42 CFR §438.420, a PRTF will remain in compliance with certification of need requirements as identified under 42 CFR Part 441 while the appeal or state fair hearing is pending. The benefits must be continued if all of the following occur: _____

- (A) The Resident or their guardian files the request for an appeal timely in accordance with 42 CFR 438.402(c)(1)(ii) and (c)(2)(ii);

(B) The appeal involves the termination, suspension, or reduction of previously authorized services;

(C) The services were ordered by an authorized provider;

(D) The period covered by the original authorization has not expired; and

(E) The Resident or their guardian timely files for continuation of benefits.

(2) Continued or reinstated benefits must be continued until one of the following occurs:

(A) The resident withdraws the appeal or request for state fair hearing.

(B) The resident fails to request a state fair hearing and continuation of benefits within 10 days of the notice of adverse resolution of an appeal.

(C) A state hearing officer issues a hearing decision adverse to the enrollee.

(3) All other Continuation of Benefits requirements in 42 CFR 441.438.420.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-408. Discharge policies.

(a) Discharge planning begins at the date of admission, and goals toward discharge shall be continually addressed in the interdisciplinary team meetings and when the comprehensive individual plan of care is reviewed.

(b) When a Resident is to be discharged, the Psychiatric Residential Treatment Facility must:

(1) Have documentation in the Resident's record that the Resident was discharged for no longer meeting medical necessity requirements for Psychiatric Residential Treatment Facility level of care;

(2) Develop a discharge plan agreed upon by the Resident's parent or legal guardian for discharge with identified and confirmed needed step-down mental health and medication management services;

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(3) Provide OLTC with a monthly report if the PRTF serves an out-of-state population.

The report shall on an approved OLTC form and must outline the discharge plans for all out of state patients during that month, and shall include the following information: the patient's name, sending state, date of discharge, discharge state and location, and receiving person/entity. Any facility that fails to provide this monthly report shall have an administrative hold placed on the facility prohibiting out of state patients until such time the report is submitted.

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(4) Provide OLTC with a monthly report, on an approved OLTC form, discharge information for each child discharged from the Facility. This report shall be provided by the 5th day of the following month.

(c) At the time of the scheduled discharge, the Psychiatric Residential Treatment Facility must:

_____ (1) Develop a final summary of the Resident's developmental, educational, behavioral, psychiatric, social, health and nutritional status and, with the consent of the Resident's parent or legal guardian, provide a copy to authorized persons and agencies, the school district for which the Resident will be returning, if applicable;

_____ (2) Provide a post-discharge individual plan of care that documents all mental health, medication services, and education services that allow the Resident to reintegrate into a home and community setting including family and school supports;

(3) Administer and provide a copy of the outcome measures established at the time of admission, every 3 months after, and at discharge; the assessment must utilize a standardized tool designed to measure outcomes; and

_____ (4) Unless otherwise prohibited, provide thirty (30) days of medication for every medication that the Resident is prescribed.

_____ (d) At the time of an unscheduled discharge, the Psychiatric Residential Treatment Facility must:

_____ (1) Provide clinical rationale for the unscheduled discharge that must be included in the Resident's medical record;

_____ (2) Develop a final summary of the Resident's developmental, educational, behavioral, psychiatric, social, health and nutritional status and, with the consent of the

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Resident's parent or legal guardian, provide a copy to authorized persons and agencies, the school district for which the Resident will be returning, if applicable;

(3) Administer and provide a copy of the outcome measures established at the time of admission, every 3 months after, and at discharge; the assessment must utilize a standardized tool designed to measure outcomes; and

(4) Provide a post-discharge individual plan of care that documents all mental health, medication services, and education services that allow the Resident to reintegrate into a home and community setting including family and school.

(5) Provide DHS with notice, within 24 hours, if an out of state child has been detained or admitted to another treatment setting in the State of Arkansas.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-409. Retention and preservation of records.

(a)(1) All medical records shall be retained in either the original, or other acceptable methods for a minimum of ten (10) years after the last discharge; and for a minor, three (3) years after a resident reaches legal age under State law, which is 18 (eighteen) years of age, in accordance with 42 CFR 483.70(h)(4)(iii).

(2) After the required retention time has passed, a medical record may be destroyed provided the Psychiatric Residential Treatment Facility permanently maintains the information contained in the Master Patient Index.

_____.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-410. Confidentiality.

(a) The information contained in the Resident records is confidential and is not to be released without legal authorization or subpoena.

(b) The records will be available to the Office of Long-Term Care or its' contractor.

(c)(1) The Psychiatric Residential Treatment Facility shall ensure the confidentiality and security of Resident records, including information in a computerized medical record system, in accordance with the HIPAA Privacy Regulations and any Arkansas state laws and regulations which provide a more stringent standard of confidentiality than the HIPAA Privacy Regulations.

(2) Information from, or copies of records may be released only to authorized individuals, and the Psychiatric Residential Treatment Facility shall ensure that unauthorized individuals cannot gain access to or alter Resident records.

(3) Original medical records shall not be released outside the Psychiatric Residential Treatment Facility unless under court order or subpoena or in order to safeguard the record in the event of a physical plant emergency or natural disaster.

(d)(1) The provider shall have written procedures for the maintenance and security of records specifying who shall supervise the maintenance of records, who shall have custody of records, and to whom records may be released.

(2) Records shall be the property of the provider, and the provider as custodian shall secure records against loss, tampering, or unauthorized use.

(e) Employees of the Psychiatric Residential Treatment Facility shall not disclose, or knowingly permit the disclosure, of any information concerning the Resident or his or her family, directly or indirectly, to any unauthorized person.

(f) When the Resident is of majority age and non-interdicted, the provider shall obtain the Resident's written, informed permission prior to releasing any information from which the Resident or his or her family might be identified, except for accreditation teams and authorized state and federal agencies.

(g) The provider shall, upon written authorization from the Resident or his or her parent or legal guardian, make available information in the case record to the Resident, his or her counsel, or the Resident's parent or legal guardian.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-411. Visitation rights.

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(a) In accordance with Arkansas Code § 20-6-407:

(1) A Psychiatric Residential Treatment Facility shall allow visitation as needed by the Resident to alleviate physical or mental distress.

(2) Personal contact with a Resident is permitted during visitation if the Psychiatric Residential Treatment Facility protocol is followed.

(3) A Psychiatric Residential Treatment Facility shall work with Residents, families, caregivers, Resident representatives, and medical providers, and may include the ombudsman program under Arkansas Code § 20-10-602 to identify the need for visitation, using a person-centered approach that takes the Resident's requests into account.

(4) The Psychiatric Residential Treatment Facility may limit:

(A) The number of visitors per Resident at a time based on the size of the building and physical space; and

(B) Movement in the Psychiatric Residential Treatment Facility, such as requiring the visitor to go directly to the Resident's room or designated visitation area.

(b) In accordance with Arkansas Code § 20-6-411, a Psychiatric Residential Treatment Facility may establish visitation policies that limit or restrict visitation when:

(1) The presence of visitors would be medically or therapeutically contraindicated;

(2) The presence of visitors would interfere with the care of or rights of any Resident;

(3) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, Resident, or other visitor; or

(4) Visitors are non-compliant with the Psychiatric Residential Treatment Facility policy.

(c) The Psychiatric Residential Treatment Facility shall provide immediate access at any time to the Resident by:

(1) A representative of the Office of Long-Term Care, Centers for Medicare & Medicaid Services, and the Arkansas Department of Human Services or the department's contractor;

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(2) The Resident's physician; and

(3) The Resident's representative.

(d)(1) The right to visit or be visited by family and friends is subject only to reasonable rules and to any specific restrictions in the Resident's treatment plan.

(2) Special restrictions shall be imposed only to prevent serious harm to the Resident.

(3) The reasons for any special restrictions shall be recorded in the Resident's treatment plan.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-412. Reportable events.

(a) The provider shall have comprehensive written procedures concerning Resident reportable events.

(b)(1) All written reports will be reviewed, initialed, and dated by the Psychiatric Residential Treatment Facility Administrator or designee.

(2) All reports involving accident or injury to Residents will also be reviewed, initialed, and dated by the Director of Nursing Services or other Psychiatric Residential Treatment Facility registered nurse.

(c) A Psychiatric Residential Treatment Facility, as defined by Arkansas Code § 20-10-213, that does not comply with this subsection, commits a Class C violation under Arkansas Code § 20-10-205 and is subject to a civil penalty under Arkansas Code § 20-10-206.

(d) It is the responsibility of the Psychiatric Residential Treatment Facility to obtain an address and telephone number at which the Resident's parent or legal guardian is available for notification.

(e) It is the responsibility of the Resident's parent or legal guardian to notify the Psychiatric Residential Treatment Facility of any change in address or telephone number.

(f) Pursuant to state law Arkansas Code § 20-10-107, within twenty-four (24) hours after the incident requiring notification occurs, a Psychiatric Residential Treatment Facility shall notify, if known, the Resident's parent, legal guardian, or other responsible party when:

- (1) The Resident suffers an injury;
- (2) The Resident is taken outside the Psychiatric Residential Treatment Facility for medical care;
- (3) The Resident is moved to a different room; or
- (4) There is any significant change in the physical or mental condition of the Resident.

(g) Pursuant to Reporting of Serious Occurrences, 42 C.F.R. § 483.374 (2001):

- (1) The Psychiatric Residential Treatment Facility must report each serious occurrence to the Office of Long-Term Care, the PASSE or the Sending State and, unless prohibited by state law, the State-designated Protection and Advocacy system.
- (2) Serious occurrences that must be reported include a Resident's death, a serious injury to a Resident as defined in 42 C.F.R. § 483.352 (2001), a Resident's suicide attempt, any significant impairment of the physical condition of the resident as determined by qualified medical personnel, any incidents of abuse and/or neglect, a pattern of injuries to a resident, elopement for longer than 15 (fifteen) minutes, physical injury that requires external medical treatment, or sexual acts between residents or residents and staff.

(3) A Psychiatric Residential Treatment Facility must report the death of any Resident in accordance to 42 C.F.R. § 483.374 (2001).

(4) Staff must report any serious occurrence involving a Resident to the Office of Long-Term Care, the PASSE or the Sending State and the State-designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence.

(5) The report must include the name of the Resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the Psychiatric Residential Treatment Facility.

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(6) The Psychiatric Residential Treatment Facility must notify the Resident's parent or legal guardian as soon as possible, and in no case later than twenty-four (24) hours after the serious occurrence.

(7) Staff must document in the Resident's record that the serious occurrence was reported to the Office of Long-Term Care, the PASSE or the Sending State, and the State-designated Protection and Advocacy system, including the name of the person to whom the incident was reported.

(8) A copy of the report must be maintained in the Resident's record, as well as in the incident and accident report logs kept by the Psychiatric Residential Treatment Facility.

(h) Reporting of Deaths:

(1) In addition to the reporting requirements contained above, Psychiatric Residential Treatment Facilities must report the death of any Resident to the Centers for Medicare & Medicaid Services regional office;

(2) Staff must report the death of any Resident to the Centers for Medicare & Medicaid Services regional office by no later than close of business the next business day after the Resident's death; and

(3) Staff must document in the Resident's record that the death was reported to the Centers for Medicare & Medicaid Services regional office.

(i) All reportable events must be entered into the Office of Long-Term Care's designated provider portal. If the child is in a PASSE, the PASSE must also be notified.

(j) In addition to all the above, the Child Maltreatment Hotline (1-800-482-5964) or the Adult Maltreatment Hotline (1-800-482-8049) may also be warranted. If the Child Maltreatment Hotline or Adult Maltreatment Hotline is contacted, the facility must provide the Office of Long-Term Care with the reference number.

(k) Any case of suspected Resident abuse or neglect shall be reported immediately to the Child Maltreatment Hotline or the Adult Maltreatment Hotline or, when appropriate, 911.

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(l) The Psychiatric Residential Treatment Facility shall notify the Resident's parent or legal guardian as soon as possible and, in no case, later than twenty-four (24) hours after the suspected Resident abuse or neglect occurred.

(m) (1) If a staff member is alleged to have committed an act of abuse or neglect, the accused shall be placed on administrative leave pending the outcome of the investigation and shall not be on the grounds of the Psychiatric Residential Treatment Facility.

(2) If criminal charges are filed, the accused shall remain removed from the Psychiatric Residential Treatment Facility until the charges are resolved.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-413. Treatment and medications.

(a) The provider shall have written policies and procedures that govern the safe administration and handling of all drugs as appropriate to the Psychiatric Residential Treatment Facility.

(b) The provider shall have a written policy governing the self-administration of both prescription and nonprescription drugs.

(c) The provider shall ensure that medications are either self-administered or administered by qualified persons according to state law.

(d) The provider shall ensure that any medication given to a Resident for therapeutic and medical purposes is in accordance with the written order of a physician.

(e)(1) Medications, including controlled substances, medical supplies, and those items necessary for the rendering of first aid shall be available and properly managed in accordance with local, state, and federal laws and regulations.

(2) Such management shall address the securing, storing, and administering of medications, medical supplies, first aid supplies, and biologicals, their disposal when discontinued or outdated, and their disposition at discharge, death, or transfer of a Resident.

(f)(1) There shall be an adequate number of first aid kits stored with appropriate safeguards but accessible to staff in appropriate locations such as living units, recreation and special purpose areas, buses, and otherwise.

(2) A first aid kit shall be equipped with at least an antiseptic solution, adhesive bandages, rolled bandages, gauze pads, medical adhesive tape, cotton-tip applications, and scissors.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-414. Administering medication and treatments.

(a) (1) Doses of medication shall be administered by the same staff member who prepared them for administration.

(2) Preparation shall occur no earlier than one (1) hour prior to administration; preparation of doses for more than one (1) scheduled administration shall not be permitted.

(3) Each physician-ordered treatment or medication dose administered or supervised shall be properly recorded by initialing on the Resident's medication administration record as the medication is administered or treatment record as treatment is rendered.

(4) Recording medication administration shall include medication name, dosage, mode of administration, date, time, and the signature of the individual administering or supervising the taking of the medication.

(5) If the ordered dosage is to be given on a varying schedule, such as, "take two (2) tablets the first day and one (1) tablet every other day by mouth with noon meal," the number of tablets shall also be recorded.

(6) The treatment record shall document the type of treatment, date and time of treatment, and signature of the individual administering treatment.

(b) Medications shall be administered only by staff members legally authorized to administer the medication(s).

(c) (1) When Residents leave the Psychiatric Residential Treatment Facility for an extended period of time, the proper amount of medications, along with dosage, mode, date, and time of administration, shall be given to a responsible person who will be in charge of the Resident during his or her absence from the Psychiatric Residential Treatment Facility; these details shall be properly documented in the Medication Administration Record.

(2) In these instances, the amount of medication needed for the designated period of time may be transferred to a prescription vial or bottle that is properly labeled.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-415. Medication containers.

(a)(1) Medications for Residents shall be obtained from a permitted pharmacy or prescriber on an individual prescription basis.

(2) These medications shall bear a label affixed to the container which reflects at least the following: name of pharmacy, name of Resident, name of the prescribing physician or other authorized healthcare provider, date and prescription number, directions for use, and the name and dosage unit of the medication.

(3) The label shall be brought into accord with the directions of the physician or other authorized healthcare provider each time the prescription is refilled.

(4) Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels shall be returned to the pharmacy for relabeling or disposal.

(5) Residents may obtain their over-the-counter medication from a pharmacy other than a pharmacy contracted with the Psychiatric Residential Treatment Facility.

(b)(1) If a physician or other authorized healthcare provider changes the dosage of a medication, a label, which does not obscure the original label, shall be attached to the container which indicates the new dosage, date, and prescriber's name.

(2) In lieu of this procedure, it is acceptable to attach a label to the container that states, "Directions changes; refer to the Medication Administration Record and

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physician or other authorized healthcare provider orders for current administration instructions.”

(3) The new directions shall be communicated to the pharmacist upon receipt of the order.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-416. Medication storage.

(a)(1) Medications shall be properly stored and safeguarded in a locked medicine preparation room or locked in a cabinet at or near the staff work area to prevent access by unauthorized individuals.

(2) If medication carts are utilized for storage, they shall be locked when not in use.

(3) When the medication cart is in use, it shall be supervised by staff legally authorized to administer medications.

(4) Expired or discontinued medications shall not be stored with current medications.

(5) Storage areas shall not be located near sources of heat, humidity, or other hazards that may negatively impact medication effectiveness or shelf life.

(b)(1) Medications requiring refrigeration shall be stored in a refrigerator at the temperature established by the United States Pharmacopeia, thirty-six degrees Fahrenheit (36°F) to forty-six degrees Fahrenheit (46°F), and recommended by the medication manufacturer.

(2) Medications requiring refrigeration shall be kept in a secured refrigerator, at or near the staff work area, used exclusively for medications, or in a secured manner in which medications are separated from other items in the refrigerator, such as a lock box.

(3) Food and drinks shall not be stored in the same refrigerator with medications.

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(4) All refrigerators storing medications shall have accurate thermometers, within plus or minus three degrees Fahrenheit (3°F).

(c) Medications shall be stored:

(1) Separately from poisonous substances or body fluids; and

(2) In a manner which provides for separation between topical and oral medications, and which provides for separation of each individual Resident's medication.

(d) A Psychiatric Residential Treatment Facility shall maintain records of receipt, administration, and disposition of all controlled substances in sufficient detail to enable accurate reconciliation including:

(1) Separate control sheets on any controlled substances. This record shall contain the following information: date, time administered, name of Resident, dose, signature of individual administering, name of physician or other legally authorized healthcare provider ordering the medication;

(2) At each shift change, a documented review of the control sheets by outgoing staff members with incoming staff members including verification by outgoing staff members indicating they have properly administered medications in accordance with orders by a physician or other authorized healthcare provider and have documented the administrations; and

(3) Errors or omissions indicated on the control sheets shall be addressed and corrective action taken at that time.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-417. Psychotropic medication report.

(a) A Psychiatric Residential Treatment Facility shall report monthly on an approved Office of Long-Term Care template, to the State-designated Protection and Advocacy system, the Office of Long-Term Care, and the Resident's PASSE, or the Resident's sending state the following data:

(1) A Resident is on four (4) or more psychotropic medications;

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(2) A Resident is on two (2) or more concomitant stimulants (long acting and an immediate release stimulant of the same chemical entity does not constitute concomitant prescribing);

(3) A Resident is on two (2) or more concomitant alpha agonists (long acting and an immediate release alpha agonist of the same chemical entity does not constitute concomitant prescribing);

(4) A Resident is on two (2) or more concomitant antidepressants;

(5) A Resident is on two (2) or more concomitant antipsychotics;

(6) A Resident is on three (3) or more concomitant mood stabilizers;

(7) A Resident is on a psychotropic medication dose that exceeds usual recommended doses; and

(8) A Resident was administered a PRN.

(b) The monthly report must include justification for each item listed above, that outlines:

(1) Why the therapeutic benefit outweighs the potential risk;

(2) What additional oversight is being provided; and

(3) On PRN orders the maximum dose allowed within twenty-four (24) hours and, also, maximum doses allowed per week shall be documented.

Authority. Arkansas Code §§, 20-76-201 et seq., and 25-10-129.

20 CAR 417-418. Disposition of medications.

(a) Residents' medications shall be destroyed by the authorized medical staff at the Psychiatric Residential Treatment Facility designee when:

(1) Medication has deteriorated or exceeded its expiration date; or

(2) Unused portions remain due to death or discharge of the Resident, or discontinuance of the medication.

(b) Medication that has been discontinued by order may be stored for a period not to exceed thirty (30) days provided that they are stored separately from current medications.

(c)(1) The destruction of medication shall be witnessed by the authorized medical staff, the mode of destruction indicated, and these steps documented.

(2) Destruction records shall be retained by the Psychiatric Residential Treatment Facility for a two-year period.

(d) The destruction of controlled substances shall be accomplished only by the Administrator or his or her designee and witnessed by the Administrator or his or her designee licensed to administer medications.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-419. Transportation.

(a) The Psychiatric Residential Treatment Facility shall ensure that each Resident is provided with the transportation necessary for implementation of the Resident's treatment plan.

(b) The Psychiatric Residential Treatment Facility shall provide or arrange transportation of its Residents to and from the Psychiatric Residential Treatment Facility and is responsible for the safety of the Residents during transport.

(c)(1) Transportation arrangements shall conform to state laws, including laws governing the use of seat belts and Resident restraints.

(2) Vehicles shall be accessible for people with disabilities or so equipped to meet the needs of the Residents served by the Psychiatric Residential Treatment Facility.

(d) The driver or attendant shall not leave a Resident unattended in the vehicle at any time.

(e) The number of persons in a vehicle used to transport Residents shall not exceed the manufacturer's recommended capacity.

(f) The Psychiatric Residential Treatment Facility shall maintain a copy of a valid appropriate Arkansas driver's license for all individuals who drive vehicles used to transport Residents on behalf of the Psychiatric Residential Treatment Facility.

(g)(1) The Psychiatric Residential Treatment Facility shall maintain in force at all times current commercial liability insurance for the operation of its vehicles, including medical coverage for Residents in the event of accident or injury.

(2) The policy shall extend coverage to any staff member who provides transportation for any Resident in the course and scope of his or her employment.

(3) Documentation shall consist of the insurance policy or current binder that includes the name of the Psychiatric Residential Treatment Facility, the name of the insurance company, policy number, period of coverage, and explanation of the coverage.

(h) The vehicle shall have evidence of a current safety inspection.

(i) There shall be first aid supplies in each Psychiatric Residential Treatment Facility or contracted vehicle.

(j) The provider shall have the means of transporting Residents in cases of emergency.

(k) The Psychiatric Residential Treatment Facility shall have agency-procured transportation that is available at all times.

(l) The Psychiatric Residential Treatment Facility vehicle or vehicles shall not be used for personal use unless other Psychiatric Residential Treatment Facility transportation is not available.

(m) Any vehicle used to transport Residents shall be:

(1) In safe working condition; and

(2) Maintained in compliance with motor vehicle laws.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-420. Meal service.

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(a) The Psychiatric Residential Treatment Facility shall not permit Residents to engage in food preparation, unless the food preparation is part of the Resident's life skills training.

(b) Special attention shall be given to preparation and prompt serving in order to maintain correct food temperatures.

(c) The same foods shall not be repetitively served during each seven-day period except to honor specific, individual Resident requests.

(d) Specific times for serving meals shall be established, documented on a posted menu, and followed.

(e) Suitable food and snacks shall be available and offered between meals.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-421. Quality of dietary management.

(a) Persons responsible for the direction of food services in Psychiatric Residential Treatment Facilities having more than fifty (50) beds, at a minimum, shall be:

(1) Certified as a certified dietary manager or food service supervisor; or

(2) Enrolled in a food service supervisor's course approved by the Office of Long-Term Care.

(b) Certified dietary managers or food service supervisors shall be required to complete fifteen (15) hours of continuing education per year.

(c) The continuing education courses shall be offered by the Association of Nutrition and Food Service Professionals or a comparable body and shall be approved by the Office of Long-Term Care in order for the courses to be counted toward completion of the fifteen (15) hours.

(d) Psychiatric Residential Treatment Facilities having fifty (50) or fewer beds shall allot adequate hours per week for the certified dietary manager or food service supervisor to perform supervisory duties.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

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20 CAR 417-422. Minimum daily food requirements.

(a) All Residents shall be served an approved, appetizing, adequate diet that conforms to the Dietary reference Intakes of the Office of Disease Prevention and Health Promotion.

(b) A minimum of three (3) nutritionally-adequate meals per twenty-four-hour period, shall be provided for each Resident unless otherwise directed by the Resident's physician or other authorized healthcare provider.

(c) Not more than fourteen (14) hours shall elapse between the serving of the evening meal and breakfast the following day.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-423. Food and diet.

(a) (1) If the Psychiatric Residential Treatment Facility accepts or retains Residents in need of medically-prescribed special diets, the menus for such diets shall be planned by a professionally-qualified dietitian or shall be reviewed and approved by a physician or other authorized healthcare provider.

(2) The Psychiatric Residential Treatment Facility shall maintain staff capable of the preparation and serving of any special diet, such as a diabetic diet.

(3) The preparation of any Resident's special diet shall follow the written guidance provided by a registered dietitian, physician, or other authorized healthcare provider authorizing the Resident's special diet.

(4) For each Resident receiving a special diet, this written guidance shall be documented in the Resident's record.

(b) If special diets are required, the necessary equipment for preparation of those diets shall be available and used.

(c) A dietitian shall be employed on a consultative basis. Responsibilities of the dietitian shall be:

(1) To observe the operation of the Food Service Program and to provide suggestions for improvement based on those observations;

(2) To develop and approve menus which meet acceptable nutrition standards;

(3) To assist with the development and implementation of dietary policies and procedures;

(4) To prepare specialized menus for Residents who have orders from a physician regarding a special diet and provide instruction for the dietary staff regarding how to prepare any special food items. The physician can delegate the task of prescribing therapeutic diets to a qualified registered dietitian, to the extent allowed by state law;

(5) To review Resident charts and counsel with a Resident and his or her parent or legal guardian regarding special dietary needs;

(6) To provide in-service for staff as needed;

(7) To develop food service documentation procedures and review records of the documentation; and

(8) To prepare quarterly quality assurance reports for review of Food Services.

(d) A person designated by the Administrator shall be responsible for the total food service of the Psychiatric Residential Treatment Facility. This person shall be responsible for:

(1) Initiating food orders or requisitions;

(2) Establishing specifications for food purchases and ensuring that such specifications are met;

(3) Storing and handling of food;

(4) Food preparation;

(5) Food serving;

(6) Orientation, training, and supervision of food service personnel;

(7) Maintaining a current list of Residents with special nutritional needs;

(8) Having an effective method of recording and transmitting diet orders and changes;

(9) Recording information in the Resident's record relating to special nutritional needs; and

(10) Providing information on the Resident's diets to the staff.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-424. Menu.

(a)(1) Menus shall be planned and written a minimum of one (1) week in advance and dated as served.

(2) The current week's menu, including routine and special diets and any substitutions or changes made, shall be readily available and posted in one (1) or more conspicuous places in a public area.

(3) All substitutions made on the master menu shall be recorded in writing.

(4) Cycled menus shall be rotated so that the same weekly menu is not duplicated for, at least, a three-week period.

(b) Records of menus, as served, shall be maintained for at least thirty (30) calendar days.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-425. Educational services.

(a) All Psychiatric Residential Treatment Facilities will request educational records from the sending school district that includes all recent evaluations, testing, grade level, and individualized educational plan, if applicable. For students served on individualized education plans, refer to Section 18 of the Arkansas Division of Elementary and Secondary Education Rules Governing Special Education and Related Services.

(b) An educational plan, for each individual Resident, must be developed in compliance with the Arkansas Department of Education's Curriculum and Instruction.

(c) A copy of the educational plan, with updates on progress or lack thereof, must be in the Resident's Educational file and included in transition planning at the time of discharge.

(d) The Resident's Educational file will be sent to the sending school district prior to the Resident being discharged to ensure adequate notice for the school.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

Subpart 5. Restraint and Seclusion

20 CAR 417-501. Use of restraints and seclusion.

(a)(1) The United States Children's Health Act of 2000 (Public Law No. 106-310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in Psychiatric Residential Treatment Facilities that provide inpatient psychiatric services for children who are under twenty-one (21) years of age.

(2) Satellite training by the Centers for Medicare & Medicaid Services may be accessed on the Centers for Medicare & Medicaid Services website at www.cms.gov. Federal regulations are located at 42 C.F.R. § 483, Subpart G (2001).

(3) The use of mechanical restraints and seclusions are strictly prohibited.

(b) A Psychiatric Residential Treatment Facility will report monthly on an approved Office of Long-Term Care template, to the State-designated Protection and Advocacy system, the Office of Long-Term Care, and the Resident's PASSE, or the Resident's sending state the following data:

(1) Physical restraints used within the Psychiatric Residential Treatment Facility, in the aggregate and by client;

(2) Chemical restraints used within the Psychiatric Residential Treatment Facility, in the aggregate and by client;

(3) Sedating PRNs within the Psychiatric Residential Treatment Facility, in the aggregate and by client; and

(4) Ratio of chemical restraints to sedating PRNs, in the aggregate and by client.

(c) An order for restraint must not be written as a standing order or on an as-needed basis.

(d) Restraint must not result in harm or injury to the Resident and must be used only:

(1) To ensure the safety of the Resident or others during an emergency safety situation; and

(2) Until the emergency safety situation has ceased, and the Resident's safety and the safety of others can be ensured, even if the restraint order has not expired.

(e) Orders for restraint must be ordered by a physician, or other licensed practitioner permitted by the state and the Psychiatric Residential Treatment Facility to order restraint and trained in the use of emergency safety interventions.

(f) If the Resident's treatment team physician is available, only he or she can order a restraint.

(g) A physician or other licensed practitioner permitted by the state and the Psychiatric Residential Treatment Facility to order a restraint must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(h)(1) If the order for restraint is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.

(2) The physician or other licensed practitioner permitted by the state and the Psychiatric Residential Treatment Facility to order restraint must verify the verbal order in a signed written form in the Resident's record.

(3) The physician or other licensed practitioner permitted by the state and the Psychiatric Residential Treatment Facility to order restraint must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

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(i) Each order for restraint must:

(1) Be limited to no longer than the duration of the emergency safety situation; and

(2) Under no circumstances exceed four (4) hours for Residents who are between eighteen (18) years of age and twenty-one (21) years of age; two (2) hours for Residents who are between nine (9) years of age and seventeen (17) years of age; or one (1) hour for Residents who are under nine (9) years of age.

(j) Within one (1) hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the Psychiatric Residential Treatment Facility to assess the physical and psychological well-being of Residents, must conduct a face-to-face assessment of the physical and psychological well-being of the Resident, including but not limited to:

(1) The Resident's physical and psychological status;

(2) The Resident's behavior;

(3) The appropriateness of the intervention measures; and

(4) Any complications resulting from the intervention.

(k) Emergency safety intervention: An emergency safety intervention must be performed in a manner that is safe and proportionate and that is appropriate to the severity of the behavior and to the Resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).

(l) Staff must document the intervention in the Resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

(1) Each order for restraint;

(2) The time the emergency safety intervention actually began and ended;

_____ (3) The time and results of the one (1) hour physical and psychological assessment required via face-to-face of the well-being of the Resident as required above;

_____ (4) The emergency safety situation that required the Resident to be restrained; and

_____ (5) The name of staff involved in the emergency safety intervention.

_____ (m) The Psychiatric Residential Treatment Facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

_____ (n) The physician or other licensed practitioner permitted by the state and the Psychiatric Residential Treatment Facility to order restraint must sign the restraint order in the Resident's record as soon as possible.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-502. Notification of parent or legal guardians.

_____ (a) The Psychiatric Residential Treatment Facility must notify the parent or legal guardian of the Resident who has been restrained as soon as possible after the initiation of each emergency safety intervention.

_____ (b) The Psychiatric Residential Treatment Facility must also notify the Resident's parent or legal guardian as soon as possible and in no case later than twenty-four (24) hours after the emergency safety intervention.

_____ (c) The Psychiatric Residential Treatment Facility must document in the Resident's record that the parent or legal guardian has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

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20 CAR 417-503. Application of time out.

(a) A Resident in time out must never be physically prevented from leaving the time out area.

(b) Time out may take place away from the area of activity or from other Residents, such as in the Resident's room (exclusionary), or in the area of activity or other Residents (inclusionary).

(c) Staff must monitor the Resident while he or she is in time out.

(d) The utilization of a time out shall be documented in the Resident's file.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-504. Post-intervention debriefings.

(a)(1) Within twenty-four (24) hours after the use of restraint, staff involved in an emergency safety intervention and the Resident must have a face-to-face discussion.

(2) This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the Resident.

(3) Other staff and the Resident's parent or legal guardian may participate in the discussion when it is deemed appropriate by the Psychiatric Residential Treatment Facility.

(4) The Psychiatric Residential Treatment Facility must conduct such discussion in a language that is understood by the Resident's parent or legal guardian.

(5) The discussion must provide both the Resident and staff the opportunity to discuss the circumstances resulting in the use of restraint and strategies to be used by the staff, the Resident, or others that could prevent the future use of restraint or seclusion.

(b) Within twenty-four (24) hours after the use of restraint, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff,

must conduct a debriefing session that includes, at a minimum, a review and discussion of:

_____ (1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;

_____ (2) Alternative techniques that might have prevented the use of the restraint;

_____ (3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint; and

_____ (4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint.

_____ (c) The staff must document in the Resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, the names of staff that were excused from the debriefing, and any changes to the Resident's treatment plan that result from the debriefings.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-505. Medical treatment for injuries resulting from an emergency safety intervention.

_____ (a) Staff must immediately obtain medical treatment from qualified medical personnel for a Resident injured as a result of an emergency safety intervention.

_____ (b) The Psychiatric Residential Treatment Facility must have affiliations or written transfer agreements in effect with one (1) or more hospitals approved for participation under the Medicaid Program that reasonably ensure that:

_____ (1) A Resident will be transferred from the Psychiatric Residential Treatment Facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

_____ (2) Medical and other information needed for care of the Resident in light of such a transfer will be exchanged between the institutions in accordance with state medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

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(3) Services are available to each Resident twenty-four (24) hours per day, and seven (7) days per week.

(c) The staff must document in the Resident's record all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

(d) The staff involved in an emergency safety intervention that results in an injury to a Resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-506. Self-attestation of compliance with restraint and seclusion standards and provider agreement validation for certification and recertification.

Attestation of Psychiatric Residential Treatment Facility Compliance:

(1) Pursuant to 42 C.F.R. § 483.374 (2001), each Psychiatric Residential Treatment Facility that provides inpatient psychiatric services to individuals who are under twenty-one (21) years of age must attest, in writing, that the Psychiatric Residential Treatment Facility is in compliance with the Centers for Medicare & Medicaid Services standards governing the use of restraint and seclusion.

(2) This attestation must be signed by the Psychiatric Residential Treatment Facility Administrator.

(3) Signed attestation letters must be sent to the Office of Long-Term Care.

(4) For additional information, please refer to the federal Psychiatric Residential Treatment Facility State Operations Manual Appendix N -Psychiatric Residential Treatment Facility Interpretive Guidance, and Chapter 2, Section 2832A.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

Subpart 6. Residents' Rights

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20 CAR 417-601. Residents' rights.

(a)(1) The Psychiatric Residential Treatment Facility shall have written policies and procedures defining the rights and responsibilities of Residents that comply with 42 C.F.R. § 483.356 (2001).

(2) The policies shall present a clear statement defining how Residents are to be treated by the Psychiatric Residential Treatment Facility, its personnel, and others involved in providing care.

(3) All policies shall be available for review upon request by a Resident or a Resident's parent or legal guardian.

(b) A copy of the synopsis of the Residents' bill of rights must be prominently displayed within the Psychiatric Residential Treatment Facility. This shall include:

(1) Restraint and seclusion policy for the protection of Residents.

(2) Each Resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

(3) An order for restraint must not be written as a standing order or on an as-needed basis.

(4) Restraint must not result in harm or injury of the Resident and must be used only:

(A) To ensure the safety of the Resident or others during an emergency safety situation; and

(B) Until the emergency safety situation has ceased and the Resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

(5) Each resident has the right to be free from abuse and neglect.

(c)(1) Upon admission to the Psychiatric Residential Treatment Facility, staff must provide the Resident and his or her parent or legal guardian with a statement of rights and responsibilities and of all rules and regulations governing Resident conduct and responsibilities.

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(2) The Psychiatric Residential Treatment Facility is to communicate these expectations and rights during the period of, not more than two (2) weeks before, or five (5) working days after, admission, unless medically contraindicated in writing.

(3) The Psychiatric Residential Treatment Facility shall obtain a signed acknowledgement from the Resident and his or her parent or legal guardian.

(4) The acknowledgement is maintained in the Resident's medical record.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

Subpart 7. Facility Physical Requirements

20 CAR 417-701. General.

(a) Every Psychiatric Residential Treatment Facility must be maintained, managed, and equipped to provide adequate care, safety, and treatment of each Resident.

(b) The buildings shall reflect good housekeeping, sanitary conditions and shall, by means of an effective pest control program, be free of insects and rodents.

(c) No Psychiatric Residential Treatment Facility shall be located in:

(1) A shopping center;

(2) A strip mall; or

(3) Other buildings that are used for commercial activity.

(d)(1) If a Psychiatric Residential Treatment Facility provider also provides a home and community-based Medicaid service, the physical structures cannot be attached or connected in any way.

(2) Nor shall Residents of the Psychiatric Residential Treatment Facility be placed with children receiving a home and community-based service at any time.

(e) Unused or vacant portions of a Psychiatric Residential Treatment Facility shall not be rented, leased, loaned, or otherwise occupied by any commercial or other business entity, or private individuals, not associated with the Psychiatric Residential Treatment Facility or its management.

(f) All buildings used by Residents or staff shall be inspected and approved annually for fire safety by fire department officials.

(g) All buildings used by Residents or staff shall be inspected and approved annually for health and sanitation as required by the Arkansas Department of Health.

(h) All buildings shall comply with local zoning ordinances and land use requirements where those exist.

(i) The Office of Long-Term Care shall be notified of any changes to buildings that:

(1) Affect usage, size, or capacity; or

(2) Are structural changes.

(j) Building usage shall be approved by licensing prior to Resident occupancy, and all required inspections, permits, and authorizations shall be provided.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-702. Facility grounds and parking.

(a) All Psychiatric Residential Treatment Facilities shall be provided with dust-free drives and parking lots.

(b) The grounds of the Psychiatric Residential Treatment Facility shall be kept clean and free of safety hazards.

(c) Swimming pools shall be inspected and approved annually by the Arkansas Department of Health.

(d) Trash collection receptacles and incinerators shall be separate from recreation and play areas and located as to avoid being a nuisance.

(e) Recreation and playground equipment shall be so located, installed, and maintained as to ensure the safety of the Residents.

(f) Areas determined unsafe, including steep grades, open pits, swimming pools, high voltage boosters or high-speed roads shall be fenced or have natural barriers to protect Residents.

(g) Fences that are in place shall be in good repair.

(h) Residents shall have access to safe, suitable outdoor recreational space and age-appropriate equipment.

(i) The provider shall ensure that exterior areas are well lit at night.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-703. Doors.

(a) All exterior doors shall be effectively weather stripped.

(b)(1) In the case of an emergency, and when an emergency alarm system is activated, exit doors shall be unlocked in such a way that a key is not necessary to open the door from the inside of the building.

(2) A latch or other fastening device on the door shall be provided with a knob, handle, panic bar or other simple type of releasing device, which is part of the door handle hardware, of which the method of operation is obvious even in darkness.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-704. Standard resident rooms, bath, and toilet facilities.

(a) There shall be no more than four (4) Residents per bedroom and Resident must only share a bedroom with other Residents of the same gender.

(b) Each Resident shall have a separate bed with a mattress, sheets, pillow, pillowcase, and adequate cover, all in good condition.

(c) Single standard Resident rooms shall measure at least fifty square feet (50 ft²).

(d) Resident beds shall be located in rooms and placed at least three feet (3') apart in all directions.

(e) Bedrooms shall not be locked in a way that would prevent a Resident from exiting their room.

(f) Each Resident room shall have direct access to a corridor.

(g) Psychiatric Residential Treatment Facilities shall have wash basins with hot and cold water, flushing toilets, and bath or shower.

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(h)(1) Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene unless Residents are individually given such items. (2) Residents shall be provided with individual items such as hairbrushes and toothbrushes.

(i) Tubs and showers shall have slip proof surfaces.

(j) A Psychiatric Residential Treatment Facility shall have toilets and baths or showers that allow for individual privacy.

(k) Toilets, wash basins and other plumbing or sanitary locations in a Psychiatric Residential Treatment Facility shall, at all times, be maintained in good operating condition and shall be kept free of any materials that might clog or otherwise impair their operation.

(l)(1) There shall be a separate toilet, bathtub or shower, and sink for every six (6) Residents.

(2) There shall be separate bathrooms and toilets in each Psychiatric Residential Treatment Facility for males and females.

(m) Beds shall be positioned to ensure that all Residents can easily exit the room in case of emergency.

(n) Rooms extending below ground level shall not be used for Residents unless they are dry, well-ventilated by required window space, and are otherwise suitable for occupancy.

(o)(1) Each Resident bedroom shall have a window not less than one-sixteenth (1/16) of the floor space.

(2) Each window shall provide privacy.

(p) Each Resident shall be provided with storage space, closet, or other enclosed space, within his or her room, for clothing and other possessions.

(q) Enuretic Residents shall have mattresses with moisture resistant covers.

(r) Sheets and pillowcases shall be changed at least weekly but shall be changed more frequently if necessary.

(s) Each Resident shall have his or her own dresser or other adequate storage space for private use and designated space for hanging clothing in proximity to the bedroom occupied by the Resident.

(t) The provider shall ensure that the ages of Residents sharing bedroom space are not greater than three (3) years in difference unless contraindicated based on diagnosis, the treatment plan, or the behavioral health assessment of the Resident.

(u)(1) Each Resident shall have his or her own bed.

(2) A Resident's bed shall be longer than the Resident is tall, no less than thirty inches (30") wide, of solid construction and shall have a clean, comfortable, non-toxic fire retardant mattress.

(3) Bunk beds must be secured to the wall and floor and included in the Psychiatric Residential Treatment Facility's accrediting body's Proactive Risk Assessment with a mitigation plan in place.

(v)(1) If the Psychiatric Residential Treatment Facility has a sexualized rehabilitation program, the Residents of that program shall reside in its own unit or wing of the Psychiatric Residential Treatment Facility that is separate from the unit or wing housing the other Residents.

(2) Residents of the sexualized rehabilitation program shall only reside in single rooms, or shared rooms with three (3) Residents.

(w) Furniture and play equipment used in the care of Residents shall be painted with lead free paint.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-705. Day room and dining room.

(a) A well-lighted, clean, orderly, and ventilated room or rooms shall be provided for Resident activities and for dining areas.

(b) The arrangement, appearance, and furnishing of all of the interior areas of the Psychiatric Residential Treatment Facility shall be similar to those of a normal family home within the community.

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(c)(1) The Psychiatric Residential Treatment Facility shall contain separate units for children based upon age ranges, or developmental functioning levels when documented, not to exceed three (3) years. Each unit shall provide a space for the free and informal use of the Residents. Documentation must include clinical justification outlining why a child's developmental age and size justify exceeding the three (3) year requirement.

(2) This space shall be constructed and equipped in a manner in keeping with the programmatic goals of the Psychiatric Residential Treatment Facility.

(d) A Psychiatric Residential Treatment Facility shall have a minimum of sixty square feet (60 ft²) of floor area per Resident in living areas accessible to the Residents and excluding halls, closets, bathrooms, bedrooms, staff or staff's family quarters, laundry areas, storage areas and office areas.

(e) The Psychiatric Residential Treatment Facility shall have comfortable customary furniture as appropriate for all living areas. Furniture for the use of Residents shall be appropriately designed to suit the size and capabilities of the Residents.

(f) The Psychiatric Residential Treatment Facility shall have a dining area that permit Residents, staff, and guests to eat together in small groups.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-706. Kitchen.

(a)(1) Kitchens used for meal preparations shall have the equipment necessary for the preparation, serving, storage, and clean-up of all meals regularly served to all of the Residents and staff.

(2) All equipment shall be maintained in proper working order.

(b) The provider shall ensure that all dishes, cups, and glasses used by Residents are free from chips, cracks or other defects and are in sufficient number to accommodate all Residents.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

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20 CAR 417-707. Video camera surveillance.

(a) All PRTFs shall have video cameras in all common areas that, at a minimum, capture movement.

(b) All reportable incidents require camera footage to be saved and will only be deleted upon a closed investigation by the Office of Long-Term Care.

(c) All camera footage must be saved for a minimum of thirty (30) days regardless of whether a known incident occurred.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-708. Preparation and storage of food.

(a) All food prepared in the Psychiatric Residential Treatment Facility shall be clean, wholesome, free from spoilage and so prepared as to be safe for human consumption.

(b) All food stored in the refrigerators shall be stored in covered containers.

(c) Leftover foods shall be labeled and dated with the date of preparation.

(d) Foods stored in freezers shall be wrapped in airtight packages, labeled, and dated.

(e) Fresh fruits and vegetables shall be thoroughly washed in clean, safe water before use.

(f) Vegetables subject to dehydration during storage shall be wrapped or bagged in plastic.

(g) All readily perishable foods, including eggs and fluids, shall be stored at or below forty-one degrees Fahrenheit (41°F).

(h) (1) All frozen foods shall be stored at a temperature that keeps frozen foods solidly frozen.

(2) Frozen foods which have been thawed shall not be refrozen.

(i) All toxic compounds shall be used with extreme caution and shall be stored in an area separate from food preparation, storage, and service areas.

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(j) Work areas and equipment shall be adequate for the efficient preparation and service of foods.

(k) (1) Supplies of perishable foods for a one-day period and of nonperishable foods for a three-day period shall be on the premises at all times to meet the requirements of the planned menus.

(2) If the Psychiatric Residential Treatment Facility consistently does not have the required one (1) day perishable and three (3) day nonperishable foods, the Office of Long-Term Care will require that the Psychiatric Residential Treatment Facility alter its food delivery schedule to meet regulations.

(l) Food served in any Psychiatric Residential Treatment Facility must have been prepared on the premises or in an establishment approved by, and meeting regulatory standards of, the Arkansas Department of Health.

(m) The use of tobacco in any form, or vaping products, is prohibited where food or drink is prepared, stored, cooked, or where dishes or pots and pans are washed or stored.

(n) If a Resident refuses food served, appropriate substitutes must be offered.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-709. Sanitary conditions.

(a) Food shall be procured from sources approved or considered satisfactory by federal, state, and local authorities.

(b) Floors shall be clean and free from dust, dirt, and debris.

(c) (1) Dishes, silverware, and glasses shall be free of breaks, tarnish, stain, cracks and chips.

(2) There shall be an ample supply to serve all Residents.

(3) Residents will be furnished appropriate utensils unless there is documentation to indicate the Resident is incapable of using these implements.

(d) Dishes, knives, forks, spoons, and other utensils used in the preparation and serving of foods must be stored in such a manner as to be protected from rodents, flies or other insects, dust, dirt, or other contamination.

(e) Silverware shall be stored in a clean container that can be thoroughly washed and sanitized.

(f) (1) Paper or loose covering shall not be used on shelves, cabinets, cabinet drawers, refrigerators or stoves.

(2) Storage cabinets shall be kept clean.

(g) Cardboard boxes shall not be saved and used for the storage of food or articles which were not packed in that original box.

(h) Dishes, trays, silverware, glasses and food preparation dishes shall be cleaned, washed, and sanitized after each use.

(i) The usage of common cups shall be prohibited.

(j) Meat and other foods shall not be placed in direct contact with ice.

(k) (1) Ice from a water system that is in compliance with State Primary Drinking Water Regulations, shall be available and precautions taken to prevent contamination.

(2) The ice scoop shall be stored in a sanitary manner outside of the ice container.

(l) Potable drinking water shall be available and accessible to Residents at all times.

(m)(1) Ice delivered to Resident areas in bulk shall be in nonporous, covered containers that shall be cleaned after each use.

(2) Only ice of assured bacterial safety shall be permitted for use in drinks, or for the cooling of drinks by direct contact.

(3) Ice used to chill bottled drinks or salads, or in any food preparation, shall not be used for drinking purposes.

(4) Portable ice chests which can be sanitized shall be cleaned daily, and any ice machine shall be cleaned at least weekly.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-710. Ceilings, walls and floors.

(a) Walls:

(1) Kitchens, and other rooms where food and drink are prepared shall have a smooth, non-perforated surface that is washable.

(2) Wallpaper shall not be used.

(3) The walls of the Psychiatric Residential Treatment Facility shall be a smooth surface with painted or equally washable finish.

(4) Walls shall be without cracks, and in conjunction with floors, shall be waterproof and free from spaces which may harbor ants and roaches.

(5) All walls shall be kept clean and in good repair.

(b) Floors:

(1) All floor surfaces throughout the Psychiatric Residential Treatment Facility shall provide a surface or finish which is smooth, waterproof, grease proof, and resistant to heavy wear.

(2) Safety devices shall be provided on ramps.

(3) All floors in baths, toilets, lavatories, and beneath kitchen dish washing in the Psychiatric Residential Treatment Facility shall have a floor covering of a continuous type.

(4) No cracks or joints in the floor covering shall be permitted in these rooms.

(5) Carpet is permitted as floor covering for the following areas, provided the carpet meets the following requirements:

(A) Offices;

(B) Corridors; and

(C) Day rooms.

(6) The carpet has a flame spread rating of seventy-five (75) or less, has a smoke density of one hundred (100) or less.

(7)(A) No pad will be permitted under the carpet.

(B) The carpet is to be glued directly to the floor.

(C) Prior approval by the Office of Long-Term Care is required before the carpet is installed.

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(8)(A) In Psychiatric Residential Treatment Facilities where carpet is installed, the Psychiatric Residential Treatment Facility must furnish equipment and have written cleaning procedures to clean and maintain the carpet.

(B) This equipment must include, as a minimum, a shampooer and wet/dry vacuum.

(9)(A) Psychiatric Residential Treatment Facilities that presently have carpets in areas other than those listed above may keep that carpet as long as it is maintained properly and free of odors.

(B) If not properly maintained and free of odors, the carpet will be removed and replaced with a hard smooth surface.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-711. Heating and cooling.

(a)(1) The Psychiatric Residential Treatment Facility shall be equipped with central heating and cooling equipment that maintains reasonable temperatures between 65 degrees Fahrenheit (65°F) and 82 degrees Fahrenheit (82°F).

(2) If temperature outside exceeds one hundred degrees Fahrenheit (100°F), there shall be a fifteen-degree Fahrenheit (15°F) difference in exterior to interior temperature.

(b) If the air conditioner breaks down or malfunctions, the Office of Long-Term Care must be notified immediately.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-712. Lighting.

(a)(1) Each Resident's room shall have natural lighting during the day and have general lighting at night.

(2) Natural lighting shall be augmented when necessary by artificial illumination.

(b) Approved "exit" lights shall be provided at all exit areas and shall be continuously illuminated.

(c) The provider shall ensure that any room, corridor, or stairway within a Psychiatric Residential Treatment Facility shall be well lit.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-713. Emergency power.

There shall be a written plan to be implemented to ensure the continuation of essential Resident support services for such reasons as power outage, water shortage, or in the event of the absence from work of any portion of the workforce resulting from inclement weather or other causes.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-714. Water service.

(a) The water supply used by the Psychiatric Residential Treatment Facility shall meet the requirements of the Arkansas Department of Health.

(b) There shall be procedures to ensure water to all essential areas in the event of loss of normal water supply.

(c) The water service shall be brought into the building to comply with the requirements of the Arkansas State Plumbing Code and shall be free of cross connections.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-715. Hot water heaters.

(a) Plumbing fixtures that require hot water and which are accessible to Residents shall be supplied with water that is thermostatically controlled to a temperature of at least one hundred degrees Fahrenheit (100°F) and not to exceed one hundred and twenty-five degrees Fahrenheit (125°F) at the fixture.

(b)(1) Temperatures of hot water at plumbing fixtures used by Residents shall be automatically regulated by control valves.

(2) Water temperature in Resident areas shall be checked weekly.

(c) All gas, oil, or coal heaters shall be vented to the outside.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-716. Plumbing and other piping systems.

(a) All plumbing systems shall be designed and installed in accordance with the requirements of Arkansas State Plumbing Code.

(b) From the cold-water service and hot water tanks, cold water and hot water mains and branches shall be run to supply all plumbing fixtures and equipment which require hot and cold water, or both, for their operation.

(c) Pipes shall be sized to supply hot and cold water to all fixtures with a minimum pressure of fifteen pounds (15 lbs.) at the top floor fixtures during maximum demand periods.

(d) Water closets shall be the elongated type, and water closet seats shall be of the open-front type.

(e)(1) Backflow preventers (vacuum breakers) shall be installed with any water supply fixture where the outlet's end may at times be submerged.

(2) Examples of such fixtures are hoses, sprays, direct flushing valves, aspirators and under-rim water supply connections to a plumbing fixture or receptacle in which the surface of the water in the fixture or receptacle is exposed at all times to atmospheric pressure.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-717. General safety.

(a) The Psychiatric Residential Treatment Facility shall have an operable telephone or comparable communication system.

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(b)(1) The Psychiatric Residential Treatment Facility shall have a continuous supply of clean drinking water.

(2) If the water source is not a municipal system, it must be approved by the Arkansas Department of Health, on an annual basis.

(c) A private sewage and septic system shall be approved by the appropriate state agency and have documentation available upon request. .

(d) There shall be an emergency evacuation plan diagramed and posted in each building that is being used by Residents.

(e) Fire drills shall be practiced with Residents, at a minimum, of one (1) time per month.

(f) Severe weather drills shall be practiced with Residents quarterly.

(g) A record of drills shall be maintained showing:

(1) Date and time of day of the drill;

(2) Number of participants; and

(3) Length of time required to reach safety.

(h) Each Resident shall be instructed in emergency procedures at admission.

(i) The Psychiatric Residential Treatment Facility shall have proof of current rabies vaccinations for all household pets as required by Arkansas law.

(j) No Resident shall be allowed to operate dangerous machinery or equipment, including firearms, without proper adult supervision and following manufacturers' guidelines for:

(1) Age;

(2) Safety precautions; and

(3) Safety gear.

(k) The agency shall have policies and procedures for carrying, storage, and use of all firearms located at the Psychiatric Residential Treatment Facility.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-718. Fire safety.

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(a) All buildings used by Residents or staff shall be inspected and approved annually for fire safety by fire department officials.

(b) There shall be operational smoke detectors:

(1) Near the cooking area and heating units; and

(2) Within ten feet (10') of each bedroom.

(c)(1) An operational chemical fire extinguisher or other fire suppression system approved by local fire inspection officials shall be in the cooking area of each building.

(2) Approval of the fire suppression system shall be documented.

(d) Smoking shall be prohibited in all areas of the Psychiatric Residential Treatment Facility.

(e) Each Psychiatric Residential Treatment Facility shall have an electrically-supervised, manually-operated fire alarm system and fire suppression system.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-719. Emergencies.

(a) Emergency call data:

(1) Emergency call data shall be posted in a conspicuous place and shall include at least the telephone numbers of local fire and police departments, ambulance service, and the poison control center.

(2) The Administrator shall be responsible for ensuring that emergency call information is posted in a conspicuous place so as to be immediately available to all personnel of the Psychiatric Residential Treatment Facility.

(3) Emergency call data shall include at least the following:

(A) Telephone number of fire and police departments;

(B) Names, addresses, and telephone numbers for emergency supplies, ambulance, minister, advisory dentist, Red Cross, and poison control center;

(C) Name, address, and telephone number of all personnel to be called in case of fire or emergency (to include the Administrator and the director of nursing services); and

DRAFT

(D) Name, address, and telephone number of an available physician to furnish necessary medical care in case of emergency.

(b) Emergency preparedness:

(1) A Psychiatric Residential Treatment Facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually in compliance with 42 C.F.R. § 483.73 (2019).

(2) A Psychiatric Residential Treatment Facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan, a risk assessment, and a communication plan that must be reviewed and updated at least annually.

(3) The policies and procedures, at a minimum, must address:

(A) Subsistence needs for staff and Residents, whether they evacuate or shelter in place;

(B) Medical and food supplies;

(C) Alternate sources of energy to maintain temperature, emergency lighting, fire detection, extinguishing and alarm systems, sewage and waste disposal;

(D) A system to track the location of on duty staff and sheltered Residents;

(E) Safe evacuation plan including transportation and alternate means of communication with external sources of assistance; and

(F) A system of medical documentation that preserves Resident information and protects and secures records.

(4) A Psychiatric Residential Treatment Facility must develop and maintain an emergency preparedness training and testing program.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-720. Laundry.

(a) The provider shall have a laundry space complete with a minimum of one (1) clothes washer and one (1) dryer per fifty (50) Residents.

DRAFT

(b) (1) An adequate supply of clean, sanitary linen and clothing shall be available at all times.

(2) In order to prevent the contamination of clean linen or clothing by dust or other airborne particles or organisms, clean linen and clothing shall be stored and transported in a sanitary manner, such as enclosed and covered.

(c)(1) Linen and clothing storage rooms shall be used only for the storage of linen and clothing.

(2) Clean linen and clothing shall be separated from storage of other purposes.

(d) Soiled linen and clothing shall neither be sorted, rinsed, nor washed outside of the laundry service area.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-721. Administrative offices.

Separate office space shall be provided for administrative and business functions.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-722. Housekeeping – maintenance.

(a) The provider shall ensure that there is evidence of routine maintenance and cleaning programs in all of the areas of the Psychiatric Residential Treatment Facility.

(b) Sufficient housekeeping and maintenance equipment shall be available to enable the Psychiatric Residential Treatment Facility to maintain a safe, clean, and orderly interior.

(c) If a Psychiatric Residential Treatment Facility has a contract with an outside resource for housekeeping services, the Psychiatric Residential Treatment Facility or outside resource shall meet the requirements of these standards.

(d) All rooms and every part of the building (exterior and interior) shall be kept clean, orderly, and free of offensive odors.

(e) The bath, toilet, and food areas in a Psychiatric Residential Treatment Facility shall be clean and sanitary at all times.

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(f) Rooms shall be cleaned and put in order daily.

(g) If a Resident keeps his or her own room, he or she shall be closely supervised to ensure a clean, orderly room.

(h)(1) After discharge of a Resident, the room and its contents shall be thoroughly cleaned, aired, and disinfected if necessary.

(2) Clean linens shall be provided.

(i)(1) Polish or wax used on floors shall be of a type that provides a non-slip finish.

(2) Floors shall be maintained in a clean and safe condition.

(j)(1) Deodorants shall not be used to cover up odors.

(2) Odor control shall be achieved by prompt cleansing and proper care of Residents and soiled linens and by approved ventilation.

(k)(1) Attics, cellars, beneath stairs, and similar areas shall be kept clean of accumulation of refuse, old newspapers, and discarded furniture.

(2) All inside openings to attics and false ceilings shall be kept closed at all times.

(3) The attic area shall be clean at all times.

(4) Storage areas shall be kept in a safe and neat order.

(l) (1) Combustibles such as rags and cleaning compounds and fluids shall be kept in closed metal containers and shall be labeled as to contents.

 (2) Matches and other flammable or dangerous items shall be stored in metal containers with tight-fitting lids and labeled as to contents.

(m)(1) Buildings and grounds shall be kept free from refuse and litter.

(2) All useless items and materials shall be removed from the Psychiatric Residential Treatment Facility area and premises.

(3) Unnecessary accumulation of possessions, including equipment and supplies shall not be kept in the Psychiatric Residential Treatment Facility.

(n) Mechanical rooms, boiler rooms, and similar areas shall not be used for storage purposes.

(o) Mop heads shall be of the removable type and shall be laundered or replaced at frequent intervals to ensure a standard of cleanliness.

(p) Straw brooms shall not be used for cleaning Psychiatric Residential Treatment Facility floors.

(q)(1) Garbage must be kept in approved containers with tight-fitting covers.

(2) The containers must be thoroughly cleaned before reuse.

(3) Garbage or rubbish and trash shall be disposed of by incineration, burial, sanitary fill, or other approved methods.

(4) Garbage areas shall be kept clean and in a state of good repair.

(r)(1) All poisons, bleaches, detergents, and disinfectants shall be kept in a safe place accessible only to Psychiatric Residential Treatment Facility staff.

(2) They shall not be kept in storage areas or containers previously containing food or medicine.

(3) Containers must have a label that states name, ingredients, and antidote.

(s)(1) Psychiatric Residential Treatment Facilities that perform their own pest control, rather than employing licensed pest control experts or exterminators, and utilize restricted-use pesticides, shall be licensed by the Arkansas State Plant Board for the use of the pesticides.

(2) To obtain a list of restricted-use pesticides, please contact the board.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

Subpart 8. Performance Management

20 CAR 417-801. Performance management.

(a)(1) The facility shall send appropriate representatives to all meetings established by the Office of Long-Term Care that are deemed by the Office of Long-Term Care to be reasonable and necessary for the administration of services.

(2) Such meetings may include, but are not limited to, youth-specific meetings, statewide meetings, Medicaid meetings, active contract management meetings, and training sessions.

(b)(1) The facility shall cooperate in and comply with quality improvement programs approved by the Office of Long-Term Care including, but not limited to, case reviews, site reviews, quality improvement forums, and Medicaid reviews.

(2) The facility represents and warrants that all information submitted by the facility in connection with such quality improvement programs will be true, complete, and accurate as of the time of submission.

(c)(1) The facility shall adhere to Medicaid documentation requirements as communicated by the Office of Long-Term Care to enable the Office of Long-Term Care to maximize any federal funding.

(2) Shall an error, omission or other material change to this information be discovered after submission, the facility will immediately notify the Office of Long-Term Care.

(d) The facility shall, for the term of these certification standards, submit all claims, service utilization management, clinical case management and quality improvement data requested by the Office of Long-Term Care.

(e)(1) The facility shall agree that achieving performance standards and outcomes is critically important.

(2) The facility shall develop standards and share data that is needed and required by the Office of Long-Term Care to ensure standards and outcomes are met.

(3) The facility shall submit data to the Office of Long-Term Care as requested.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

20 CAR 417-802. Quality assurance.

(a)(1) The facility must maintain a continuous quality assurance plan.

(2) This plan must review and monitor each service provided by the facility and to the Residents on a quarterly basis.

(3) The goal is to ensure the highest quality of service, address any identified issues, and confirm that the services meet the facility's expected outcomes.

(b) (1) The facility must describe the quality assurance plan in a written plan which describes mechanisms, committees, or other methods used to coordinate the facility's approach to monitoring and evaluating the quality and appropriateness of services.

_____ (2) The written quality assurance plan shall be available upon request for review by the Office of Long-Term Care.

(c) All organized services related to Resident care, including services furnished by a contractor, shall be evaluated.

(d) Psychiatric Residential Treatment Facility staff must be trained and demonstrate understanding of the quality assurance plan.

(e) The quality assurance plan must include procedures to improve the quality of care, and to evaluate the adequacy, appropriateness, and effectiveness of the care and treatment that will be provided to the Residents.

(f) At a minimum, the continuous quality improvement policies and procedures shall include processes for the following:

(1) Review and analysis of the data collected and reported to the Office of Long-Term Care.

(2) Collection, review, and analysis of feedback from Residents and their parent or legal guardian.

(3) Collection, review, and analysis of complaints received.

Authority. Arkansas Code §§ 20-76-201 et seq., and 25-10-129.

SECTION II – PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES FOR UNDER AGE 21

CONTENTS

TOC required

200.000 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES FOR UNDER AGE 21 GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Providers of Psychiatric Residential Treatment Facilities **10-27-25**

All enrolled Medicaid providers must follow the guidelines specified in Section I of this manual.

Psychiatric Residential Treatment (PRTF) services for residents under age 21 are facility based. Facilities and treatment services in this program shall be referred to as PRTF providers and PRTF services throughout Section II of this manual.

Reimbursement may be made for PRTF services when provided to eligible Medicaid residents by licensed providers who are enrolled in the Arkansas Medicaid Program.

202.000 Arkansas Participation Requirements for Inpatient Psychiatric Providers **10-27-25**

PRTF providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual to be eligible to participate in the Arkansas Medicaid Program. These requirements apply to all enrolling as PRTF providers for under age 21.

A. An in-state PRTF must be licensed by the Office of Long-term Care as a PRTF. An out-of-state PRTF must be licensed by the appropriate licensing agency within its home state as a PRTF. A copy of the current license must accompany the provider application and Medicaid contract.

DHS or its designated vendor shall require proof of unavailable treatment or extenuating circumstances prior to authorizing services. PASSE Single Case Agreements (SCA) may be utilized on an as needed basis for out of network providers enrolled in Arkansas Medicaid. SCAs must be approved for each individual instance.

203.000 Psychiatric Residential Treatment Facilities **10-27-25**

To enroll as a freestanding psychiatric residential treatment facility, the PRTF provider must meet both of the conditions listed below:

- A. The provider must meet the child and adolescent standards of The Joint Commission (TJC) and be accredited by TJC as a PRTF.
- B. Any provider located within Arkansas must be licensed by the Office of Long-term Care, and have a permit issued by the Health Permit Agency as a psychiatric residential treatment facility.

204.000 Documentation **10-27-25**

The provider must develop and maintain complete written documentation to support each medical or remedial therapy, service, activity, or session for each receiving treatment. This documentation, at a minimum, must consist of:

- A. The specific services provided.
- B. The date and actual time the services were provided (Time frames may not overlap between services. All services must be outside the time frame of other services).
- C. Name and title of the person who provided the services.
- D. The setting in which the services were provided.
- E. The relationship of the services to the treatment regimen described in the plan of care and
- F. Updates describing the patient's progress.

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level.

All documentation must be available to representatives of DHS, DHS contractors, and PASSEs at the time of an audit. All documentation must be available at the provider's place of business. If an audit results in sanction or recoupment, no more than thirty (30) days will be allowed after the date on the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30-day period.

210.000 PROGRAM COVERAGE

210.000 Definitions

10-27-25

- A. Active Treatment means beneficiaries are to be consistently engaged in active treatment during their waking hours. Active treatment will begin immediately upon admission utilizing information gathered for the certification of need (CON). Moreover, diagnostic assessment conducted by the multidisciplinary team encompassing medical, psychosocial, and behavioral evaluations informs the development of a comprehensive plan of care and discharge criteria. Active Treatment encompasses a variety of therapeutic modalities including family, group, individual, and milieu therapy, accompanied by continual treatment planning. All active treatment shall be designed to achieve the individual's discharge to a lower level of care at the earliest time possible. For beneficiaries attributed to a Provider-Led Arkansas Shared Savings Entity (PASSE), active treatment can be further defined by the respective PASSE

- B. Psychiatric Residential Treatment Facility means a non-hospital facility offering intensive inpatient services through Medicaid to individuals who have various mental health diagnoses and resulting functional deficits who required a higher level of service than can be obtained within the community, but do not require hospitalization for their issues. All services must be provided under the direction of a physician.

PRTFs are designed to offer intensive, time-limited (generally less than six (6) months) care for beneficiaries and their families/guardians/caregivers, who require a higher level of support and supervision than what can be provided in a traditional outpatient setting. These facilities are staffed by a multidisciplinary team of professionals, under the supervision of the physician, including psychiatrists, licensed mental health professionals, nurses, direct care staff, and when necessary, psychologists, speech-language pathologists, occupational therapists, and physical therapists.

The main goal of a PRTF is to provide a structured and therapeutic environment where beneficiaries can receive the necessary treatment and support to stabilize their mental health and develop skills to successfully transition back to their communities in the shortest possible timeframe.

The specific services and treatment approaches may vary between PRTFs, as they are tailored to meet the unique needs of each beneficiary.

PRTFs must provide a trauma-informed response to service delivery with staff trained to recognize how individuals are impacted by traumatic events and have skills to avoid re-traumatization.

- C. *Sexualized Rehabilitation Program* means a specialized program designed to address and treat beneficiaries who have engaged in sexually inappropriate or harmful behaviors. These programs aim to provide comprehensive treatment and support to help individuals understand and change their behaviors, develop healthier attitudes towards sexuality, and promote healthy relationships.

The primary focus of a sexualized rehabilitation program is to ensure the safety and well-being of beneficiaries who have engaged in sexually harmful behaviors, as well as the safety of potential victims or potential future victims. The programs will follow a structured, evidence-based curriculum to address the underlying factors contributing to problematic behaviors and to promote accountability and responsibility. Medical necessity is determined by the beneficiary's PASSE and consideration is given on the beneficiary's progress through the curriculum.

- D. *Required Services* means the treatment provided to individuals admitted to the PRTF used to decrease or ameliorate the symptoms of the diagnosed mental health condition. Coverage includes all medical, psychiatric, and social services required of the admitting facility for licensure, certification and accreditation (Section 202.000). This includes, but is not limited to:

1. Intake/Initial Comprehensive Assessment and Diagnosis: Comprehensive evaluation, within 60 hours of admission, of the beneficiary's mental health needs, including, but not limited to psychiatric assessment, health assessment, biopsychosocial, nursing assessment, and when necessary psychological, developmental testing, and psychosexual assessment. Information shall be gathered from the beneficiary's parent or legal guardian, medical records from previous behavioral health service providers, community providers and schools shall also be utilized in the evaluation.
2. Ongoing Assessment and Diagnosis: Additional evaluation should be completed throughout the patients stay to measure response to interventions and may include observation or additional testing.
3. Individualized Treatment Planning: Development of a personalized treatment plan that addresses the beneficiary's specific needs and goals. Treatment planning must be strengths-based, with measurable and attainable goals, and appropriate for the beneficiary's developmental stage and cognitive ability. The treatment plan shall consider parent or legal guardian input on goals that would contribute to successful transition and stabilization upon discharge.
4. 24/7 Supervision and Support: Continuous supervision and support from trained staff to ensure the safety and well-being of the beneficiaries. This may include assistance with daily living activities, medication administration, and crisis management.
5. Psychiatric Services: Access to psychiatric care, including psychiatric evaluation, medication evaluation, medication management, establishing a written plan of care, coordinating care with treatment team; directing and monitoring the use of restraints. Medications should be prescribed in line with professional best standards and current guidance (e.g. UpToDate, Epocrates, American Academy of Child & Adolescent Psychiatry).
6. Mental Health Therapy Services: evidenced-based individual and group therapy to address emotional and behavioral issues, develop coping skills, and improve interpersonal relationships.
7. Milieu Therapy: Aims to enhance the beneficiary's problem-solving abilities, increase capacity for self-control and self-regulation, while minimizing specific behaviors that jeopardize their safety at home and in the community. The program establishes clear

rules and behavioral boundaries, emphasizing structure. Every interaction between beneficiaries and staff or other beneficiaries serves as an opportunity for therapeutic intervention. All PRTF staff who have interaction with a beneficiary shall have training in trauma informed care.

8. Education Services: On-site educational programming, in compliance with curriculum standards approved by the Arkansas Department of Education, to ensure beneficiaries continue their academic progress while receiving treatment.
 9. Recreational and Therapeutic Activities: Engagement in recreational and therapeutic activities, such as art therapy, music therapy, and physical fitness, to promote overall well-being and skill development.
 10. Family Involvement: Inclusion of family members in the treatment process through therapeutic leave days, family therapy sessions, and family support in developing strategies to support the beneficiary's mental health after discharge.
 11. Discharge Planning: planning begins during the intake and continues throughout placement with ongoing discussions with family. Discharge planning includes, but not limited to, referral to appropriate home and community resources, coordination with appropriate education programs, safety planning, beneficiary education that is specific to the diagnosis, and transportation plan including contingencies.
- E. Elective means an admission in which the decision to admit can be separated in time from the actual admission and usually requires at least a one-night stay.
- F. A total of forty (40) hours per week of documented treatment services must be provided not to include education/classroom time. Five hours/encounters per week must be provided by a licensed mental health professional (LMHP), with a minimum of one being in an individual rather than group setting. Included in the five LMHP hours/encounters per week there should be a minimum of two family therapy sessions per month, as well as a weekly visit with the psychiatrist or APRN with a behavioral health specialty.

The Facility shall ensure that treatment and support interventions have a strong focus on strategies to address significant trauma, reduce symptomology and increase youth capacity for self- control and self- regulation, with a focus on four (4) major areas that research has found has the most long-term positive impact:

- A. Short-term crisis stabilization
- B. Intensive clinical services
- C. Engagement and work with the family and natural supports
- D. Ensuring comprehensive family and community supports following the residential stay

The Facility shall provide evidence-based programs and practices and shall have policies and procedures in place to ensure fidelity to the evidence-based programs and practices utilized by the Facility. The Facility shall provide training, supervision, and quality assurance and quality improvement strategies to monitor fidelity to evidence-based practices and track related outcomes.

211.000 Sexualized Rehabilitation Program

10-27-25

The Arkansas Medicaid Program designed a Sexualized Rehabilitation Program to specifically treat those patients under age 21 who have engaged in sexually inappropriate or harmful behaviors.

This manual, the Psychiatric Residential Treatment Facility Services for Under Age 21 Provider Manual, shall govern all aspects of services provided in the Sexualized Rehabilitation Program.

All treatment must be evidence based and therapist must be Credentialed Sexually Abusive Youth Clinicians (CSAYC). Evidence based practice models include children with Problematic Sexual Behavior Cognitive Behavior Treatment Program, Multisystemic Therapy (MST), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Treatment protocols are different based on age/developmental level, and thus programs shall demonstrate training and deliver of evidence-based programming that aligns with the individual's developmental and chronological age.

211.100 Human and Sex Trafficking Program

10-27-25

A Human and Sex Trafficking Program shall include specialized services delivered within the PRTF to deliver intensive treatment for youth experiencing symptoms of a mental health condition related to their experience of being trafficked. Trafficking causes complex trauma which often results in complex intense behaviors that require supervision and services delivered by a specially trained staff.

PRTF staff must be trained in trauma informed care, receive yearly training regarding sex and human trafficking and effects on victims. Therapist providing individual and group treatment must be trained in an evidence-based trauma model as well as certified clinical trauma specialist- sex trafficking and exploitation, or similar training.

The treatment team will ensure that patients are provided with weekly trauma therapy services, group services, individualized treatment plans, family therapy, life skills, and other supportive treatment as ordered on their treatment plan. The treatment team shall be staffed by a multidisciplinary team of professionals, under the supervision of the physician, including psychiatrists, licensed mental health professionals, nurses, direct care staff, and when necessary, psychologists, speech-language pathologists, occupational therapists, and physical therapists.

211.200 Other Medical Services

10-27-25

Medical services that are not within the scope of PRTF Services may be provided to the beneficiary while in the facility, but must be billed to the Arkansas Medicaid Program or by their respective PASSE by the performing provider of the services, e.g., physician, hospital etc. The performing provider must be an Arkansas Medicaid provider in order to receive reimbursement from the Arkansas Medicaid Program. These services may not be billed with the beneficiary's psychiatric diagnosis.

If not already enrolled the potential provider may **contact the Provider Enrollment Unit** to receive information about the process required to become an Arkansas Medicaid provider.

212.000 Scope

10-27-25

PRTF services covered by the Arkansas Medicaid Program must be provided:

- A. By a PRTF provider enrolled in the Arkansas Medicaid Program;
- B. By an enrolled PRTF provider selected by the beneficiary/guardian;
- C. To eligible Arkansas Medicaid beneficiaries who have a certification of need determined by the independent PASSE team that the beneficiary meets the criteria for PRTF services;
- D. To eligible Arkansas Medicaid beneficiaries who have a prior authorization documenting the need for this level of service;
- E. To eligible Arkansas Medicaid beneficiaries after the beneficiary has reached age 10 and before the beneficiary reaches age 21 or, if the beneficiary was receiving PRTF services at the time he or she reached age 21, services may continue until the beneficiary no longer

requires the services or the beneficiary becomes 22 years of age, whichever comes first; and

- F. Under the direction of a psychiatrist or physician with oversight by a psychiatrist (contracted physicians are acceptable).

213.000 Age Considerations

10-27-25

PRTF services should be designed with age and developmental needs in mind recognizing that the needs of youth vary based on their developmental functioning. Youth will not be placed in units with other youth when ages ranges exceed more than three (3) years apart. Considerations will be made for developmental versus chronological age. Size and behaviors of youth may also be considered. Documentation must include clinical justification outlining why a child's developmental age and size justify exceeding the three (3) year requirement.

214.000 General Requirements

10-27-25

Each beneficiary must be evaluated to determine the need for PRTF services by the respective PASSE. The Certification of Need (CON) must be made prior to admission.

Tests and evaluations used by providers to certify need cannot be more than one (1) year old. All histories and information submitted to certify need must have been compiled within the year prior to the CON.

In compliance with 42 CFR 441.152, the CON must ensure:

- A. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;
- B. Proper treatment of the beneficiary's psychiatric condition requires inpatient services under the direction of a physician and
- C. The services can be reasonably expected to prevent further regression or to improve the beneficiary's condition so that the services will no longer be needed.

All elective admissions of current Medicaid beneficiaries must be certified prior to admission.

214.100 Facility-Based CON Team

10-27-25

The facility-based team must be an interdisciplinary team composed of a physician, and other personnel who are employed by, or provide services to, Medicaid beneficiaries in the admitting PRTF. The team must have competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and must have knowledge of the individual's situation. See 42 CFR 441.153.

214.110 Facility-Based Team Responsibilities

10-27-25

Based on education and experience, preferably including competence in child psychiatry, the facility-based team must be capable of and responsible for:

- A. Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- B. Assessing the potential resources of the beneficiary's family;
- C. Making a recommendation regarding whether the beneficiary should be admitted to the facility;
- D. Setting individualized treatment objectives;

E. Prescribing therapeutic modalities to achieve the individual plan of care objectives and

F. Preparing or reviewing information to be sent to the independent CON Team.

214.120 Composition of the Facility-Based Team (42 CFR 441.156)

10-27-25

A. The team must include at least one of the following:

1. A board eligible or board-certified psychiatrist;
2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Board of Examiners in Psychology.

B. The team must also include at least one of the following:

1. A Psychiatric social worker;
2. A registered nurse with specialized training or one year's experience in treating individuals with mental illness;
3. An occupational therapist who is licensed by the State, and who has specialized training or one year of experience in treating individuals with mental illness or
4. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Psychological Association.

214.200 Independent Certification of Need (CON) Team

10-27-25

The independent CON Team shall be an interdisciplinary team composed of a physician, and other personnel who are employed by (or contracted by) the independent evaluator.

214.210 Composition of the Independent CON Team

10-27-25

The independent certification team must:

- A. Include a physician;
- B. Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry;
- C. Have knowledge of the beneficiary's situation and
- D. Is not in an employment or consultant relationship with an inpatient psychiatric or PRTF provider.

214.220 Information Required for Pre-Certification Review

10-27-25

To receive a CON, also often referred to as a Prior Authorization, the admitting facility must initiate a pre-certification review by submitting the required information to the members PASSE. This information must be maintained in the client's record.

215.000 Individual Plan of Care (42 CFR 441.154)

10-27-25

PRTF must involve "active treatment" as specified in the written plan of care. Implementation of the individual plan of care must be supervised by professional staff. The original of each individual plan of care must be placed in the beneficiary's records.

215.100 Development of the Individual Plan of Care**10-27-25**

An individual plan of care means a written plan developed for each beneficiary to improve the condition of the beneficiary to the extent that PRTF care is no longer necessary. The individual plan of care must be:

- A. Developed no later than seven (7) days after admission;
- B. Designed to improve the beneficiary's condition to the extent that inpatient psychiatric services will no longer be necessary and to achieve the beneficiary's discharge from PRTF status at the earliest possible time;
- C. Based on a diagnostic evaluation that includes examination of the medical, social, psychological, behavioral and developmental aspects of the beneficiary's situation and reflects the need for PRTF services; and
- D. Developed:
 - 1. By the facility-based team and
 - 2. In consultation with the beneficiary and his or her parent(s), legal guardian(s) or others in whose care he or she will be released after discharge.

215.110 Requirements for the Individual Plan of Care (42 CFR 456.180)**10-27-25**

The individual plan of care must:

- A. Include diagnoses, symptoms, complaints and complications indicating the need for admission;
- B. Include a description of the developmental and functional level of the beneficiary;
- C. Include that are measurable treatment objectives;
- D. Include any orders for medications, diet, treatments, restorative and rehabilitative services or special procedures recommended for the health and safety of the beneficiary;
- E. Contain an integrated program of therapies, social services, activities and experiences designed to meet the treatment objectives;
- F. Include plans for continuing care, regular review and modification to the plan of care and
- G. Include discharge plans and, at an appropriate time, post-discharge plans, and include the coordination of PRTF services with partial discharge plans and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.

215.120 Individual Plan of Care Review**10-27-25**

The plan of care must be reviewed at least every thirty (30) calendar days by the facility-based team as specified in 42 CFR §441.155(c) with an additional review and staffing note completed fifteen (15) calendar days prior to the plan of care review to:

- A. Determine whether services being provided are or were required on an inpatient basis and
- B. Recommend changes in the plan as indicated by the beneficiary's overall adjustment as an inpatient within the PRTF.

216.000 Therapeutic Leave Days**10-27-25**

Therapeutic visits away from the PRTF to home, relatives, or friends are encouraged and authorized if certified by the attending physician as medically necessary in the treatment of the recipient. The Arkansas Medicaid Program and/or the PASSEs cover a maximum of seven (7) consecutive days for therapeutic leave days. Therapeutic leave days must be clearly documented in the beneficiary's record. At a minimum, the beneficiary's record must reflect:

- A. The purpose of the therapeutic leave (therapeutic leave shall be listed in the plan of care along with the objectives, goals and frequency of this therapy);
- B. The destination or location (the place where the beneficiary will go for this therapy must be recorded as well as the date and time of departure and return and the person(s) responsible for the beneficiary during the leave period);
- C. A therapeutic leave evaluation documentation that provides unquestionable support to the plan of care objectives and goals;
- D. Documentation of staff contact with the beneficiary and the person(s) responsible for the beneficiary for those therapeutic leaves in excess of seventy-two (72) consecutive hours and
- E. Progress notes that provide statements that track a beneficiary's actions and reactions and must clearly reveal the beneficiary's achievements or regressions while on therapeutic leave.

216.100 Absent Without Permission Days

10-27-25

The Arkansas Medicaid Program and/or the PASSEs do not cover days when a beneficiary is absent without permission. Absent without permission days are those days when a beneficiary is away from the PRTF without permission. When a beneficiary is absent without permission, the facility must document when the beneficiary left, if possible, why the beneficiary left and where the beneficiary was going, and when applicable, the beneficiary's expected return date to the PRTF.

When a beneficiary is absent without permission, the PRTF provider must:

- A. Formally discharge the beneficiary. If the beneficiary is to be readmitted, the PRTF provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

or

- B. Keep the beneficiary's case on hold for up to 7 consecutive days without Medicaid reimbursement:
 - 1. If the beneficiary returns to the PRTF within the seven (7) days, the PRTF provider must conduct a plan of care review within three (3) days of the beneficiary's return and modify the plan of care as necessary.
 - 2. If the beneficiary does not return to PRTF within the seven (7) days, the provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

216.110 Acute Care Leave Days

10-27-25

The Arkansas Medicaid Program and/or the PASSE cover no PRTF services during acute care leave days. Acute care leave days are those days when a beneficiary is an inpatient in an acute care medical/surgical hospital. When a beneficiary is admitted to an acute care hospital, the PRTF provider must document when, why and where the beneficiary was admitted and, if applicable, the beneficiary's expected return date.

When a beneficiary is admitted to an acute care hospital as an inpatient, the PRTF provider must:

A. Formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual;

_____ or

B. Keep the beneficiary's case open for up to five (5) consecutive days without Medicaid reimbursement.

1. If the beneficiary returns to the PRTF facility within the five (5) days, the provider must conduct a plan of care review within three (3) days of the beneficiary's return and modify the plan of care as necessary.
2. If the beneficiary does not return to the inpatient psychiatric facility within the five (5) days, the provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

217.000 Survey Activity for Psychiatric Residential Treatment Facilities (PRTFs) **10-27-25**

Federal regulations regarding facility reporting and survey activity are located at 42 CFR Part 483, Subpart G §§483.374 – 483.376 and can be found in the Office of Long Term Care PRTF Licensure Manual.

217.100 Utilization Control **10-27-25**

217.200 General Information **10-27-25**

All PRTF providers must meet federal requirements for utilization control as stated in the Code of Federal Regulations, 42 CFR §§456.150 through 456.245.

217.300 Utilization Review (UR) Plan **10-27-25**

Each PRTF provider must have in effect a written UR plan which provides for a review of each beneficiary's need for the services provided. Each written UR plan must meet the requirements specified in the Code of Federal Regulations, 42 CFR §§456.201 through 456.245.

217.310 UR Plan Administrative Requirement **10-27-25**

217.320 UR Plan Requirements **10-27-25**

The UR plan must:

- A. Provide for a committee to perform UR requirements;
- B. Describe the organization, composition, and functions of the committee and
- C. Specify the frequency of committee meetings.

217.330 Organization and Composition of UR Committee (§42 CFR 456.206) **10-27-25**

The UR committee must be composed of two or more physicians assisted by other professional personnel. At least one of the physicians must be knowledgeable in the diagnosis and treatment of mental diseases.

The UR committee must be constituted as:

- A. A committee of the PRTF provider staff;
- B. A group outside the PRTF provider staff, established by the local medical or osteopathic society and at least some of the inpatient psychiatric providers in the locality, or
- C. A group capable of performing utilization reviews, established and organized in a manner consistent with 42 CFR §§456.150 through 456.245.

The committee may not include any individual who is directly responsible for the care of a beneficiary whose care is being reviewed or who has a financial interest in any inpatient psychiatric hospital or PRTF facility. (Financial interest is defined as direct or indirect stock or ownership of 5% or more in any inpatient psychiatric hospital or PRTF facility.

217.340 UR Plan Information Requirement

217.350 Beneficiary Information Required for UR

10-27-25

The UR plan must provide that each beneficiary's record includes information needed to perform UR requirements. This information must include:

- A. Identification of the beneficiary;
- B. Name of the beneficiary's physician;
- C. Date of admission;
- D. Dates of application and authorization for Medicaid benefits, if application is made after admission;
- E. Individual plan of care;
- F. Initial and subsequent continued stay review dates;
- G. Reasons and plan for continued stay if the attending physician believes continued stay is necessary or
- H. Other supporting material believed appropriate by the committee.

218.000 Records and Reports

10-27-25

The UR plan must describe the type of records which are kept by the committee, the type and frequency of committee reports and the arrangements for distribution to the appropriate individuals.

218.100 Confidentiality

10-27-25

The plan must provide that the identities of individual beneficiaries in all UR records and reports are kept confidential.

218.200 Review of Need for Continued Stay

10-27-25

218.210 Continued Stay Review Required

10-27-25

The UR plan must provide for a review of each beneficiary's continued stay in the PRTF facility to decide whether it is needed. See Sections 218.400 through 218.450.

218.220 Evaluation Criteria for Continued Stay

10-27-25

The UR plan must provide that the UR Committee develops:

- A. Written medical care criteria to assess the need for continued stay and
- B. More extensive written criteria for cases which experience shows are:
 - 1. Associated with high costs;
 - 2. Associated with the frequent furnishing of excessive services or
 - 3. Attended by physicians whose patterns of care are frequently found to be questionable.

218.230 Initial Continued Stay Review Date

10-27-25

The UR plan must provide that when a beneficiary is admitted to the PRTF, the committee will assign a specified date by which the need for continued stay will be reviewed. If an individual applies for Medicaid while in the PRTF, the committee must assign the initial continued stay review date within one (1) working day after the PRTF is notified of the application for Medicaid.

The committee must base its assignment of the initial continued stay review date on:

- A. The methods and criteria described in this manual;
- B. The beneficiary's condition and
- C. The beneficiary's projected discharge date.

The committee must use any available appropriate regional medical care appraisal norms, such as those developed by abstracting services or third-party payers, to assign the initial continued stay review date. These norms must be based on current and statistically valid data on duration of stay in PRTFs for beneficiaries whose characteristics, such as age and diagnosis, are similar to those of the beneficiary whose need for continued stay is being reviewed. If the committee uses norms to assign the initial continued stay review day, the number of days between the beneficiary's admission and the initial continued stay review date must not be greater than the 50th percentile of the norms. However, the committee may assign a later review date if it documents that the later date is more appropriate. The initial continued stay review date is not in any case later than thirty (30) calendar days after admission of the beneficiary or notice to the PRTF of the beneficiary's application for Medicaid. The committee must ensure that the initial continued stay review date is recorded in the beneficiary's record.

218.240 Subsequent Continued Stay Review Dates

10-27-25

The UR plan must provide:

- A. That the committee assigns subsequent continued stay review dates in accordance with this manual;
- B. That the committee assigns a subsequent continued stay review date at least every ninety (90) days each time it decides that the continued stay is needed and
- C. That the committee ensures that each continued stay review date it assigns is recorded in the beneficiary's record.

218.250 Description of Methods and Criteria: Continued Stay Review Dates

10-27-25

The UR plan must describe:

- A. The methods and criteria, including norms if used, by which the committee assigns initial and subsequent continued stay review dates and

- B. The methods that the committee uses to modify an approved length of stay when the beneficiary's condition or treatment schedule changes.

218.260 Continued Stay Review Process

10-27-25

The UR plan must provide that review of continued stay cases is conducted by:

- A. The UR committee;
B. A subgroup of the UR committee; or
C. A designee of the UR committee

The UR plan must provide that the committee, subgroup or designee reviews a beneficiary's continued stay on or before the expiration of each assigned continued stay review date.

For each continued stay of a beneficiary in the PRTF, the committee, subgroup or designee must review and evaluate the information in the beneficiary's record listed in this manual against the criteria provided in the UR plan as listed in this manual and apply close professional scrutiny to cases described in this manual.

218.270 Continued Stay Approval

10-27-25

The UR plan must provide that, if the committee, subgroup, or designee finds that a beneficiary's continued stay in the PRTF is needed, the committee assigns a new continued stay review date.

218.280 Continued Stay Denial

10-27-25

The UR plan must provide that, if the committee, subgroup or designee finds that a continued stay case does not meet the criteria, the committee or a subgroup that includes at least one physician must review the case to decide the need for continued stay. If the committee or subgroup making the review finds that a continued stay is not needed, it must notify the beneficiary's attending or staff physician and give him or her an opportunity to present his or her views before it makes a final decision on the need for the continued stay.

If the attending or staff physician does not present additional information or clarification of the need for the continued stay, the decision of the committee or subgroup is final. If the attending or staff physician presents additional information or clarification, at least two physician beneficiaries of the committee, one of whom is knowledgeable in the treatment of mental diseases, must review the need for the continued stay. If they find that the beneficiary no longer needs PRTF services, their decision is final.

218.300 Notification of Adverse Action

10-27-25

The UR plan must provide that written notice of any adverse final decision on the need for continued stay is sent to:

- A. The PRTF administrator;
B. The attending or staff physician;
C. The independent CON Team;
D. The beneficiary and
E. The next of kin or the sponsor or guardian (if possible).

218.310 Time Limits for Final Decision and Notification

10-27-25

The UR plan must provide that:

- A. The committee will make a final decision on a beneficiary's need for continued stay and will give notice of an adverse action within two (2) working days after the assigned continued stay review date and
- B. If the committee makes an adverse final decision on a beneficiary's need for continued stay before the assigned review date, the committee gives notice within two (2) working days after the date of the final decision.

218.400 UR Plan Medical Care Evaluation Studies**10-27-25****218.410 Purpose and General Description****10-27-25**

The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with the beneficiary's needs and professionally recognized standards of health care. Medical care evaluation studies must emphasize identification and analysis of patterns of beneficiary care and suggest appropriate changes needed to maintain consistently high-quality beneficiary care and effective and efficient use of services.

218.420 UR Plan Requirements for Medical Care Evaluation Studies**10-27-25**

The UR plan must describe the methods the UR committee uses to select and conduct medical care evaluation studies and must provide that the UR committee will:

- A. Determine, for each study, the methods to be used in selecting and conducting medical care evaluation studies in the PRTF;
- B. Document, for each study, the results and how the results have been used to make changes to improve the quality of care and promote more effective and efficient use of PRTFs and services;
- C. Analyze the findings for each study and
- D. Act as needed to correct or investigate any further deficiencies or problems in the review process, or to recommend more effective and efficient care procedures.

218.430 Content of Medical Care Evaluation Studies**10-27-25**

Each medical care evaluation study must:

- A. Identify and analyze medical or administrative factors related to the PRTF beneficiary care and
- B. Include analysis of at least the following:
 - 1. Admissions;
 - 2. Durations of stay;
 - 3. Ancillary services furnished, including drugs and biologicals;
 - 4. Professional services performed in the PRTF and
 - 5. If indicated, contain recommendations for change beneficial to beneficiaries, staff, the PRTF and the community.

218.440 Data Sources**10-27-25**

Data that the committee uses to perform the studies must be obtained from one or more of the following sources:

- A. Medical records and other appropriate PRTF data;
- B. External organizations that compile statistics, design profiles and produce other comparative data;
- C. Cooperative endeavors with:
 - 1. Peer Review Organizations (PROs);
 - 2. Fiscal agents;
 - 3. Other inpatient psychiatric hospitals or facilities or
 - 4. Other appropriate agencies.

218.450 Number of Studies Required**10-27-25**

The PRTF provider must have at least one study in progress at any time and must complete one study each calendar year.

219.000 Electronic Signatures**10-27-25**

Arkansas Medicaid will accept electronic signatures, in compliance with Arkansas Code § 25-31-103, et seq.

220.000 PRIOR AUTHORIZATION**220.100 Prior Authorization Information****10-27-25**

Prior authorization (PA) is required for all PRTF services.

The prior authorization function is the responsibility of the members assigned PASSE utilization management team. All PRTF providers must follow the process outlined by the PASSE in order to receive prior authorization

220.110 Prior Authorization Approvals**10-27-25**

Approved PA requests for PRTF services will be prior authorized for a specific period. An approval letter will be transmitted to the admitting facility specifying the dates PRTF services are authorized, as well as the prior authorization control number and other necessary billing information. Prior authorizations are effective for a minimum of one (1) day up to a maximum of 180 calendar days. Each letter will have the number of days for time period the member is authorized to receive treatment services in the PRTF.

230.000 REIMBURSEMENT**230.100 Provider Review Information****10-27-25**

The Arkansas Medicaid Program, through the PASSE program, reimburses PRTF providers for medically necessary services only. Prior authorization, including Certification of need are prerequisites for reimbursement.

240.000 BILLING PROCEDURES**240.100 Billing****10-27-25**

A Medicaid claim may contain only one billing provider's charges for services furnished to only one Medicaid beneficiary.

SECTION II – PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES FOR UNDER AGE 21

CONTENTS

TOC required

200.000 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES FOR UNDER AGE 21 GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Providers of Psychiatric Residential Treatment Facilities 10-27-25

All enrolled Medicaid providers must follow the guidelines specified in Section I of this manual.

Psychiatric Residential Treatment (PRTF) services for residents under age 21 are facility based. Facilities and treatment services in this program shall be referred to as PRTF providers and PRTF services throughout Section II of this manual.

Reimbursement may be made for PRTF services when provided to eligible Medicaid residents by licensed providers who are enrolled in the Arkansas Medicaid Program.

202.000 Arkansas Participation Requirements for Inpatient Psychiatric Providers 10-27-25

PRTF providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual to be eligible to participate in the Arkansas Medicaid Program. These requirements apply to all enrolling as PRTF providers for under age 21.

- A. An in-state PRTF must be licensed by the Office of Long-term Care as a PRTF. An out-of-state PRTF must be licensed by the appropriate licensing agency within its home state as a PRTF. A copy of the current license must accompany the provider application and Medicaid contract.

DHS or its designated vendor shall require proof of unavailable treatment or extenuating circumstances prior to authorizing services. PASSE Single Case Agreements (SCA) may be utilized on an as needed basis for out of network providers enrolled in Arkansas Medicaid. SCAs must be approved for each individual instance.

203.000 Psychiatric Residential Treatment Facilities 10-27-25

To enroll as a freestanding psychiatric residential treatment facility, the PRTF provider must meet both of the conditions listed below:

- A. The provider must meet the child and adolescent standards of The Joint Commission (TJC) and be accredited by TJC as a PRTF.
- B. Any provider located within Arkansas must be licensed by the Office of Long-term Care, and have a permit issued by the Health Permit Agency as a psychiatric residential treatment facility.

204.000 Documentation 10-27-25

The provider must develop and maintain complete written documentation to support each medical or remedial therapy, service, activity, or session for each receiving treatment. This documentation, at a minimum, must consist of:

- A. The specific services provided,
- B. The date and actual time the services were provided (Time frames may not overlap between services. All services must be outside the time frame of other services),
- C. Name and title of the person who provided the services,
- D. The setting in which the services were provided,
- E. The relationship of the services to the treatment regimen described in the plan of care and
- F. Updates describing the patient's progress.

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level.

All documentation must be available to representatives of DHS, DHS contractors, and PASSEs at the time of an audit. All documentation must be available at the provider's place of business. If an audit results in sanction or recoupment, no more than thirty (30) days will be allowed after the date on the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30-day period.

210.000 PROGRAM COVERAGE

210.000 Definitions

10-27-25

- A. *Active Treatment* means beneficiaries are to be consistently engaged in active treatment during their waking hours. Active treatment will begin immediately upon admission utilizing information gathered for the certification of need (CON). Moreover, diagnostic assessment conducted by the multidisciplinary team encompassing medical, psychosocial, and behavioral evaluations informs the development of a comprehensive plan of care and discharge criteria. Active Treatment encompasses a variety of therapeutic modalities including family, group, individual, and milieu therapy, accompanied by continual treatment planning. All active treatment shall be designed to achieve the individual's discharge to a lower level of care at the earliest time possible. For beneficiaries attributed to a Provider-Led Arkansas Shared Savings Entity (PASSE), active treatment can be further defined by the respective PASSE
- B. *Psychiatric Residential Treatment Facility* means a non-hospital facility offering intensive inpatient services through Medicaid to individuals who have various mental health diagnoses and resulting functional deficits who required a higher level of service than can be obtained within the community, but do not require hospitalization for their issues. All services must be provided under the direction of a physician.

PRTFs are designed to offer intensive, time-limited (generally less than six (6) months) care for beneficiaries and their families/guardians/caregivers, who require a higher level of support and supervision than what can be provided in a traditional outpatient setting. These facilities are staffed by a multidisciplinary team of professionals, under the supervision of the physician, including psychiatrists, licensed mental health professionals, nurses, direct care staff, and when necessary, psychologists, speech-language pathologists, occupational therapists, and physical therapists.

The main goal of a PRTF is to provide a structured and therapeutic environment where beneficiaries can receive the necessary treatment and support to stabilize their mental health and develop skills to successfully transition back to their communities in the shortest possible timeframe.

The specific services and treatment approaches may vary between PRTFs, as they are tailored to meet the unique needs of each beneficiary.

PRTFs must provide a trauma-informed response to service delivery with staff trained to recognize how individuals are impacted by traumatic events and have skills to avoid re-traumatization.

- C. *Sexualized Rehabilitation Program* means a specialized program designed to address and treat beneficiaries who have engaged in sexually inappropriate or harmful behaviors. These programs aim to provide comprehensive treatment and support to help individuals understand and change their behaviors, develop healthier attitudes towards sexuality, and promote healthy relationships.

The primary focus of a sexualized rehabilitation program is to ensure the safety and well-being of beneficiaries who have engaged in sexually harmful behaviors, as well as the safety of potential victims or potential future victims. The programs will follow a structured, evidence-based curriculum to address the underlying factors contributing to problematic behaviors and to promote accountability and responsibility. Medical necessity is determined by the beneficiary's PASSE and consideration is given on the beneficiary's progress through the curriculum.

- D. *Required Services* means the treatment provided to individuals admitted to the PRTF used to decrease or ameliorate the symptoms of the diagnosed mental health condition. Coverage includes all medical, psychiatric, and social services required of the admitting facility for licensure, certification and accreditation (Section 202.000). This includes, but is not limited to:

1. **Intake/Initial Comprehensive Assessment and Diagnosis:** Comprehensive evaluation, within 60 hours of admission, of the beneficiary's mental health needs, including, but not limited to psychiatric assessment, health assessment, biopsychosocial, nursing assessment, and when necessary psychological, developmental testing, and psychosexual assessment. Information shall be gathered from the beneficiary's parent or legal guardian, medical records from previous behavioral health service providers, community providers and schools shall also be utilized in the evaluation.
2. **Ongoing Assessment and Diagnosis:** Additional evaluation should be completed throughout the patients stay to measure response to interventions and may include observation or additional testing.
3. **Individualized Treatment Planning:** Development of a personalized treatment plan that addresses the beneficiary's specific needs and goals. Treatment planning must be strengths-based, with measurable and attainable goals, and appropriate for the beneficiary's developmental stage and cognitive ability. The treatment plan shall consider parent or legal guardian input on goals that would contribute to successful transition and stabilization upon discharge.
4. **24/7 Supervision and Support:** Continuous supervision and support from trained staff to ensure the safety and well-being of the beneficiaries. This may include assistance with daily living activities, medication administration, and crisis management.
5. **Psychiatric Services:** Access to psychiatric care, including psychiatric evaluation, medication evaluation, medication management, establishing a written plan of care, coordinating care with treatment team; directing and monitoring the use of restraints. Medications should be prescribed in line with professional best standards and current guidance (e.g. UpToDate, Epocrates, American Academy of Child & Adolescent Psychiatry).
6. **Mental Health Therapy Services:** evidenced-based individual and group therapy to address emotional and behavioral issues, develop coping skills, and improve interpersonal relationships.
7. **Milieu Therapy:** Aims to enhance the beneficiary's problem-solving abilities, increase capacity for self-control and self-regulation, while minimizing specific behaviors that jeopardize their safety at home and in the community. The program establishes clear

rules and behavioral boundaries, emphasizing structure. Every interaction between beneficiaries and staff or other beneficiaries serves as an opportunity for therapeutic intervention. All PRTF staff who have interaction with a beneficiary shall have training in trauma informed care.

8. Education Services: On-site educational programming, in compliance with curriculum standards approved by the Arkansas Department of Education, to ensure beneficiaries continue their academic progress while receiving treatment.
 9. Recreational and Therapeutic Activities: Engagement in recreational and therapeutic activities, such as art therapy, music therapy, and physical fitness, to promote overall well-being and skill development.
 10. Family Involvement: Inclusion of family members in the treatment process through therapeutic leave days, family therapy sessions, and family support in developing strategies to support the beneficiary's mental health after discharge.
 11. Discharge Planning: planning begins during the intake and continues throughout placement with ongoing discussions with family. Discharge planning includes, but not limited to, referral to appropriate home and community resources, coordination with appropriate education programs, safety planning, beneficiary education that is specific to the diagnosis, and transportation plan including contingencies.
- E. *Elective* means an admission in which the decision to admit can be separated in time from the actual admission and usually requires at least a one-night stay.
- F. A total of forty (40) hours per week of documented treatment services must be provided not to include education/classroom time. Five hours/encounters per week must be provided by a licensed mental health professional (LMHP), with a minimum of one being in an individual rather than group setting. Included in the five LMHP hours/encounters per week there should be a minimum of two family therapy sessions per month, as well as a weekly visit with the psychiatrist or APRN with a behavioral health specialty.

The Facility shall ensure that treatment and support interventions have a strong focus on strategies to address significant trauma, reduce symptomology and increase youth capacity for self-control and self-regulation, with a focus on four (4) major areas that research has found has the most long-term positive impact:

- A. Short-term crisis stabilization
- B. Intensive clinical services
- C. Engagement and work with the family and natural supports
- D. Ensuring comprehensive family and community supports following the residential stay

The Facility shall provide evidence-based programs and practices and shall have policies and procedures in place to ensure fidelity to the evidence-based programs and practices utilized by the Facility. The Facility shall provide training, supervision, and quality assurance and quality improvement strategies to monitor fidelity to evidence-based practices and track related outcomes.

211.000 Sexualized Rehabilitation Program

10-27-25

The Arkansas Medicaid Program designed a Sexualized Rehabilitation Program to specifically treat those patients under age 21 who have engaged in sexually inappropriate or harmful behaviors.

This manual, the Psychiatric Residential Treatment Facility Services for Under Age 21 Provider Manual, shall govern all aspects of services provided in the Sexualized Rehabilitation Program.

All treatment must be evidence based and therapist must be Credentialed Sexually Abusive Youth Clinicians (CSAYC). Evidence based practice models include children with Problematic Sexual Behavior Cognitive Behavior Treatment Program, Multisystemic Therapy (MST), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Treatment protocols are different based on age/developmental level, and thus programs shall demonstrate training and deliver of evidence-based programming that aligns with the individual's developmental and chronological age.

211.100 Human and Sex Trafficking Program

10-27-25

A Human and Sex Trafficking Program shall include specialized services delivered within the PRTF to deliver intensive treatment for youth experiencing symptoms of a mental health condition related to their experience of being trafficked. Trafficking causes complex trauma which often results in complex intense behaviors that require supervision and services delivered by a specially trained staff.

PRTF staff must be trained in trauma informed care, receive yearly training regarding sex and human trafficking and effects on victims. Therapist providing individual and group treatment must be trained in an evidence-based trauma model as well as certified clinical trauma specialist- sex trafficking and exploitation, or similar training.

The treatment team will ensure that patients are provided with weekly trauma therapy services, group services, individualized treatment plans, family therapy, life skills, and other supportive treatment as ordered on their treatment plan. The treatment team shall be staffed by a multidisciplinary team of professionals, under the supervision of the physician, including psychiatrists, licensed mental health professionals, nurses, direct care staff, and when necessary, psychologists, speech-language pathologists, occupational therapists, and physical therapists.

211.200 Other Medical Services

10-27-25

Medical services that are not within the scope of PRTF Services may be provided to the beneficiary while in the facility, but must be billed to the Arkansas Medicaid Program or by their respective PASSE by the performing provider of the services, e.g., physician, hospital etc. The performing provider must be an Arkansas Medicaid provider in order to receive reimbursement from the Arkansas Medicaid Program. These services may not be billed with the beneficiary's psychiatric diagnosis.

If not already enrolled the potential provider may [contact the Provider Enrollment Unit](#) to receive information about the process required to become an Arkansas Medicaid provider.

212.000 Scope

10-27-25

PRTF services covered by the Arkansas Medicaid Program must be provided:

- A. By a PRTF provider enrolled in the Arkansas Medicaid Program;
- B. By an enrolled PRTF provider selected by the beneficiary/guardian;
- C. To eligible Arkansas Medicaid beneficiaries who have a certification of need determined by the independent PASSE team that the beneficiary meets the criteria for PRTF services;
- D. To eligible Arkansas Medicaid beneficiaries who have a prior authorization documenting the need for this level of service;
- E. To eligible Arkansas Medicaid beneficiaries after the beneficiary has reached age 10 and before the beneficiary reaches age 21 or, if the beneficiary was receiving PRTF services at the time he or she reached age 21, services may continue until the beneficiary no longer

requires the services or the beneficiary becomes 22 years of age, whichever comes first; and

- F. Under the direction of a psychiatrist or physician with oversight by a psychiatrist (contracted physicians are acceptable).

213.000 Age Considerations

10-27-25

PRTF services should be designed with age and developmental needs in mind recognizing that the needs of youth vary based on their developmental functioning. Youth will not be placed in units with other youth when ages ranges exceed more than three (3) years apart. Considerations will be made for developmental versus chronological age. Size and behaviors of youth may also be considered. Documentation must include clinical justification outlining why a child's developmental age and size justify exceeding the three (3) year requirement.

214.000 General Requirements

10-27-25

Each beneficiary must be evaluated to determine the need for PRTF services by the respective PASSE. The Certification of Need (CON) must be made prior to admission.

Tests and evaluations used by providers to certify need cannot be more than one (1) year old. All histories and information submitted to certify need must have been compiled within the year prior to the CON.

In compliance with 42 CFR 441.152, the CON must ensure:

- A. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;
- B. Proper treatment of the beneficiary's psychiatric condition requires inpatient services under the direction of a physician and
- C. The services can be reasonably expected to prevent further regression or to improve the beneficiary's condition so that the services will no longer be needed.

All elective admissions of current Medicaid beneficiaries must be certified prior to admission.

214.100 Facility-Based CON Team

10-27-25

The facility-based team must be an interdisciplinary team composed of a physician, and other personnel who are employed by, or provide services to, Medicaid beneficiaries in the admitting PRTF. The team must have competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and must have knowledge of the individual's situation. See 42 CFR 441.153.

214.110 Facility-Based Team Responsibilities

10-27-25

Based on education and experience, preferably including competence in child psychiatry, the facility-based team must be capable of and responsible for:

- A. Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- B. Assessing the potential resources of the beneficiary's family;
- C. Making a recommendation regarding whether the beneficiary should be admitted to the facility;
- D. Setting individualized treatment objectives;

- E. Prescribing therapeutic modalities to achieve the individual plan of care objectives and
- F. Preparing or reviewing information to be sent to the independent CON Team.

214.120 Composition of the Facility-Based Team (42 CFR 441.156)**10-27-25**

- A. The team must include at least one of the following:
 - 1. A board eligible or board-certified psychiatrist;
 - 2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
 - 3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Board of Examiners in Psychology.
- B. The team must also include at least one of the following:
 - 1. A Psychiatric social worker;
 - 2. A registered nurse with specialized training or one year's experience in treating individuals with mental illness;
 - 3. An occupational therapist who is licensed by the State, and who has specialized training or one year of experience in treating individuals with mental illness or
 - 4. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Psychological Association.

214.200 Independent Certification of Need (CON) Team**10-27-25**

The independent CON Team shall be an interdisciplinary team composed of a physician, and other personnel who are employed by (or contracted by) the independent evaluator.

214.210 Composition of the Independent CON Team**10-27-25**

The independent certification team must:

- A. Include a physician;
- B. Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry;
- C. Have knowledge of the beneficiary's situation and
- D. Is not in an employment or consultant relationship with an inpatient psychiatric or PRTF provider.

214.220 Information Required for Pre-Certification Review**10-27-25**

To receive a CON, also often referred to as a Prior Authorization, the admitting facility must initiate a pre-certification review by submitting the required information to the members PASSE. This information must be maintained in the client's record.

215.000 Individual Plan of Care (42 CFR 441.154)**10-27-25**

PRTF must involve "active treatment" as specified in the written plan of care. Implementation of the individual plan of care must be supervised by professional staff. The original of each individual plan of care must be placed in the beneficiary's records.

215.100 Development of the Individual Plan of Care**10-27-25**

An individual plan of care means a written plan developed for each beneficiary to improve the condition of the beneficiary to the extent that PRTF care is no longer necessary. The individual plan of care must be:

- A. Developed no later than seven (7) days after admission;
- B. Designed to improve the beneficiary's condition to the extent that inpatient psychiatric services will no longer be necessary and to achieve the beneficiary's discharge from PRTF status at the earliest possible time;
- C. Based on a diagnostic evaluation that includes examination of the medical, social, psychological, behavioral and developmental aspects of the beneficiary's situation and reflects the need for PRTF services; and
- D. Developed:
 - 1. By the facility-based team and
 - 2. In consultation with the beneficiary and his or her parent(s), legal guardian(s) or others in whose care he or she will be released after discharge.

215.110 Requirements for the Individual Plan of Care (42 CFR 456.180)**10-27-25**

The individual plan of care must:

- A. Include diagnoses, symptoms, complaints and complications indicating the need for admission;
- B. Include a description of the developmental and functional level of the beneficiary;
- C. Include that are measurable treatment objectives;
- D. Include any orders for medications, diet, treatments, restorative and rehabilitative services or special procedures recommended for the health and safety of the beneficiary;
- E. Contain an integrated program of therapies, social services, activities and experiences designed to meet the treatment objectives;
- F. Include plans for continuing care, regular review and modification to the plan of care and
- G. Include discharge plans and, at an appropriate time, post-discharge plans, and include the coordination of PRTF services with partial discharge plans and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.

215.120 Individual Plan of Care Review**10-27-25**

The plan of care must be reviewed at least every thirty (30) calendar days by the facility-based team as specified in 42 CFR §441.155(c) with an additional review and staffing note completed fifteen (15) calendar days prior to the plan of care review to:

- A. Determine whether services being provided are or were required on an inpatient basis and
- B. Recommend changes in the plan as indicated by the beneficiary's overall adjustment as an inpatient within the PRTF.

216.000 Therapeutic Leave Days**10-27-25**

Therapeutic visits away from the PRTF to home, relatives, or friends are encouraged and authorized if certified by the attending physician as medically necessary in the treatment of the recipient. The Arkansas Medicaid Program and/or the PASSEs cover a maximum of seven (7) consecutive days for therapeutic leave days. Therapeutic leave days must be clearly documented in the beneficiary's record. At a minimum, the beneficiary's record must reflect:

- A. The purpose of the therapeutic leave (therapeutic leave shall be listed in the plan of care along with the objectives, goals and frequency of this therapy);
- B. The destination or location (the place where the beneficiary will go for this therapy must be recorded as well as the date and time of departure and return and the person(s) responsible for the beneficiary during the leave period);
- C. A therapeutic leave evaluation documentation that provides unquestionable support to the plan of care objectives and goals;
- D. Documentation of staff contact with the beneficiary and the person(s) responsible for the beneficiary for those therapeutic leaves in excess of seventy-two (72) consecutive hours and
- E. Progress notes that provide statements that track a beneficiary's actions and reactions and must clearly reveal the beneficiary's achievements or regressions while on therapeutic leave.

216.100 Absent Without Permission Days

10-27-25

The Arkansas Medicaid Program and/or the PASSEs do not cover days when a beneficiary is absent without permission. Absent without permission days are those days when a beneficiary is away from the PRTF without permission. When a beneficiary is absent without permission, the facility must document when the beneficiary left, if possible, why the beneficiary left and where the beneficiary was going, and when applicable, the beneficiary's expected return date to the PRTF.

When a beneficiary is absent without permission, the PRTF provider must:

- A. Formally discharge the beneficiary. If the beneficiary is to be readmitted, the PRTF provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.
- or**
- B. Keep the beneficiary's case on hold for up to 7 consecutive days without Medicaid reimbursement:
 - 1. If the beneficiary returns to the PRTF within the seven (7) days, the PRTF provider must conduct a plan of care review within three (3) days of the beneficiary's return and modify the plan of care as necessary.
 - 2. If the beneficiary does not return to PRTF within the seven (7) days, the provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

216.110 Acute Care Leave Days

10-27-25

The Arkansas Medicaid Program and/or the PASSE cover no PRTF services during acute care leave days. Acute care leave days are those days when a beneficiary is an inpatient in an acute care medical/surgical hospital. When a beneficiary is admitted to an acute care hospital, the PRTF provider must document when, why and where the beneficiary was admitted and, if applicable, the beneficiary's expected return date.

When a beneficiary is admitted to an acute care hospital as an inpatient, the PRTF provider must:

- A. Formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual;

or

- B. Keep the beneficiary's case open for up to five (5) consecutive days without Medicaid reimbursement.
 - 1. If the beneficiary returns to the PRTF facility within the five (5) days, the provider must conduct a plan of care review within three (3) days of the beneficiary's return and modify the plan of care as necessary.
 - 2. If the beneficiary does not return to the inpatient psychiatric facility within the five (5) days, the provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

217.000 Survey Activity for Psychiatric Residential Treatment Facilities (PRTFs) 10-27-25

Federal regulations regarding facility reporting and survey activity are located at 42 CFR Part 483, Subpart G §§483.374 – 483.376 and can be found in the Office of Long Term Care PRTF Licensure Manual.

217.100 Utilization Control 10-27-25

217.200 General Information 10-27-25

All PRTF providers must meet federal requirements for utilization control as stated in the Code of Federal Regulations, 42 CFR §§456.150 through 456.245.

217.300 Utilization Review (UR) Plan 10-27-25

Each PRTF provider must have in effect a written UR plan which provides for a review of each beneficiary's need for the services provided. Each written UR plan must meet the requirements specified in the Code of Federal Regulations, 42 CFR §§456.201 through 456.245.

217.310 UR Plan Administrative Requirement 10-27-25

217.320 UR Plan Requirements 10-27-25

The UR plan must:

- A. Provide for a committee to perform UR requirements;
- B. Describe the organization, composition, and functions of the committee and
- C. Specify the frequency of committee meetings.

217.330 Organization and Composition of UR Committee (§42 CFR 456.206) 10-27-25

The UR committee must be composed of two or more physicians assisted by other professional personnel. At least one of the physicians must be knowledgeable in the diagnosis and treatment of mental diseases.

The UR committee must be constituted as:

- A. A committee of the PRTF provider staff;
- B. A group outside the PRTF provider staff, established by the local medical or osteopathic society and at least some of the inpatient psychiatric providers in the locality, or
- C. A group capable of performing utilization reviews, established and organized in a manner consistent with 42 CFR §§456.150 through 456.245.

The committee may not include any individual who is directly responsible for the care of a beneficiary whose care is being reviewed or who has a financial interest in any inpatient psychiatric hospital or PRTF facility. (Financial interest is defined as direct or indirect stock or ownership of 5% or more in any inpatient psychiatric hospital or PRTF facility.)

217.340 UR Plan Information Requirement

217.350 Beneficiary Information Required for UR

10-27-25

The UR plan must provide that each beneficiary's record includes information needed to perform UR requirements. This information must include:

- A. Identification of the beneficiary;
- B. Name of the beneficiary's physician;
- C. Date of admission;
- D. Dates of application and authorization for Medicaid benefits, if application is made after admission;
- E. Individual plan of care;
- F. Initial and subsequent continued stay review dates;
- G. Reasons and plan for continued stay if the attending physician believes continued stay is necessary or
- H. Other supporting material believed appropriate by the committee.

218.000 Records and Reports

10-27-25

The UR plan must describe the type of records which are kept by the committee, the type and frequency of committee reports and the arrangements for distribution to the appropriate individuals.

218.100 Confidentiality

10-27-25

The plan must provide that the identities of individual beneficiaries in all UR records and reports are kept confidential.

218.200 Review of Need for Continued Stay

10-27-25

218.210 Continued Stay Review Required

10-27-25

The UR plan must provide for a review of each beneficiary's continued stay in the PRTF facility to decide whether it is needed. See Sections 218.400 through 218.450.

218.220 Evaluation Criteria for Continued Stay

10-27-25

The UR plan must provide that the UR Committee develops:

- A. Written medical care criteria to assess the need for continued stay and
- B. More extensive written criteria for cases which experience shows are:
 - 1. Associated with high costs;
 - 2. Associated with the frequent furnishing of excessive services or
 - 3. Attended by physicians whose patterns of care are frequently found to be questionable.

218.230 Initial Continued Stay Review Date

10-27-25

The UR plan must provide that when a beneficiary is admitted to the PRTF, the committee will assign a specified date by which the need for continued stay will be reviewed. If an individual applies for Medicaid while in the PRTF, the committee must assign the initial continued stay review date within one (1) working day after the PRTF is notified of the application for Medicaid.

The committee must base its assignment of the initial continued stay review date on:

- A. The methods and criteria described in this manual;
- B. The beneficiary's condition and
- C. The beneficiary's projected discharge date.

The committee must use any available appropriate regional medical care appraisal norms, such as those developed by abstracting services or third-party payers, to assign the initial continued stay review date. These norms must be based on current and statistically valid data on duration of stay in PRTFs for beneficiaries whose characteristics, such as age and diagnosis, are similar to those of the beneficiary whose need for continued stay is being reviewed. If the committee uses norms to assign the initial continued stay review day, the number of days between the beneficiary's admission and the initial continued stay review date must not be greater than the 50th percentile of the norms. However, the committee may assign a later review date if it documents that the later date is more appropriate. The initial continued stay review date is not in any case later than thirty (30) calendar days after admission of the beneficiary or notice to the PRTF of the beneficiary's application for Medicaid. The committee must ensure that the initial continued stay review date is recorded in the beneficiary's record.

218.240 Subsequent Continued Stay Review Dates

10-27-25

The UR plan must provide:

- A. That the committee assigns subsequent continued stay review dates in accordance with this manual;
- B. That the committee assigns a subsequent continued stay review date at least every ninety (90) days each time it decides that the continued stay is needed and
- C. That the committee ensures that each continued stay review date it assigns is recorded in the beneficiary's record.

218.250 Description of Methods and Criteria: Continued Stay Review Dates

10-27-25

The UR plan must describe:

- A. The methods and criteria, including norms if used, by which the committee assigns initial and subsequent continued stay review dates and

- B. The methods that the committee uses to modify an approved length of stay when the beneficiary's condition or treatment schedule changes.

218.260 Continued Stay Review Process**10-27-25**

The UR plan must provide that review of continued stay cases is conducted by:

- A. The UR committee;
- B. A subgroup of the UR committee; or
- C. A designee of the UR committee

The UR plan must provide that the committee, subgroup or designee reviews a beneficiary's continued stay on or before the expiration of each assigned continued stay review date.

For each continued stay of a beneficiary in the PRTF, the committee, subgroup or designee must review and evaluate the information in the beneficiary's record listed in this manual against the criteria provided in the UR plan as listed in this manual and apply close professional scrutiny to cases described in this manual.

218.270 Continued Stay Approval**10-27-25**

The UR plan must provide that, if the committee, subgroup, or designee finds that a beneficiary's continued stay in the PRTF is needed, the committee assigns a new continued stay review date.

218.280 Continued Stay Denial**10-27-25**

The UR plan must provide that, if the committee, subgroup or designee finds that a continued stay case does not meet the criteria, the committee or a subgroup that includes at least one physician must review the case to decide the need for continued stay. If the committee or subgroup making the review finds that a continued stay is not needed, it must notify the beneficiary's attending or staff physician and give him or her an opportunity to present his or her views before it makes a final decision on the need for the continued stay.

If the attending or staff physician does not present additional information or clarification of the need for the continued stay, the decision of the committee or subgroup is final. If the attending or staff physician presents additional information or clarification, at least two physician beneficiaries of the committee, one of whom is knowledgeable in the treatment of mental diseases, must review the need for the continued stay. If they find that the beneficiary no longer needs PRTF services, their decision is final.

218.300 Notification of Adverse Action**10-27-25**

The UR plan must provide that written notice of any adverse final decision on the need for continued stay is sent to:

- A. The PRTF administrator;
- B. The attending or staff physician;
- C. The independent CON Team;
- D. The beneficiary and
- E. The next of kin or the sponsor or guardian (if possible).

218.310 Time Limits for Final Decision and Notification**10-27-25**

The UR plan must provide that:

- A. The committee will make a final decision on a beneficiary's need for continued stay and will give notice of an adverse action within two (2) working days after the assigned continued stay review date and
- B. If the committee makes an adverse final decision on a beneficiary's need for continued stay before the assigned review date, the committee gives notice within two (2) working days after the date of the final decision.

218.400 UR Plan Medical Care Evaluation Studies**10-27-25****218.410 Purpose and General Description****10-27-25**

The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with the beneficiary's needs and professionally recognized standards of health care. Medical care evaluation studies must emphasize identification and analysis of patterns of beneficiary care and suggest appropriate changes needed to maintain consistently high-quality beneficiary care and effective and efficient use of services.

218.420 UR Plan Requirements for Medical Care Evaluation Studies**10-27-25**

The UR plan must describe the methods the UR committee uses to select and conduct medical care evaluation studies and must provide that the UR committee will:

- A. Determine, for each study, the methods to be used in selecting and conducting medical care evaluation studies in the PRTF;
- B. Document, for each study, the results and how the results have been used to make changes to improve the quality of care and promote more effective and efficient use of PRTFs and services;
- C. Analyze the findings for each study and
- D. Act as needed to correct or investigate any further deficiencies or problems in the review process, or to recommend more effective and efficient care procedures.

218.430 Content of Medical Care Evaluation Studies**10-27-25**

Each medical care evaluation study must:

- A. Identify and analyze medical or administrative factors related to the PRTF beneficiary care and
- B. Include analysis of at least the following:
 - 1. Admissions;
 - 2. Durations of stay;
 - 3. Ancillary services furnished, including drugs and biologicals;
 - 4. Professional services performed in the PRTF and
 - 5. If indicated, contain recommendations for change beneficial to beneficiaries, staff, the PRTF and the community.

218.440 Data Sources**10-27-25**

Data that the committee uses to perform the studies must be obtained from one or more of the following sources:

- A. Medical records and other appropriate PRTF data;
- B. External organizations that compile statistics, design profiles and produce other comparative data;
- C. Cooperative endeavors with:
 - 1. Peer Review Organizations (PROs);
 - 2. Fiscal agents;
 - 3. Other inpatient psychiatric hospitals or facilities or
 - 4. Other appropriate agencies.

218.450 Number of Studies Required

10-27-25

The PRTF provider must have at least one study in progress at any time and must complete one study each calendar year.

219.000 Electronic Signatures

10-27-25

Arkansas Medicaid will accept electronic signatures, in compliance with Arkansas Code § 25-31-103, et seq.

220.000 PRIOR AUTHORIZATION**220.100 Prior Authorization Information**

10-27-25

Prior authorization (PA) is required for all PRTF services.

The prior authorization function is the responsibility of the members assigned PASSE utilization management team. All PRTF providers must follow the process outlined by the PASSE in order to receive prior authorization

220.110 Prior Authorization Approvals

10-27-25

Approved PA requests for PRTF services will be prior authorized for a specific period. An approval letter will be transmitted to the admitting facility specifying the dates PRTF services are authorized, as well as the prior authorization control number and other necessary billing information. Prior authorizations are effective for a minimum of one (1) day up to a maximum of 180 calendar days. Each letter will have the number of days for time period the member is authorized to receive treatment services in the PRTF.

230.000 REIMBURSEMENT**230.100 Provider Review Information**

10-27-25

The Arkansas Medicaid Program, through the PASSE program, reimburses PRTF providers for medically necessary services only. Prior authorization, including Certification of need are prerequisites for reimbursement.

240.000 BILLING PROCEDURES**240.100 Billing**

10-27-25

A Medicaid claim may contain only one billing provider's charges for services furnished to only one Medicaid beneficiary.

TOC required**201.000 Arkansas Medicaid Participation Requirements for Providers of Inpatient Psychiatric Services for Under Age 21****8-15-0510-27-25**

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual.

Inpatient psychiatric services for beneficiaries under age 21 ~~may be either are~~ hospital-based, ~~or facility-based.~~ Inpatient psychiatric hospitals/programs in a psychiatric hospital or inpatient psychiatric residential treatment facilities/programs in a psychiatric facility shall be referred to as inpatient psychiatric providers and/or inpatient psychiatric facilities throughout Section II of this manual.

Reimbursement may be made for inpatient psychiatric services when provided to eligible Medicaid beneficiaries by qualified providers who are enrolled in the Arkansas Medicaid Program.

202.200 Residential Treatment Facilities**7-1-17**

~~To enroll as a freestanding residential treatment center or as a residential treatment unit within an inpatient psychiatric hospital, the inpatient psychiatric provider must meet both of the conditions listed below:~~

- ~~A. The provider must meet the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be accredited by JCAHO.~~
- ~~B. Any provider located within Arkansas must be licensed by the Arkansas Department of Human Services as a psychiatric residential treatment facility.~~

203.000 Sexual Offender Program**10-14-16**

~~The Arkansas Medicaid Program designed a Sexual Offender Program to specifically treat those patients under age 21 who are designated as sexual offenders through referral by the Division of Children and Family Services (DCFS) or Division of Youth Services (DYS).~~

~~A certification of need (CON) must be established before a child may enter the Sexual Offender Program. Arkansas Medicaid has entered into a contractual agreement with an independent certification team to make the CON determination for Medicaid-eligible children referred by DCFS and DYS and for other Medicaid-eligible children who have been referred for the Sexual Offender Program. View or print current contractor contact information.~~

~~This manual, the Inpatient Psychiatric Services for Under Age 21 Provider Manual, shall govern all aspects of services provided as well as claim submissions for beneficiaries of the Sexual Offender Program.~~

211.000 Scope**7-1-1710-27-25**

Inpatient psychiatric services covered by the Arkansas Medicaid Program must be provided:

- A. By an inpatient psychiatric provider enrolled in the Arkansas Medicaid Program;
- B. By an enrolled inpatient psychiatric provider selected by the beneficiary;
- C. To eligible Arkansas Medicaid beneficiaries only after receipt of a primary care physician (PCP) referral except in cases of emergency;

- D. To eligible Arkansas Medicaid beneficiaries who have a certification of need issued by the facility-based and independent teams that the beneficiary meets the criteria for inpatient psychiatric services;
- E. To eligible Arkansas Medicaid beneficiaries who have a prior authorization;
- F. To eligible Arkansas Medicaid beneficiaries before the beneficiary reaches age 21 or, if the beneficiary was receiving inpatient psychiatric services at the time he or she reached age 21, services may continue until the beneficiary no longer requires the services or the beneficiary becomes 22 years of age, whichever comes first and
- G. Under the direction of a physician (contracted physicians are acceptable).

~~A standardized independent assessment will determine eligibility for Inpatient Psychiatric Services for Persons Under Age 21. The standardized independent assessment must be performed by an independent entity.~~

~~The independent assessment will contain additional criteria and questions, which will be asked based upon results from the independent assessment to determine eligibility for Inpatient Psychiatric Services for Persons Under Age 21. Acute inpatient psychiatric care will not require an independent assessment.~~

~~The standardized independent assessment must be conducted at least every 12 months by an independent assessor in consultation with the beneficiary and anyone the beneficiary requests to participate in the standardized independent assessment. The standardized independent assessment will also take into consideration information obtained from behavioral health service providers that are providing services to the beneficiary.~~

~~A beneficiary must be referred to the independent assessment entity to evaluate whether the beneficiary meets the eligibility criteria for Inpatient Psychiatric Services for Persons Under Age 21. The following are allowable methods of referral to receive a standardized independent assessment for determination of eligibility for Inpatient Psychiatric Services for Persons Under Age 21:~~

- ~~A. Trigger from claims data/MMIS claims data~~
- ~~B. Referral from counseling level services provider~~
- ~~C. Referral from physician (including those in acute settings, mobile crisis units)~~
- ~~D. An individual determined to be medically fragile due to behavior health needs~~
- ~~E. Referral from the Division of Children and Family Services (DCFS)/the Division of Youth Services (DYS) when they are the legal guardian of the beneficiary~~
- ~~F. Referral/court order from the court system/justice system~~
- ~~G. Referral from care coordination entity~~

~~A re-assessment can be requested by the direct behavioral health service provider or the care coordination entity if the direct behavioral health service provider or care coordination entity determines the beneficiary's needs are not being met or the beneficiary is not benefitting from the Inpatient Psychiatric Services for Persons Under Age 21 being provided.~~

~~The independent assessor will contact the beneficiary to be assessed within 48 hours of referral and will complete the face-to-face assessment within 14 calendar days. For identified priority populations, the independent assessor will contact the beneficiary to be assessed within 24 hours of notification from the beneficiary's provider and will complete the assessment within 7 days of the notification. Examples of priority population include, but are not to be limited to:~~

- ~~A. Youth involved in the juvenile justice system~~

- ~~B. Individuals involved in the foster care system~~
- ~~C. Individuals discharged from acute hospital stays~~
- ~~D. Individuals discharged from crisis residential stays~~
- ~~E. Adults involved in the criminal justice system~~
- ~~F. Clients identified and referred by the Division of Behavioral Health Services (DBHS)~~

212.100 Covered Locations**40-4-1710-
27-25**

Inpatient psychiatric services are covered by Arkansas Medicaid only when provided in:

- A. An inpatient psychiatric hospital
- B. A residential treatment unit within a psychiatric hospital
- ~~C. A residential treatment center (freestanding)~~
- ~~D. A Sexual Offender Program~~

213.000 Primary Care Physician (PCP) Referral**40-13-03**

~~Effective for dates of service on or after December 1, 2002, a primary care physician (PCP) referral is required before a Medicaid beneficiary under age 21 is eligible for inpatient psychiatric services.~~

Exceptions:

- ~~A. Section I contains a list of Medicaid beneficiaries that are exempt from the PCP requirement with one exception. Medicaid beneficiaries who are Children's Medical Services (CMS) clients must choose a PCP.~~
- ~~B. A PCP referral is not required for emergency admissions.~~

~~See Section I of the provider manual for PCP verification procedures. If a PCP is required but not listed on the system, the beneficiary must choose a PCP.~~

~~Section I explains the form a PCP referral may take.~~

213.100 Medicaid Eligible at Admission**7-4-20**

~~A PCP referral is generally obtained for Medicaid-eligible children prior to each admission to an inpatient psychiatric facility. However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a service has been provided, the referral must be received by the Outpatient Behavioral Health Services (OBHS) provider no later than forty-five (45) calendar days after the date of service. The PCP has no obligation to give a retroactive referral.~~

~~The inpatient psychiatric provider may not file a claim and will not be reimbursed for any service that requires a PCP referral unless the referral has been received.~~

213.200 Child is not a Medicaid Beneficiary at Admission**8-15-05**

- ~~A. When a child who is not a Medicaid beneficiary enters an inpatient psychiatric facility, whether voluntarily or by court order, an application for Medicaid eligibility may be filed on behalf of the child.~~

~~B. A PCP referral is not required for the period from the date of admission to the authorization date for Medicaid. Any part of that period that is approved for Medicaid coverage is considered retroactive eligibility and does not require a PCP referral.~~

~~C. PCP referrals are required no later than forty-five calendar days after the Medicaid authorization date. If the PCP referral is not obtained within forty-five days of the Medicaid authorization date, coverage will begin, if all other requirements are met, on the date of the PCP referral.~~

~~— A PCP is given the option of providing a referral after a service is provided. However, the PCP has no obligation to give a retroactive referral. The inpatient psychiatric provider may not file a claim and will not be reimbursed for any service provided that require a PCP referral unless the referral has been received.~~

~~— To verify the authorization date, contact the Provider Assistance Center. [View or print the Provider Assistance Center contact information.](#)~~

213.300 — Renewal of PCP Referral

10-13-03

~~The PCP referral must be renewed every 6 months if a beneficiary continues to require inpatient psychiatric services.~~

215.400 — Individual Applies for Medicaid While in the Facility

10-13-03

~~The certification of need for services for an individual who applies for Medicaid after admission into the facility must:~~

~~A. Be requested by the facility-based team responsible for the individual plan of care;~~

~~B. Specify whether CON is needed for any retroactive period for which Medicaid reimbursement will be sought and~~

~~C. Be requested when the application is made for beneficiary Medicaid eligibility and before the independent CON Team issues a certification of need for a specified length of stay.~~

~~1. The independent CON Team will not issue a CON for a specified length of stay prior to receiving the beneficiary's current Medicaid ID number and adequate admission information.~~

~~2. The admitting facility has thirty (30) days from the Medicaid authorization date (issuance of the beneficiary's Medicaid ID number) to request a retroactive CON.~~

220.400 — Out-of-State Placements

10-13-03

~~Out-of-state placements will not be considered for certification of need or prior authorization review until the MART receives documentation from the out-of-state facility certifying the following:~~

~~A. Treatment offered by the out-of-state facility is not offered by any existing Arkansas inpatient psychiatric facility or~~

~~B. There is no vacant bed in any existing Arkansas inpatient psychiatric facility.~~

~~Supporting documentation must include, but is not limited to, detailed program description of the out-of-state facility's treatment methodology and correspondence from Arkansas inpatient psychiatric facilities regarding current bed availability or lack of specific services requested. Once five different letters of denial are received verifying lack of availability of in-state services, then the out-of-state service may be considered by the MART.~~

Children in the legal custody of the Department of Human Services (DHS) for whom out-of-state placement is being sought must be reviewed by the DHS Children's Case Review Committee (CCRC) prior to placement of the children out of state. Out-of-state facilities requesting certification of need for children in DHS custody are required to provide verification that the child was approved for out of state placement by the CCRC rather than submitting the five letters of denial from in-state providers. The purpose of this review is to determine if all in-state resources have been exhausted.

Facilities located in bordering cities (e.g., Memphis, Tennessee and Texarkana, Texas) are exempt from the above referenced out-of-state placement requirements.

221.800 — Survey Activity for Psychiatric Residential Treatment Facilities (PRTFs) 8-15-05

Federal regulations regarding facility reporting and survey activity are located at 42 CFR Part 483, Subpart G §§483.374—483.376.

221.801 — Attestation of Facility Compliance 7-1-17

Each psychiatric residential treatment facility and Facility Based Community Reintegration Program that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with the Centers for Medicare and Medicaid Service (CMS) standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

A. — Current Medicaid Providers

— A facility with a current provider agreement with the Medicaid agency must provide a letter of attestation no later than July 21st of each year. Attestations must be sent to each state Medicaid agency (SMA) where the PRTF has established a provider agreement.

— Exceptions:

1. — If July 21st occurs on a weekend or holiday, the attestation is due on the first business day following the weekend or holiday and
2. — If the letter of attestation is not received by the due date, the provider will be given 30 calendar days to submit it. If it is not received by the 30th day after the due date, the provider will be terminated from participation in the Arkansas Medicaid Program.

— Attestation letters must be sent to the Medicaid Provider Enrollment Unit. [View or print the contact information for the Medicaid Provider Enrollment Unit.](#)

B. — New Medicaid Provider Applicants

— A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

221.802 — Federal Provider Identification Numbers 10-1-17

A federal provider identification number is assigned to each provider who meets the attestation requirement. The identification numbers for PRTFs will have five digits and one letter. The first two digits identify the state in which the facility is located. This number is then followed by the letter L and then by three digits and is numbered according to the order in which a facility was identified.

A. — Federal provider numbers are assigned by the State Medicaid agency (SMA).

B. — A provider number is coded based on where the PRTF is physically located.

221.803 — Roles and Responsibilities for the Reporting of Deaths, Serious Injuries and Attempted Suicides

10-1-17

The interim process for reporting deaths will follow a similar process as currently in place for the death reporting process for hospitals. The roles and responsibilities of the appropriate entities are outlined below.

A. — PRTFs

1. — Report to the SMA, no later than close of business the next business day, all deaths, serious injuries, and attempted suicides via fax at (501) 682-6171.
2. — Report to the CMS regional office (RO) all deaths no later than close of business the next business day after the resident's death. Death reporting information should be reported to CMS at (214) 767-4434.
3. — Document in the resident's record that the death was reported to the CMS regional office.

B. — CMS Regional Office (RO)

1. — The regional office should receive the report directly from the PRTF. Pursuant to 42 CFR 483.374(b)(1), the report must include the name of the resident, a description of the occurrence, and the name, street address and telephone number of the facility.
2. — The CMS regional office should make sure the survey agency (SA) has received the report. The SA is responsible for carrying out the investigation in conjunction with instructions from the State Medicaid agency.
3. — Since the PRTF is responsible for reporting to the agencies listed previously in addition to the CMS RO, the regional office should obtain the completed investigation from the SA.
4. — The report should be received from the PRTF, according to 42 CFR 483.374(c)(1), no later than close of business the next business day after the resident's death.
5. — The CMS regional office will send the death report to the CMS central office (CMS CO).

C. — CMS Central Office (CO)

- The CMS CO is responsible for maintaining a central log of the death information reported from the CMS RO.

221.804 — PRTF Staff Education and Training

10-1-17

The facility must require staff to have ongoing education, training and demonstrated knowledge of:

- A. — Techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situations;
- B. — The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and
- C. — The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.
 1. — Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

- ~~2. Individuals who are qualified by education, training and experience must provide staff training.~~
- ~~3. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.~~
- ~~4. The staff must be trained and demonstrate competency before participating in an emergency safety intervention.~~
- ~~5. The staff must demonstrate their competencies as specified in paragraph A of this section on a semiannual basis and their competencies as specified in paragraph B of this section on an annual basis.~~
- ~~6. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.~~
- ~~7. All training programs and materials used by the facility must be available for review by CMS, the SMA and the State SA.~~

230.010 Prior Authorization Information

~~10-14-1610-
27-25~~

Prior authorization (PA) is required for all inpatient psychiatric residential unit services.

The prior authorization function is the responsibility of the patients PASSE. ~~has been contracted with an independent contractor, hereafter referred to as "contractor" in the PA process. All inpatient psychiatric providers must follow the process outlined by the contractor in order to receive prior authorization. View or print current contractor contact information.~~

241.000 On-Site Inspection of Care (IOC)

~~12-1-1310-
27-25~~

The Department of Human Services (DHS) requires the contractor to conduct annual On-Site Inspections of Care for acute inpatient ~~and residential~~ services provided to Medicaid beneficiaries under age 21.

The inpatient psychiatric provider will be notified of the time of the inspection no more than forty-eight (48) hours before the scheduled arrival of the inspection team.

~~241.500 DMS/DBHS Work Group Reports and Recommendations~~

~~12-1-13~~

~~The DMS/DBHS Work Group (comprised of representatives from the Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General, the Division of Behavioral Health Services, the Office of Quality Assurance, the utilization review agency, as well as other units or divisions as required) will meet monthly to discuss IOC reports. When warranted by IOC results, the DMS/DBHS Work Group shall recommend to the DHS Review Team one or more actions in Section 241.700. Recommendations shall be in writing and shall include supporting documentation.~~

~~If a deficiency related to safety or potential risk to the beneficiary or others is found, then the utilization review agency shall immediately report this to the DMS Director (or the Director's designee).~~

242.000 Retrospective Review

~~10-14-1610-
27-25~~

The Division of Medical Services (DMS) of Arkansas Department of Human Services has contracted with a QIO-like entity to perform retrospective (post payment) reviews of acute ~~and~~

~~residential~~ services to Medicaid beneficiaries by Inpatient Psychiatric Services for Under Age 21 providers. [View or print current contractor contact information.](#) ~~The member's PASSE will complete reviews of residential unit services.~~

The reviews are conducted by licensed mental health professionals and are based on applicable federal and state standards.

250.300**~~Residential Treatment Centers~~Suggested Budget Format****~~7-1-0410-~~
27-25**

~~The per diem rates for residential treatment centers (RTCs) are established at the lesser of: 1) the center's budgeted cost per day which includes the professional component or 2) a \$350 per day upper limit (cap). This is a prospective rate with no cost settlement.~~

~~The budgeted per diem cost is calculated from the annual budget, which all RTC providers are required to submit for the upcoming state fiscal year (July 1st through June 30th). Annual budgets are due by April 30th. Should April 30th fall on a Saturday, Sunday or state or federal holiday, the due date shall be the following business day. Failure to submit the budget by April 30th may result in the suspension of reimbursement until the budget is submitted. Rates are calculated annually and are effective for dates of service occurring during the state fiscal year for which the budgets have been prepared. See this section for a suggested budget format.~~

~~New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment. This budget is used to set their rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) of \$350 per day.~~

Suggested Budget Format for Inpatient Psychiatric Hospitals, and Residential Treatment Units, ~~Residential Treatment Centers and Sexual Offender Programs~~

ADMINISTRATIVE AND OPERATING EXPENSES	Total Expenses	Less: Cost NOT Related to Patient Care	Total Cost Related to Patient Care
Salaries – Director	-	-	\$ -
Salaries – Assistant Director	-	-	\$ -
Salaries – Other Administrative	-	-	\$ -
Salaries – Nursing, Other Care Related	-	-	\$ -
Salaries – Professional – MD	-	-	\$ -
Salaries – Housekeeping & Maintenance	-	-	\$ -
Salaries – Teachers, Teacher Aides	-	-	0
SUB-TOTAL SALARIES (1)	-	-	\$ -
Professional Fees – Nursing, Other Care Related	-	-	\$ -
Professional Fees – MD	-	-	\$ -
Professional Fees – Administrative	-	-	\$ -
SUB-TOTAL FEES (2)	-	-	\$ -
FICA Tax	-	-	\$ -
State Unemployment Tax	-	-	\$ -
Workmen's Compensation Insurance	-	-	\$ -
Pension Plan	-	-	\$ -
Group Insurance	-	-	\$ -
Professional Liability Insurance	-	-	\$ -
SUB-TOTAL FRINGE BENEFITS (3)	-	-	\$ -
Advertising	-	-	\$ -
Bad Debts	-	-	\$ 0

ADMINISTRATIVE AND OPERATING EXPENSES	Total Expenses	Less: Cost NOT Related to Patient Care	Total Cost Related to Patient Care
Cable TV	-		\$ 0
Cleaning Service & Grounds	-	-	\$ -
Depreciation	-	-	\$ -
Dues & Subscriptions	-	-	\$ -
Food	-	-	\$ -
Food – USDA	-	-	\$ 0
Fund Raising	-	-	\$ -
Interest	-	-	\$ -
Office Equipment	-	-	\$ -
Postage	-	-	\$ -
Rents & Leases	-	-	\$ -
Repairs and Maintenance	-	-	\$ -
Supplies – Care Related Program	-	-	\$ -
Supplies – Medical	-	-	\$ -
Supplies – Office	-	-	\$ -
Supplies – School	-	-	\$ 0
Travel & Entertainment	-	-	\$ -
Utilities	-	-	\$ -
*Other Expenses	-	-	\$ -
SUB-TOTAL OPERATING EXPENSES (4)			\$ -
	TOTAL EXPENDITURES (1 + 2 + 3 + 4)		\$ -

* Please provide a brief description of Other Expenses.

250.400 Sexual Offender Program

7-1-04

Hospital-based and freestanding Sexual Offender Programs are cost settled per provider submitted hospital cost reports at the lesser of the audited per diem cost (includes the professional component) or the upper limit (cap). Cost settlements are calculated using the same methodology as that for residential treatment units with the same professional component cap and the same annual state fiscal year per diem cap. Although they are not hospitals, the freestanding programs are required to report their costs using the hospital cost report format and applicable instructions and reporting requirements.

Interim reimbursement rates are established at the lesser of the per diem cost as calculated from the most recent submitted unaudited cost report or the upper limit (cap) in effect as of the first day after the cost report ending date.

New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) in effect as of the first day of their enrollment.

TOC required**201.000 Arkansas Medicaid Participation Requirements for Providers 10-27-25**
of Inpatient Psychiatric Services for Under Age 21

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual.

Inpatient psychiatric services for beneficiaries under age 21 are hospital-based. Inpatient psychiatric hospitals/programs in a psychiatric hospital or inpatient psychiatric residential treatment facilities/programs in a psychiatric facility shall be referred to as inpatient psychiatric providers and/or inpatient psychiatric facilities throughout Section II of this manual.

Reimbursement may be made for inpatient psychiatric services when provided to eligible Medicaid beneficiaries by qualified providers who are enrolled in the Arkansas Medicaid Program.

211.000 Scope 10-27-25

Inpatient psychiatric services covered by the Arkansas Medicaid Program must be provided:

- A. By an inpatient psychiatric provider enrolled in the Arkansas Medicaid Program;
- B. By an enrolled inpatient psychiatric provider selected by the beneficiary;
- C. To eligible Arkansas Medicaid beneficiaries only after receipt of a primary care physician (PCP) referral except in cases of emergency;
- D. To eligible Arkansas Medicaid beneficiaries who have a certification of need issued by the facility-based and independent teams that the beneficiary meets the criteria for inpatient psychiatric services;
- E. To eligible Arkansas Medicaid beneficiaries who have a prior authorization;
- F. To eligible Arkansas Medicaid beneficiaries before the beneficiary reaches age 21 or, if the beneficiary was receiving inpatient psychiatric services at the time he or she reached age 21, services may continue until the beneficiary no longer requires the services or the beneficiary becomes 22 years of age, whichever comes first and
- G. Under the direction of a physician (contracted physicians are acceptable).

212.100 Covered Locations 10-27-25

Inpatient psychiatric services are covered by Arkansas Medicaid only when provided in:

- A. An inpatient psychiatric hospital
- B. A residential treatment unit within a psychiatric hospital

230.010 Prior Authorization Information 10-27-25

Prior authorization (PA) is required for all inpatient psychiatric residential unit services.

The prior authorization function is the responsibility of the patients PASSE.

241.000 On-Site Inspection of Care (IOC) 10-27-25

The Department of Human Services (DHS) requires the contractor to conduct annual On-Site Inspections of Care for acute inpatient services provided to Medicaid beneficiaries under age 21.

The inpatient psychiatric provider will be notified of the time of the inspection no more than forty-eight (48) hours before the scheduled arrival of the inspection team.

242.000 Retrospective Review

10-27-25

The Division of Medical Services (DMS) of Arkansas Department of Human Services has contracted with a QIO-like entity to perform retrospective (post payment) reviews of acute services to Medicaid beneficiaries by Inpatient Psychiatric Services for Under Age 21 providers. [View or print current contractor contact information.](#) The member's PASSE will complete reviews of residential unit services.

The reviews are conducted by licensed mental health professionals and are based on applicable federal and state standards.

250.300 Suggested Budget Format

10-27-25

Suggested Budget Format for Inpatient Psychiatric Hospitals and Residential Treatment Units

ADMINISTRATIVE AND OPERATING EXPENSES	Total Expenses	Less: Cost NOT Related to Patient Care	Total Cost Related to Patient Care
Salaries – Director	-	-	\$ -
Salaries – Assistant Director	-	-	\$ -
Salaries – Other Administrative	-	-	\$ -
Salaries – Nursing, Other Care Related	-	-	\$ -
Salaries – Professional – MD	-	-	\$ -
Salaries – Housekeeping & Maintenance	-	-	\$ -
Salaries – Teachers, Teacher Aides	-	-	0
SUB-TOTAL SALARIES (1)	-	-	\$ -
Professional Fees – Nursing, Other Care Related	-	-	\$ -
Professional Fees – MD	-	-	\$ -
Professional Fees – Administrative	-	-	\$ -
SUB-TOTAL FEES (2)	-	-	\$ -
FICA Tax	-	-	\$ -
State Unemployment Tax	-	-	\$ -
Workmen's Compensation Insurance	-	-	\$ -
Pension Plan	-	-	\$ -
Group Insurance	-	-	\$ -
Professional Liability Insurance	-	-	\$ -
SUB-TOTAL FRINGE BENEFITS (3)	-	-	\$ -
Advertising	-	-	\$ -
Bad Debts	-	-	\$ 0
Cable TV	-	-	\$ 0
Cleaning Service & Grounds	-	-	\$ -
Depreciation	-	-	\$ -
Dues & Subscriptions	-	-	\$ -
Food	-	-	\$ -
Food – USDA	-	-	\$ 0
Fund Raising	-	-	\$ -
Interest	-	-	\$ -

ADMINISTRATIVE AND OPERATING EXPENSES	Total Expenses	Less: Cost NOT Related to Patient Care	Total Cost Related to Patient Care
Office Equipment	-	-	\$ -
Postage	-	-	\$ -
Rents & Leases	-	-	\$ -
Repairs and Maintenance	-	-	\$ -
Supplies – Care Related Program	-	-	\$ -
Supplies – Medical	-	-	\$ -
Supplies – Office	-	-	\$ -
Supplies – School	-	-	\$ 0
Travel & Entertainment	-	-	\$ -
Utilities	-	-	\$ -
*Other Expenses	-	-	\$ -
SUB-TOTAL OPERATING EXPENSES (4)			\$ -
TOTAL EXPENDITURES (1 + 2 + 3 + 4)			\$ -

* Please provide a brief description of Other Expenses.

State of Arkansas *As Engrossed: H3/5/25 H3/31/25*

95th General Assembly

A Bill

Regular Session, 2025

HOUSE BILL 1653

By: Representatives Cavanaugh, Wooldridge

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO MOVE LICENSING AND REGULATION OF
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FROM THE
CHILD WELFARE AGENCY REVIEW BOARD TO THE DEPARTMENT
OF HUMAN SERVICES; TO SET STANDARDS FOR THE LICENSING
AND REGULATION OF PSYCHIATRIC RESIDENTIAL TREATMENT
FACILITIES; TO DECLARE AN EMERGENCY; AND FOR OTHER
PURPOSES.

Subtitle

TO SET STANDARDS FOR LICENSING AND
REGULATION OF PSYCHIATRIC RESIDENTIAL
TREATMENT FACILITIES; AND TO DECLARE AN
EMERGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

*SECTION 1. Arkansas Code § 20-8-107(c) and (d), concerning the
expansion of facilities or services permitted by Health Services Permit
Agency, are amended to read as follows:*

*(c) ~~In no event shall the requirements of this subchapter apply to any
facility licensed or approved as of March 1, 2003, by the Child Welfare
Agency Review Board pursuant to the Child Welfare Agency Licensing Act, § 9-
28-401 et seq., and as specifically exempted by § 9-28-407(a)(3).~~*

*~~(d)~~ Beginning July 1, 2005, the Health Services Permit Agency may not
accept applications or requests for permits of approval to add new beds or to
expand existing bed capacity of residential care facilities.*

(d)(1) The Health Services Permit Agency shall recognize an exception



1 to the moratorium regarding bed capacity and beds in a psychiatric
2 residential treatment facility.

3 (2) The Health Services Permit Agency shall add to the permitted
4 bed capacity for psychiatric residential treatment facilities:

5 (A) Beds that are not currently permitted by the Health
6 Services Permit Agency but are licensed by the Child Welfare Agency Review
7 Board for the purpose of operating as a psychiatric residential treatment
8 facility before the effective date of this subsection; and

9 (B) Beds that are fully constructed and could be used for
10 the purpose of operating a psychiatric residential treatment facility as of
11 January 1, 2025.

12 (3) The total amount of additional beds authorized under this
13 subsection shall not exceed nine hundred (900) beds for the purpose of
14 operating as a psychiatric residential treatment facility.

15 (4) The Health Services Permit Agency shall require prior
16 approval under § 20-8-109 for any new construction of a psychiatric
17 residential treatment facility and for any renovation project that exceeds
18 two hundred fifty thousand dollars (\$250,000) for an existing psychiatric
19 residential treatment facility.

20 (5) Any increase or decrease in the total number of authorized
21 beds under this section shall be reviewed and approved by the Legislative
22 Council before receiving a permit from the Health Services Permit Agency or a
23 license from the Office of Long-Term Care.

24 (6) For the purposes of this section, beds used for both in-
25 state and out-of-state clients shall be counted in capacity for the purpose
26 of obtaining a permit from the Health Services Permit Agency.

27
28 SECTION 2. Arkansas Code § 20-10-101(1), concerning the definition of
29 "administrative remedy" relating to long-term care facilities and services,
30 is amended to read as follows:

31 (1) "Administrative remedy" means temporary management, denial
32 of payment for all new admissions, transfer of residents, termination or
33 suspension of license, termination of provider agreement, directed plan of
34 correction, directed in-service training, and remedies established by
35 Arkansas law, ~~including remedies provided in § 20-10-1408 [repealed];~~
36

1 SECTION 3. Arkansas Code § 20-10-101(9)(A), concerning the definition
2 of "long-term care facility" relating to long-term care facilities and
3 services, is amended to read as follows:

4 (9)(A) "Long-term care facility" means a nursing home,
5 residential care facility, assisted living facility, psychiatric residential
6 treatment facility, post-acute head injury retraining and residential care
7 facility, or any other facility which provides long-term medical or personal
8 care.

9
10 SECTION 4. Arkansas Code § 20-10-101, concerning definitions relating
11 to long-term care facilities and services, is amended to add an additional
12 subdivision to read as follows:

13 (16)(A) "Psychiatric residential treatment facility" means a
14 standalone, nonhospital facility with a provider agreement with the Arkansas
15 Medicaid Program to provide inpatient services benefits to individuals who
16 are under twenty-one (21) years of age and that:

17 (i) Is accredited by The Joint Commission or any
18 other accrediting organization with comparable standards recognized by this
19 state;

20 (ii) Attests to meeting the conditions of
21 participation found at 42 C.F.R. Part 483, Subpart G, as existing on January
22 1, 2025; and

23 (iii) Attests that all of the residents in the
24 facility meet the certification of need for services requirements as
25 identified under 42 C.F.R. Part 441, Subpart D, as existing on January 1,
26 2025.

27 (B)(i) A survey and certification review of a psychiatric
28 residential treatment facility by the department shall apply to all residents
29 being served by the entity regardless of residency or payment source.

30 (ii) All residents of a psychiatric residential
31 treatment facility shall require intensive inpatient services for psychiatric
32 conditions under the direction of a physician and the services provided shall
33 be reasonably expected to improve the resident's condition or prevent further
34 regression until the services are no longer needed.

35
36 SECTION 5. Arkansas Code § 20-10-110(a)(2), concerning the definition

1 of "long-term care facility" relating to the protection of residents'
2 personal funds, is amended to read as follows:

3 (2) "Long-term care facility" means a nursing home, residential
4 care facility, post-acute head injury retraining and residential care
5 facility, assisted living facility, psychiatric residential treatment
6 facility, or any other facility that provides long-term medical or personal
7 care;

8
9 SECTION 6. Arkansas Code § 20-10-402 is amended to read as follows:

10 20-10-402. License required.

11 (a) It shall be unlawful for any person to act or serve in the
12 capacity of ~~nursing home~~ long-term care facility administrator in this state
13 unless the person has been licensed to do so as authorized in this
14 subchapter.

15 (b) A person who serves as an administrator of a long-term care
16 facility conducted exclusively for persons who rely upon treatment by
17 spiritual means through prayer in accordance with the creed or tenets of a
18 church or religious denomination shall be exempt from subsection (a) of this
19 section and § 20-10-101(1)-(6), § 20-10-203(b), § 20-10-212, §§ 20-10-301 –
20 20-10-303 [repealed], § 20-10-403, ~~§ 20-10-405(b)~~ § 20-10-405(a)(2), § 20-10-
21 406, and § 20-10-407.

22
23 SECTION 7. Arkansas Code § 20-10-404(a), concerning the application
24 and fees for licensure as a long-term care facility administrator, is amended
25 to read as follows:

26 (a) Any person desiring to be licensed as a ~~nursing home~~ long-term
27 care facility administrator shall make application to the Office of Long-Term
28 Care on forms prescribed by the office and shall furnish such information
29 with the application as shall be required by the office.

30
31 SECTION 8. Arkansas Code § 20-10-405 is amended to read as follows:

32 20-10-405. Renewal.

33 (a)(1) Every active nursing home administrator's license shall be
34 renewed on or before July 1 of each year by paying a fee of one hundred
35 dollars (\$100) to the Office of Long-Term Care and by furnishing written
36 documentation that the licensee has attended and accumulated a specific

1 number of continuing education clock hours as established by the office.

2 ~~(b)~~(2) The fee for those nursing home administrators not actively
3 employed by a nursing home facility as an administrator shall be fifty
4 dollars (\$50.00), payable on or before July 1 of each year.

5 ~~(e)~~(3) If the annual licensure fee in full along with the renewal
6 application and satisfactory documentation of compliance with continuing
7 education requirements is not postmarked or received by the office on or
8 before July 1, the licensee shall be ineligible to perform the duties of
9 nursing home administrator, and the license shall be deemed suspended
10 effective July 2.

11 ~~(d)~~(4) No request for renewal postmarked or received by the office
12 after July 1 shall be considered unless, in addition to other requirements
13 imposed by law or rule, the licensee tenders a late charge in the amount of
14 fifty dollars (\$50.00).

15 ~~(e)~~(5) Any nursing home administrator license not renewed on or before
16 September 1 shall expire effective September 2.

17 (b) An administrator for a long-term care facility other than a
18 nursing home shall be required to renew his or her license as follows:

19 (1) Every active administrator license shall be renewed on or
20 before January 1 of each year by submitting a renewal application to the
21 Department of Human Services and by furnishing written documentation that the
22 licensee has attended and accumulated a specific number of continuing
23 education clock hours as established by the department;

24 (2) If the renewal application and satisfactory documentation of
25 compliance with continuing education requirements is not postmarked or
26 received by the department on or before January 1, the licensee shall be
27 ineligible to perform the duties of long-term care facility administrator,
28 and the license shall be deemed suspended effective January 2;

29 (3) A request for renewal postmarked or received by the
30 department after January 1 shall not be considered unless the licensee
31 complies with all of the requirements imposed by law or rule; and

32 (4) Any long-term care facility administrator license not
33 renewed on or before March 1 shall expire effective March 2.
34

35 SECTION 9. Arkansas Code § 20-10-407(a), concerning the denial,
36 revocation, or suspension of a long-term care facility administrator's

1 license, is amended to read as follows:

2 (a) The Department of Human Services may refuse to issue or renew a
3 long-term care facility administrator's license or may revoke or suspend the
4 license of a long-term care facility administrator if the department finds
5 that the applicant or licensee does not qualify for licensure or has violated
6 § 20-10-101(1)-(6), § 20-10-203(b), § 20-10-212, §§ 20-10-402 and 20-10-403,
7 ~~§ 20-10-405(b)~~ § 20-10-405(a)(2), § 20-10-406, and this section or rules of
8 the department relating to the proper administration and management of a
9 long-term care facility.

10
11 SECTION 10. Arkansas Code Title 20, Chapter 46, Subchapter 4 is
12 amended to read as follows:

13 Subchapter 4 – Psychiatric Residential Treatment Facilities

14
15 ~~20-46-401 – 20-46-404. [Repealed.]~~

16
17 20-46-401. Admission of children to psychiatric residential treatment
18 facilities.

19 (a) A psychiatric residential treatment facility licensed under this
20 subchapter and holding a permit from the Health Services Permit Agency or the
21 Health Services Permit Commission shall not admit a child for psychiatric
22 residential treatment unless the child is:

23 (1) An Arkansas resident;

24 (2) A child of a parent who is an Arkansas resident;

25 (3) A child placed by or on behalf of another state's child
26 welfare agency;

27 (4) A child for whom the facility is being paid by another
28 state's Medicaid program;

29 (5) A child of an active-duty member or veteran of the uniformed
30 services as defined in § 6-4-302; or

31 (6) A nonresident child victim of human trafficking when the
32 regulated facility maintains responsibility for the return of the child to an
33 out-of-state custodian.

34 (b) The Department of Human Services may promulgate rules to enforce
35 this section.

1
2 20-46-402. Licensure – Unlawful acts.

3 (a)(1) It is unlawful for any person, partnership, group, corporation,
4 association, or other entity or identifiable group of entities having a
5 coordinated ownership with controlling interest to operate or assist in the
6 operation of a psychiatric residential treatment facility that has not been
7 licensed by the Office of Long-Term Care under this subchapter.

8 (2) Before obtaining a license under this subchapter, a
9 psychiatric residential treatment facility shall obtain a permit from the
10 Health Services Permit Agency or Health Services Permit Commission to operate
11 in Arkansas.

12 (3) The bed capacity allowed by the permit issued by the Health
13 Services Permit Agency or Health Services Permit Commission includes both in-
14 state and out-of-state clients.

15 (4) Any expansion of bed capacity by an existing licensee shall
16 require a license from the office and a permit from the Health Services
17 Permit Agency.

18 (5)(A) A license issued by the office under this subchapter is
19 effective unless revoked, suspended, or terminated by the office.

20 (B) In addition to any other basis provided by law or
21 rule, the Department of Human Services shall terminate the license of a
22 psychiatric residential treatment facility licensee that has not been in
23 operation for a consecutive twelve-month period.

24 (C) The department may revoke, suspend, or terminate a
25 license upon any basis provided by law or rule, including without limitation
26 the failure to be in operation or in substantial compliance for a consecutive
27 six-month period.

28 (b) It is unlawful for any person to falsify an application for
29 licensure, to knowingly circumvent the authority of this subchapter, to
30 knowingly violate the orders issued by the department, or to advertise for
31 inpatient psychiatric residential treatment when not licensed under this
32 subchapter to provide those services.

33 (c) Any violation of this section shall constitute a Class D felony.
34

35 20-46-403. Licensure posting and display.

36 If the Department of Human Services issues a license to operate a

1 psychiatric residential treatment facility, the license shall be posted and
2 displayed in a conspicuous place in the facility and must state at a minimum:

3 (1) The full legal name of the person, partnership, group,
4 corporation, organization, association, or other entity or identifiable group
5 of entities having a coordinated ownership with controlling interest holding
6 the license, including the business name, if different;

7 (2) The address of the psychiatric residential treatment
8 facility;

9 (3) The effective date and expiration date of the license, if
10 applicable;

11 (4) The type of psychiatric residential treatment facility the
12 licensee is authorized to operate;

13 (5) The ages and maximum number of children that may receive
14 services from the psychiatric residential treatment facility;

15 (6) The status of the license, whether regular, provisional, or
16 probationary; and

17 (7) Any special conditions or limitations of the license.

18
19 20-46-404. Services provided by psychiatric residential treatment
20 facilities.

21 (a) A psychiatric residential treatment facility licensed under this
22 subchapter shall:

23 (1)(A) Provide a range of comprehensive services to treat the
24 psychiatric condition of residents on an inpatient basis under the direction
25 of a physician.

26 (B) The psychiatric residential treatment facility shall
27 certify that:

28 (i) Ambulatory care services available in the
29 community do not meet the treatment needs of the resident;

30 (ii) Proper treatment of the resident's psychiatric
31 condition requires services on an inpatient basis under the direction of a
32 physician; and

33 (iii) The services can reasonably be expected to
34 improve the resident's condition or prevent further regression so that the
35 services will no longer be needed.

36 (C) The certification required in subdivision (a)(1)(B) of

1 this section shall be made by an independent team that:

2 (i) Includes a physician;

3 (ii) Has competence in diagnosis and treatment of
4 mental illness, preferably in child psychiatry; and

5 (iii) Has knowledge of the resident's situation; and

6 (2) Provide services to a resident according to an individual
7 plan of care that:

8 (A) Is based on a diagnostic evaluation that includes
9 examination of the medical, psychological, social, behavioral, and
10 developmental aspects of the resident's situation and reflects the need for
11 inpatient psychiatric care;

12 (B) Is developed by a team of professionals in
13 consultation with the resident, parents, legal guardians, or other
14 individuals in whose care the resident will be released after discharge;

15 (C) Describes clear and concise treatment objectives;

16 (D) Ensures continuity of care with the resident's family,
17 school and educational requirements, and community upon discharge;

18 (E) Determines that services being provided are or were
19 required on an inpatient basis; and

20 (F) Recommends changes in the plan of care as indicated by
21 the resident's overall adjustment as an inpatient.

22 (b) The Department of Human Services shall promulgate rules to
23 implement this subchapter, which shall include components that ensure quality
24 of care, health and safety of residents and facility staff, and compliance
25 with all educational requirements.

26
27
28 SECTION 11. Arkansas Code § 9-28-402(8), concerning the definition of
29 "child welfare agency" within the Child Welfare Agency Licensing Act, is
30 amended to read as follows:

31 (8) "Child welfare agency" means any person, corporation,
32 partnership, voluntary association, or other entity or identifiable group of
33 entities having a coordinated ownership of controlling interest, whether
34 established for profit or otherwise, that is not excluded under this
35 subchapter and engages in any of the following activities:

36 (A) Receives a total number of six (6) or more unrelated

1 minors for care on a twenty-four-hour basis for the purpose of ensuring the
2 minors receive care, training, education, custody, or supervision, whether or
3 not there are six (6) or more children cared for at any single physical
4 location;

5 (B) Places any unrelated minor for care on a twenty-four-
6 hour basis with persons other than themselves;

7 (C) Plans for or assists in the placements described in
8 subdivision (8)(B) of this section; or

9 (D) Receives, places, plans, or assists in the placement
10 of a child victim of human trafficking in a home or any type of shelter or
11 facility;

12
13 SECTION 12. Arkansas Code § 9-28-402(12), concerning the definition of
14 "exempt child welfare agency" within the Child Welfare Agency Licensing Act,
15 is amended to read as follows:

16 (12) "Exempt child welfare agency" means any person,
17 corporation, partnership, voluntary association or other entity, whether
18 established for profit or otherwise, that otherwise fits the definition of a
19 child welfare agency but that is specifically exempt from the requirement of
20 obtaining a license under this subchapter. Those agencies specifically exempt
21 from the license requirement are:

22 (A) A facility or program owned or operated by an agency
23 of the United States Government;

24 (B)(i) Any agency of the State of Arkansas that is
25 statutorily authorized to administer or supervise child welfare activities.

26 (ii) In order to maintain exempt status, the state
27 child welfare agency shall state every two (2) years in written form signed
28 by the persons in charge that their agency is in substantial compliance with
29 published state agency child welfare standards.

30 (iii) Visits to review and advise exempt state
31 agencies shall be made as deemed necessary by the Child Welfare Agency Review
32 Board to verify and maintain substantial compliance with the standards;

33 (C) A facility or program owned or operated by or under
34 contract with the Division of Correction;

35 ~~(D) A hospital providing acute care licensed pursuant to §~~
36 ~~20-9-201 et seq.;~~

1 ~~(E)~~(D) Any facility governed by the Department of Human
2 Services State Institutional System Board or its successor;

3 ~~(F)~~ Human development centers regulated by the Board of
4 Developmental Disabilities Services pursuant to the Location Act for
5 Community Homes for Individuals with Intellectual and Developmental
6 Disabilities, § 20-48-601 et seq.;

7 ~~(G)~~ Any facility licensed as a family home pursuant to the
8 Location Act for Community Homes for Individuals with Intellectual and
9 Developmental Disabilities, § 20-48-601 et seq.;

10 ~~(H)~~(E) Any boarding school as defined in this section;

11 ~~(I)~~(F) Any temporary camp as defined in this section;

12 ~~(J)~~(G) Any state-operated facility to house juvenile
13 delinquents or any serious offender program facility operated by a state
14 designee to house juvenile delinquents. Those facilities shall be subject to
15 program requirements modeled on nationally recognized correctional facility
16 standards that shall be developed, administered, and monitored by the
17 Division of Youth Services; and

18 ~~(K)~~(H) Any child welfare agency operated solely by a
19 religious organization that elects to be exempt from licensing and that
20 complies within the conditions of the exemption for church-operated agencies
21 as set forth in this subchapter;

22 ~~(L)~~ The Division of Developmental Disabilities Services;
23 and

24 ~~(M)~~ Any intellectual or other developmental disabilities
25 services waiver provider licensed under § 20-48-208 or the Location Act for
26 Community Homes for Individuals with Intellectual and Developmental
27 Disabilities, § 20-48-601 et seq.;

28
29 SECTION 13. Arkansas Code § 9-28-402(18) is repealed.

30 ~~(18)~~ "Psychiatric residential treatment facility" means a
31 residential childcare facility in a nonhospital setting that provides a
32 structured, systematic, therapeutic program of treatment under the
33 supervision of a psychiatrist, for children who are emotionally disturbed and
34 in need of daily nursing services, psychiatrist's supervision, and
35 residential care but who are not in an acute phase of illness requiring the
36 services of an inpatient psychiatric hospital;

1
2 SECTION 14. Arkansas Code § 9-28-402(22), concerning the definition of
3 "residential childcare facility" within the Child Welfare Agency Licensing
4 Act, is amended to read as follows:

5 (22)(A) "Residential childcare facility" means any child welfare
6 agency that is not an excluded child welfare agency under this subchapter and
7 provides care, training, education, custody, or supervision on a twenty-four-
8 hour basis for six (6) or more unrelated children, excluding foster homes
9 that have six (6) or more children who are all related to each other but who
10 are not related to the foster parents.

11 (B) A "residential childcare facility" does not include a
12 facility that provides inpatient psychiatric treatment, which shall not be
13 licensed as a residential childcare facility;
14

15 SECTION 15. Arkansas Code § 9-28-402, concerning the definitions
16 within the Child Welfare Agency Licensing Act, is amended to add an
17 additional subdivision to read as follows:

18 (32) "Excluded child welfare agency" means any person,
19 corporation, partnership, voluntary association, or other entity, whether
20 established for-profit or otherwise, that meets the definition of a child
21 welfare agency or an exempt child welfare agency but is licensed or certified
22 by the Department of Human Services or the Department of Health and is
23 enrolled in the Arkansas Medicaid Program.
24

25 SECTION 16. Arkansas Code § 9-28-403(a), concerning the creation and
26 authority of the Child Welfare Agency Review Board, is amended to read as
27 follows:

28 (a)(1) There is created the Child Welfare Agency Review Board to serve
29 as the administrative body to carry out the provisions of this subchapter.

30 (2) The board shall have the authority to promulgate rules to
31 enforce the provisions of this subchapter.

32 (3) An excluded child welfare agency is not subject to the
33 provisions of this subchapter.
34

35 SECTION 17. Arkansas Code § 9-28-404(a)(5), concerning the membership
36 of the Child Welfare Agency Review Board, is repealed.

~~(5) One (1) representative from a licensed psychiatric
residential treatment facility;~~

SECTION 18. Arkansas Code § 9-28-407(a)(3) and (4), concerning
licenses required and issued by the Child Welfare Agency Review Board, are
repealed.

~~(3) Any child welfare agency capacity licensed by the board as
of March 1, 2003, whether held by the original licensee or by a successor in
interest to the original licensee, is exempted from:~~

~~(A) Obtaining any license or permit from the Office of
Long-Term Care; and~~

~~(B)(i) Obtaining any permit from the Health Services
Permit Agency or the Health Services Permit Commission to operate at the
capacity licensed by the board as of March 1, 2003, except as required under
subdivision (a)(3)(B)(ii) of this section.~~

~~(ii)(a) If a licensee is operating at less than or
at the capacity licensed by the board as of March 1, 2021, the licensee shall
obtain a permit from the Health Services Permit Agency or the Health Services
Permit Commission for any increase in capacity.~~

~~(b) For the purposes of subdivision
(a)(3)(B)(ii)(a) of this section, both in-state and out-of-state clients
shall be counted in capacity for the purpose of obtaining a license from the
board and a permit from the Health Services Permit Agency or the Health
Services Permit Commission.~~

~~(4) Any new license or expansion of capacity by an
existing licensee of the board shall require a license and permit from the
Office of Long-Term Care or the Health Services Permit Agency.~~

SECTION 19. Arkansas Code § 9-28-407(a)(5), concerning licenses
required and issued by the Child Welfare Agency Review Board, is amended to
read as follows:

(5)(A) A license issued by the board under this subchapter is
effective unless revoked, suspended, or terminated by the board.

(B) ~~In addition to any other basis provided by law or
rule, the board shall terminate the license of a psychiatric residential
treatment facility licensee that has not been in operation for a consecutive~~

1 ~~twelve-month period.~~

2 ~~(G) The Department of Human Services may recommend to the~~
3 ~~board the revocation, suspension, or termination of a license for any basis~~
4 ~~provided by law or rule, including without limitation the failure to be in~~
5 ~~operation or in substantial compliance for a consecutive six-month period.~~

6
7 SECTION 20. Arkansas Code § 9-28-407(f)(3)(F), concerning licenses
8 required and issued by the Child Welfare Agency Review Board, is amended to
9 read as follows:

10 (F) The provisions of subsection (a) of this section,
11 ~~including those provisions regarding obtaining licenses or permits from the~~
12 ~~Office of Long-Term Care and regarding obtaining any permits from the Health~~
13 ~~Services Permit Agency or the Health Services Permit Commission, shall apply~~
14 ~~in their entirety to the new owner of the child welfare agency~~

15
16 SECTION 21. Arkansas Code § 9-28-416 is repealed.

17 ~~9-28-416. Admission of children to psychiatric residential treatment~~
18 ~~facilities.~~

19 ~~(a) A psychiatric residential treatment facility licensed under this~~
20 ~~subchapter and holding a permit from the Health Services Permit Agency or the~~
21 ~~Health Services Permit Commission shall not admit a child for psychiatric~~
22 ~~residential treatment unless the child is:~~

23 ~~(1) An Arkansas resident;~~

24 ~~(2) A child of a parent who is an Arkansas resident;~~

25 ~~(3) A child placed by or on behalf of another state's child~~
26 ~~welfare agency;~~

27 ~~(4) A child for whom the facility is being paid by another~~
28 ~~state's Medicaid program;~~

29 ~~(5) A child of an active-duty member or veteran of the uniformed~~
30 ~~services as defined in § 6-4-302; or~~

31 ~~(6) A nonresident child victim of human trafficking when the~~
32 ~~regulated facility maintains responsibility for the return of the child to~~
33 ~~the out-of-state custodian.~~

34 ~~(b) The Department of Human Services may promulgate rules to enforce~~
35 ~~this section.~~

SECTION 22. Arkansas Code Title 9, Chapter 28, Subchapter 13, is repealed.

~~Subchapter 13 — Psychiatric Residential Treatment Facilities and Other
Regulated Facilities~~

~~9-28-1301. Definitions.~~

~~As used in this subchapter:~~

~~(1) "Psychiatric residential treatment facility" means the same as defined in § 9-28-402; and~~

~~(2) "Regulated facility" means:~~

~~(A) A psychiatric residential treatment facility licensed under the Child Welfare Agency Licensing Act, § 9-28-401 et seq.; and~~

~~(B) A psychiatric hospital licensed under § 20-9-201 et seq., that admits a child for the purpose of providing behavioral health treatment, regardless of whether the child is placed in an acute, subacute, or otherwise unlicensed bed.~~

~~9-28-1302. Quality of care—Quality assurance reviews.~~

~~(a) The Department of Human Services shall promulgate rules setting minimum standards and metrics governing the quality of care provided by a regulated facility to a child.~~

~~(b) Quality of care standards shall include that a regulated facility shall provide:~~

~~(1) Trauma informed programming and clinical services and, when applicable, evidence based treatments;~~

~~(2) Services that will be short term, target treatment episodes to reduce the likelihood of re-entry into residential treatment settings;~~

~~(3) Services that are family driven and youth guided;~~

~~(4) Mental health services and clinical services provided by clinical staff as appropriate for the child's needs;~~

~~(5) Educational services in compliance with state and federal law and rules of the Department of Education;~~

~~(6) Coordination of all needs including medical, dental, and other needs; and~~

~~(7) Clinical discharge planning throughout the child's stay that includes the custodian and child involvement.~~

~~(c)(1) The Department of Human Services and its designees may inspect and investigate the quality of care for behavioral health provided to any child admitted to a regulated facility, whether or not the child is an Arkansas resident.~~

~~(2) The Department of Human Services or any other public agency having authority or responsibility with respect to child maltreatment, including without limitation the Medicaid Fraud Control Unit of the Attorney General's office, may investigate any alleged or suspected child maltreatment in any regulated facility.~~

~~(d) The Department of Human Services shall conduct quality assurance reviews for each regulated facility, consisting of the following:~~

~~(1) A review of treatment structure including without limitation:~~

~~(A) Observation of paraprofessional and direct-care staff interaction with patients;~~

~~(B) Review of daily activity structure outside of school and treatment;~~

~~(C) Review of paraprofessional and direct-care staff training and personnel records;~~

~~(D) Review of staff-to-client ratios; and~~

~~(E) Completion of client interviews;~~

~~(2) An analysis of referral data, statistics, and psychotropic medication prescriptions;~~

~~(3) An on-site visit of a regulated facility's operation, to be conducted at least once per year; and~~

~~(4) Technical assistance and ongoing quality assurance and collaboration as needed.~~

~~(e) This subchapter does not require any additional licensure or certification for a regulated facility.~~

~~9-28-1303. Department enforcement authority.~~

~~(a) The Department of Human Services may initiate an adverse action against a regulated facility that:~~

~~(1) Fails to comply with the provisions of this subchapter or any rule of the department relating to quality of care;~~

~~(2) Furnishes or makes any statement or report to the department~~

1 ~~that is false or misleading;~~

2 ~~(3) Refuses or fails to submit required reports or to make~~
3 ~~available to the department any records required by the department in making~~
4 ~~an investigation of the agency for quality of care purposes;~~

5 ~~(4) Refuses or fails to submit to an investigation or to~~
6 ~~reasonable inspection by the department;~~

7 ~~(5) Retaliates against an employee who in good faith reports a~~
8 ~~suspected violation of the provisions of this subchapter or the rules~~
9 ~~promulgated under this subchapter;~~

10 ~~(6) Fails to engage in a course of professional conduct in~~
11 ~~dealing with clients being served by the regulated facility, as defined by~~
12 ~~rules promulgated under this subchapter; or~~

13 ~~(7) Demonstrates gross negligence in carrying out the duties at~~
14 ~~the regulated facility.~~

15 ~~(b) The department may impose an adverse action as follows:~~

16 ~~(1) Issue letters of reprimand or caution;~~

17 ~~(2) Require a corrective action plan; and~~

18 ~~(3)(A) Impose civil penalties of up to two thousand five hundred~~
19 ~~dollars (\$2,500) per violation, with each day of noncompliance and each~~
20 ~~client injured as a result of noncompliance constituting a separate~~
21 ~~violation.~~

22 ~~(B) If any person upon whom the department has levied a~~
23 ~~civil penalty fails to pay the civil penalty within sixty (60) days of the~~
24 ~~decision of the department to impose the penalty, the amount of the fine~~
25 ~~shall be considered to be a debt owed to the State of Arkansas and may be~~
26 ~~collected by civil action.~~

27 ~~(C) Civil penalties collected under this section may be~~
28 ~~expended only for the purpose of providing technical assistance and training~~
29 ~~to regulated facilities.~~

30 ~~(c)(1) For a regulated facility licensed under the Child Welfare~~
31 ~~Agency Licensing Act, § 9-28-401 et seq., the department may petition the~~
32 ~~Child Welfare Agency Review Board to deny, suspend, or revoke the regulated~~
33 ~~facility's license on the basis of any adverse action imposed by the~~
34 ~~department under this section.~~

35 ~~(2) For a regulated facility licensed under § 20-9-201 et seq.,~~
36 ~~the department may petition the State Board of Health to deny, suspend, or~~

~~revoke the regulated facility's license on the basis of any adverse action imposed by the department under this section.~~

~~(d) The department shall notify the regulated facility of the adverse action of the department in writing and set forth the facts forming the basis for the adverse action.~~

~~(e)(1) Adverse action hearings shall comply with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.~~

~~(2) Within ten (10) business days after rendering a decision, the department shall forward to the regulated facility written findings of fact and conclusions of law articulating the decision of the department.~~

~~9-28-1304. Rules.~~

~~The Department of Human Services shall promulgate rules to implement this subchapter.~~

SECTION 23. DO NOT CODIFY. TEMPORARY LANGUAGE. Rules.

(a) Beds within a psychiatric residential treatment facility, whether licensed on the effective date of this act or otherwise, shall not be approved and licensed under the new regulatory structure established in this act until:

(1) The Office of Long-Term Care promulgates a certification manual; and

(2) The Arkansas Medicaid Program promulgates a provider manual for psychiatric residential treatment facility services.

(b) Providers of psychiatric residential treatment facility services in this state shall have one (1) year from the effective date of this act to develop, implement, and operate services that establish the appropriate continuum of care for families as defined by the Department of Human Services.

SECTION 24. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that beds in psychiatric residential treatment facilities have been permitted but are not currently licensed; that these beds in psychiatric residential treatment facilities that are not licensed cannot be used for children in need of healthcare services despite the demand for the beds; that this act would authorize

licensing of the beds in psychiatric residential treatment facilities and therefore allow the use of these beds in psychiatric residential treatment facilities for children in need; and that this act is immediately necessary to provide healthcare services to children in need across this state who are currently not able to be admitted into a psychiatric residential treatment facility. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/Cavanaugh

APPROVED: 4/16/25

DHS Responses to Public Comments Regarding Rule 307 - Psychiatric Residential Treatment Facility Services for Under 21

Caroline Cole, Strategic Advocacy Lead

On behalf of 11:11 Media Impact

Co-Host, iHeart's Trapped in Treatment

Comment: Thank you for the opportunity to submit comments on the proposed rulemaking for Psychiatric Residential Treatment Facility (PRTF) services for youth under 21. I write to commend DHS for undertaking this much-needed update to PRTF standards and to offer recommendations to ensure the final rules provide strong protections, consistent oversight, and trauma-informed care for youth in these facilities. Recent national findings have underscored the urgent need for reform – a 2024 U.S. Senate report found “endemic harm within RTFs, including unsafe restraint practices, improper medication use, ... and insufficient oversight,” contributing to tragic outcomes.

In light of such concerns, the proposed Arkansas rules represent a critical step forward. My comments below, organized by topic, draw on best-practice policy recommendations from our organization 11:11 Media Impact report “From Crisis to Care” and are offered to help ensure Arkansas’s PRTF regulations fully align with national best practices and close any remaining gaps.

Use of Restraint and Seclusion

Support for Prohibitions and Reporting:

The proposed rules make significant strides by completely prohibiting mechanical restraints and seclusion in PRTFs. This prohibition is commendable and consistent with trauma-informed care – eliminating practices like strapping down residents or isolating them alone, which are known to risk both physical and psychological harm. Additionally, the requirement that any use of personal (physical) or chemical restraint be strictly limited to true emergencies and be reported monthly to oversight entities (Office of Long-Term Care, the resident’s PASSE, the state Protection & Advocacy system, etc.) is a strong accountability measure. I also support the mandate to notify parents/guardians within 24 hours of each emergency safety intervention, ensuring families are informed and involved in addressing such incidents. Taken together, these provisions will help ensure that restraint is used only as an absolute last resort to protect safety, with transparency to regulators and families.

Recommendations for Strengthening Protections: I urge DHS to consider a few additions to further strengthen these protections, in line with national best practices:

- Ban Dangerous Restraint Techniques: Explicitly prohibit prone restraints and any technique that restricts breathing or blood flow (e.g. choking, chest compressions). We recommend that “no residential facility serving minors shall use or permit prone restraints or any restraint that restricts airflow or blood flow to the brain”. Including a clear ban on prone restraints and neck holds in the Arkansas rules would reinforce the commitment to youth safety and prevent tragic outcomes like asphyxiation.

- Limit and Regulate Chemical Restraints: While mechanical restraints would be disallowed, the rules should also discourage or strictly limit chemical restraints (sedating a child for behavioral control). National policy experts call for prohibiting chemical restraints in all youth facilities, except when medically necessary and prescribed as part of treatment. If Arkansas continues to permit emergency sedative medication, I recommend adding guardrails – for example, require that any “as-needed” sedating medication used for behavioral control be treated and reported as a chemical restraint, not as routine PRN medication. Tightening this definition will prevent facilities from over-relying on drugs to control behavior in lieu of therapeutic interventions. Tracking the ratio of chemical restraints to PRN sedatives, as the rule proposes, is an excellent step to identify any misuse; an outright prohibition on chemical restraints would be an even stronger protection.
- Emphasize Restraint as Last Resort Only: The rule appropriately states that physical restraint may only be used to ensure immediate safety during an emergency and never as a standing order or punishment. I support this and suggest adding language to underscore that restraints are a last resort. For example, the policy report recommends specifying that “physical restraints may only be used when imminent serious bodily harm is present and no other de-escalation is effective, and never for discipline, convenience, or as a substitute for treatment”. Including such language in the Arkansas rule (even if in guidance or training requirements) will reinforce a culture where staff exhaust all de-escalation options before resorting to any physical hold.
- Post-Incident Review and Oversight: I commend the inclusion of post-restraint procedures such as prompt physician evaluation within one hour and detailed documentation in the resident’s record. To build on this, Arkansas could require a formal post-incident debriefing with the resident and staff involved, to learn from the event and adjust the care plan – and involve the parent/guardian in that discussion when appropriate. In addition, I support that all incidents must be reported internally and suggest that DHS consider requiring aggregate public reporting of restraint/seclusion incidence. According to 11:11 Media Impact’s recommendations, facilities or the state should publish facility-level data on restraint and seclusion quarterly (without personal identifiers) to promote transparency. Publicly sharing how often these interventions occur will incentivize reduction in use and allow stakeholders to monitor trends across facilities.

In summary, DHS’s proposed rules on restraint/seclusion mark a progressive policy that prioritizes youth safety. By incorporating the above recommendations – banning high-risk techniques, further curbing chemical restraints, emphasizing “last resort” usage, and enhancing transparency – Arkansas can set a national example in protecting children from the well-documented dangers of restraint and seclusion in treatment facilities.

Staff Training and Trauma-Informed Care

Support for Strong Training Standards: The proposed rule establishes robust staff training requirements that are crucial for quality care. Requiring all PRTF staff to be trained upon hire and annually in key areas – including crisis de-escalation, management of aggressive behavior, seclusion/restraint policies, mandatory abuse reporting, and trauma-informed care principles – is very positive. Notably, “trauma-informed care” and understanding of child development and behavioral health are listed as required training topics, which aligns with the best practice of ensuring staff can recognize and respond appropriately to youth who have histories of trauma. The rule also smartly mandates that no staff may initiate or participate in a physical or chemical restraint until properly trained and able to demonstrate

competency in those techniques. This competency-based training approach (including in-person skill demonstration) will help ensure that if staff ever must intervene in a crisis, they do so safely and with minimal force necessary. I strongly support these provisions.

Recommendations for Strengthening Training: To further enhance staff capabilities and promote a therapeutic, trauma-informed environment, I offer a few suggestions:

- Require Ongoing Trauma-Informed and De-escalation Training: The final rules should explicitly maintain that all staff receive annual refreshers in trauma-informed care and de-escalation techniques, consistent with expert recommendations. 11:11 Media Impact suggests that all staff complete a minimum number of hours of such training each year, with records audited during inspections. This could be implemented by specifying a baseline (for example, “at least 8 hours annually of continuing education in de-escalation and trauma-informed approaches”). Regular refreshers will ensure staff stay up-to-date on best practices for calming agitated youth and avoiding re-traumatization.
- Emphasize Mandatory Reporter and Abuse-Prevention Training: While the rule references the Child Maltreatment Mandated Reporter rule, DHS should ensure that comprehensive abuse recognition and reporting training is part of the annual curriculum. Staff must be empowered to recognize signs of abuse/neglect and obligated to report concerns. We recommend annual training for all staff on abuse recognition/reporting, with certification of completion kept on file. Incorporating this will reinforce a culture of vigilance and accountability to protect residents from harm, whether caused by staff or peers.
- Cultural Competence and Family Engagement: It may also strengthen the program to include training in cultural competence and family engagement strategies. Many youths in PRTFs come from diverse backgrounds or are in state custody. Staff should be prepared to work with families (when available) as partners in the treatment process and to provide culturally and linguistically appropriate care. Ensuring family-inclusive, culturally sensitive practices are covered in training aligns with trauma-informed care principles and could be folded into the existing topics (for example, under “appropriate relationships with clients” or “trauma-informed care” modules).

Overall, Arkansas’s training standards as proposed are in line with national best practices that call for well-trained, trauma-informed staff. By mandating annual refreshers in critical areas and highlighting abuse prevention and cultural competency, DHS can further ensure that PRTF personnel have the knowledge, skills, and mindset to create a safe and healing environment for youth. This will help shift facility culture away from punitive approaches and toward supportive, therapeutic care.

Licensing and Accreditation Standards

Support for High Standards (Licensure & JCAHO Accreditation): The creation of a dedicated PRTF licensure manual and the requirement that facilities obtain Arkansas DHS licensure as a PRTF and maintain accreditation by The Joint Commission (JCAHO) are excellent provisions. Requiring Joint Commission accreditation (meeting nationally recognized child and adolescent psychiatric care standards) will ensure that any PRTF operating in Arkansas adheres to rigorous quality and safety benchmarks. This aligns with recommendations that all residential facilities meet accreditation standards equal to or exceeding those of the state. I commend DHS for including accreditation as a

baseline – this external oversight will complement state licensing surveys and help drive continuous quality improvement.

In addition, the licensure standards themselves (20 CAR 417) appear appropriately comprehensive – covering administration, staffing, rights, treatment planning, environment, and more – and serve as the “minimum standards” to protect the health and safety of residents. Making these standards clear and enforceable via licensure is a critical step.

Recommendations: A few recommendations to reinforce licensing effectiveness:

- No Exceptions or Loopholes: Ensure that all organizations housing and treating under-21 youth with mental/behavioral needs are required to be licensed as PRTFs (or licensed equivalents). Sometimes facilities attempt to evade licensure by labeling themselves as “boarding schools” or “camps.” Act 636 and these rules should firmly close such loopholes by bringing any such facilities under regulation if they provide similar services. The intent is to prevent unlicensed programs from operating without oversight. DHS should clarify that any residential program for treating youth mental health must meet these standards or cease operation.
- Out-of-State Placements: Many states place youth in facilities across state lines, which raises concern if those facilities are subject to weaker standards. I encourage DHS to apply stringent criteria to any out-of-state PRTFs serving Arkansas youth. Ideally, Arkansas should only contract or allow placement with out-of-state facilities that are licensed and accredited to standards equal to Arkansas’s (as recommended in the policy report). Requiring out-of-state providers to submit annual performance reports and data on incidents, as a condition of use, would further ensure accountability. Since the proposed rules require in-state PRTFs to report on any out-of-state residents they serve, it is logical to also reciprocally demand oversight of any Arkansas youth sent outside. In short, strong licensing/accreditation standards should follow the youth, wherever they receive care.
- Transparency of Ownership and Certification: The rules might include a requirement that facilities disclose any changes in ownership, accreditation status, or key personnel to DHS promptly. Joint Commission accreditation loss or a change in administrators could trigger a review. This will help DHS stay informed and respond quickly if a facility’s situation changes (for example, if financial or leadership issues threaten care quality).

Arkansas’s commitment to high licensing and accreditation standards is laudable and will set a strong foundation for quality. Implementing the above suggestions will ensure no facility falls through the cracks of oversight and that all youth, whether in-state or placed elsewhere, are treated in settings that meet Arkansas’s high bar for safety and care.

Discharge and Transition Planning

Support for Comprehensive Discharge Planning: I am very pleased to see the proposed rule requires that discharge planning begin at the time of admission and that clear plans are in place to transition each youth to a less-restrictive setting as soon as safely possible. The explicit requirement that the PRTF develop a formal discharge plan, agreed to by the resident’s parent/guardian, identifying and confirming needed step-down services and supports is a best practice that will facilitate continuity of care. In particular, the rule mandates that the plan include confirmed follow-up mental health services,

educational arrangements, and other supports post-discharge. This is critical – too often children leaving residential care fall through the gaps, so ensuring those connections are made before discharge (with family involvement) greatly improves the chances of a successful reintegration.

The proposal also smartly requires specific steps at discharge, such as providing a post-discharge plan of care summarizing the youth's treatment, medications, and needed services, and notifying the home school district with adequate lead time so educational placements can resume smoothly. Collecting outcome data at admission, periodically, and at discharge using a standardized tool is another excellent element, as it will help evaluate treatment effectiveness. Taken together, these policies show DHS's focus on making PRTF stays as brief and effective as possible, with strong planning for what comes next – which is exactly what we want for youth who have to be in residential care.

Recommendations for Strengthening Transitions: To build on this solid framework, I recommend:

- Ensure Aftercare Support and Case Management: The rule could be enhanced by requiring or encouraging PRTFs to facilitate some form of post-discharge follow-up or aftercare coordination. National recommendations emphasize that youth coming out of residential placements should have access to transitional support services (like intensive case management, peer support, or family support services) for at least 6 months after discharge. While the PRTF itself may not provide these services directly, the discharge plan should include warm hand-offs to community providers and possibly a scheduled follow-up meeting or call after 30, 60, and 90 days to check on the youth's status. Arkansas's Provider-Led Arkansas Shared Savings Entity (PASSE) care coordinators may play a role here. I suggest the final rule or accompanying guidance state that facilities must coordinate with the youth's PASSE or community mental health provider prior to discharge to ensure a seamless transition (e.g. scheduling the first outpatient appointment, arranging community support). By formalizing aftercare coordination, DHS can significantly improve outcomes and reduce readmissions.
- Family and Youth Engagement in Planning: The rules rightly require the discharge plan to be agreed upon by the parent or guardian. I encourage facilities to involve the youth and family in every step of transition planning, as developmentally appropriate. This could include family therapy sessions focused on preparing for the youth's return home, teaching the family strategies to support the youth, and including the youth's voice in identifying what they need for a successful transition. The 11:11 Media Impact policy recommendations highlight the importance of family inclusion, noting that facilities should work on "engagement and work with the family and natural supports" and ensure "comprehensive family and community supports following the residential stay." Embedding this philosophy into discharge planning (for example, requiring documentation of how the family was educated or involved in aftercare planning) would strengthen the rule.
- Cross-State Transitions: In cases where an Arkansas youth was placed out-of-state or an out-of-state youth is in an Arkansas PRTF, special care is needed for discharge. The rules already require monthly reporting of discharges of out-of-state residents from Arkansas facilities. I recommend adding that if an Arkansas youth is returning from an out-of-state facility, that facility must coordinate with Arkansas authorities to provide a proper hand-off. Arkansas DHS could mirror the recommendation that "facilities and child welfare agencies develop comprehensive transition plans for youth exiting out-of-state placements, including coordination of education, healthcare, and mental health

services in the youth's home state". This ensures youth coming home to Arkansas are not lost in the shuffle.

In summary, the discharge and transition planning provisions in the proposed rule are very forward-thinking and child-centered. By ensuring early planning, confirmed community services, family involvement, and continued support after release, Arkansas will help youth successfully step down from residential care to home and community. This focus on discharge is vital to fulfilling the rule's purpose of achieving each resident's earliest appropriate return to a less restrictive environment.

Enforcement Mechanisms and Oversight

Transparency Support for Strong Enforcement Tools: The proposed rules appropriately equip DHS's Office of Long-Term Care (OLTC) with a robust array of enforcement mechanisms to ensure provider compliance. I support the clear statement that remedies are aimed at prompt compliance, and the flexible authority for OLTC to impose sanctions for any deficiencies found during surveys or investigations. The list of potential remedies is comprehensive and very encouraging: it includes civil monetary penalties, admissions moratoria, mandatory training or corrective action plans, increased state monitoring, appointment of a temporary facility administrator, emergency transfer of residents, license termination, and even exclusion from Medicaid participation. These graduated sanctions give DHS the tools to address problems proportionately – from requiring extra training for minor issues up to shutting down a facility for serious or uncorrected violations. Empowering the regulator in this way is essential to keep children safe, as facilities will face real consequences for non-compliance. I also note the rule allows OLTC to immediately void a license if a facility stops operating, and outlines procedures for orderly closure and record disposition, which are important details for enforcement and continuity.

Support for Transparency Measures: I applaud the inclusion of oversight transparency in the rules. Notably, facilities must "post the Statement of Deficiencies and facility's response, and the outcome of the response from the latest survey, in a public area" for residents, families, and visitors to see. They also must provide the past 12 months of deficiency notices and responses to guardians upon request. This is an excellent requirement that will ensure families are not kept in the dark about a facility's performance. Public postings of survey results create an incentive for facilities to correct problems and maintain high standards, since their reputation with consumers is on the line.

Recommendations for Strengthening Oversight: To further enhance enforcement and transparency, I recommend the following:

- Increase Unannounced Inspection Frequency: The rules allow unannounced complaint investigations and require at least an annual on-site survey. Given the vulnerability of the youth served, DHS should consider conducting unannounced inspections more frequently than once a year. National advocates recommend a minimum of two unannounced inspections per year, with private interviews of a substantial sample of residents. More frequent visits (e.g. every six months) would increase the likelihood of catching problems early and deter facilities from "cutting corners" in between surveys. It is understandable that resources are a factor, but if feasible, increasing inspection frequency (even if one is a narrower review) could greatly strengthen oversight. At minimum, DHS might target additional unannounced visits to facilities with a history of deficiencies or higher-risk profiles.

- Zero Tolerance for Abuse – Immediate Staff Suspension: I urge DHS and PRTF operators to adopt a zero-tolerance policy for abuse or neglect by staff. While the rules enforce reporting of abuse and cooperation with investigators, the regulations could explicitly require facilities to take immediate protective action when abuse allegations arise. For example, the 11:11 Media Impact report recommends that facilities institute policies mandating immediate suspension of any staff member accused of abuse pending investigation. Implementing this as a standard would ensure that children are not left in the care of someone under credible suspicion of harm. It also sends a strong message that abuse will not be tolerated. DHS might incorporate this expectation in the rules (e.g., under personnel or incident reporting requirements) or at least emphasize it during provider trainings and licensing processes. Swift removal of accused staff, coupled with prompt investigations (within 48 hours per the recommendation), will prioritize resident safety and align with best practices for child protection.
- Public Reporting of Aggregate Data: Building on the facility-level transparency already in the rules, DHS should consider publishing aggregate statewide data on PRTF performance and incidents on a regular basis. The public, legislators, and stakeholders would benefit from an annual or quarterly report summarizing key metrics: e.g. number of restraints and seclusions reported by each facility, serious incidents, licensing survey results, and enforcement actions taken. The 11:11 Media policy recommendations suggest requiring facilities to publish quarterly performance and incident reports, which the state licensing office would make publicly available. Arkansas could implement a centralized version of this – for instance, an online dashboard or report listing each PRTF and statistics on critical incidents (with no personal information). This level of transparency can build public trust and help identify systemic issues. It also aligns with the overall push for accountability: shining a light on outcomes pushes facilities to improve and allows informed decision-making by families and policymakers.
- Stakeholder Inclusion and Feedback: As part of oversight, I encourage DHS to maintain open channels for youth, family, and advocate feedback on PRTFs. Consider establishing a youth and family advisory group or listening sessions to hear directly from those with lived experience. The perspective of youth who have been in care, and their families, can be invaluable in identifying blind spots in oversight. This could be an informal practice outside the rule, but it would complement the formal surveys and incident data with qualitative insights. It echoes the report’s emphasis on including “youth and families with lived experience” in developing policies and rights.

In conclusion on oversight, Arkansas’s proposed enforcement scheme is very strong. By adopting a stance of rigorous, transparent oversight and swift corrective action, DHS will help ensure that PRTFs truly provide therapeutic care and do not become, in the words of the Senate report, “warehouses of neglect.” I believe the recommended additions – more frequent unannounced checks, a formal zero-tolerance abuse policy, public data reporting, and stakeholder engagement – will further enhance the accountability and credibility of Arkansas’s PRTF regulatory system.

Conclusion

In summary, I would like to commend Arkansas DHS for developing these comprehensive PRTF rules. The proposal demonstrates a clear commitment to improving safety, quality, and accountability in psychiatric residential treatment for youth. By addressing critical issues such as restraint/seclusion use, staff training in trauma-informed care, resident rights, discharge planning, and oversight enforcement,

the rule is poised to significantly elevate standards and protect vulnerable youth. The additional recommendations I have provided are intended to bolster these rules even further, ensuring no gaps remain that might allow substandard care or abuse to persist. Implementing these suggestions would help Arkansas fully align its regulations with emerging national reforms aimed at ending abuse and trauma in youth residential programs.

I strongly support the adoption of this rule package with the enhancements noted above. These changes will help to ensure that PRTFs in Arkansas operate as safe, therapeutic, and transparent environments where treatment is truly in the best interest of the child. Arkansas has an opportunity to lead by example, showing how state oversight can transform residential treatment into a model of trauma-informed, evidence-based care rather than a source of further harm.

Thank you for considering my comments and for your dedication to the well-being of youth in psychiatric residential treatment. I am grateful for DHS's work on this issue. Please feel free to contact me for any clarification or further input. I look forward to the finalization and implementation of these important rules, and to the positive impact they will have on children and families in Arkansas. Sincerely,



From Crisis to Care_
Creating Safe and Em

Response: Arkansas Medicaid and our Office of Long-Term Care appreciate the thoughtful feedback. We have committed to relooking at the PRTF licensure standards after the permanent rules are in place for six months and will amend if needed. Your feedback will be considered. Thank you.

Christin Harper

Arkansas Advocates for Children and Families

Public hearing held remotely 08/27/25 @ 10:00 AM CST

Comment: Good morning, Christin Harper, Arkansas Advocates for Children and Families. For the public comment hearing this morning, I really want to reiterate some of the public comments that we submitted during the first public comment period. Specifically, regarding the on-site inspections of the care. Right now, the rule appears to only require an annual on-site inspection of care and given the number of child abuse hotline reports involving PRTF's and past issues with lack of quality treatment provided in some of these facilities, we would recommend a biannual on-site inspection of care. At one point, when the placement and Residential Licensing Unit oversaw PRTFs, they did actually quarterly visits, so there is precedent for more frequent visits. In addition, while the rule acknowledges the possibility of unannounced visits, it doesn't require them with any prescribed frequency and even traditional foster homes actually have to have at least one annual unannounced visit. Of course, there are differences between foster homes and PRTFs, we recognize that. But, again, requiring annual unannounced visit to each PRTFs just seem prudent, given the mental

and behavioral health needs children place in these facilities, as well as some of the other concerns I already mentioned.

Specific to the quality assurance sections. You know, definitely we're encouraged by the requirement for PRTF facilities to maintain a continuous assurance plan that provides the residents on a quarterly basis. However, the rule only mandates that these plans be available upon request for review by the Office of Long-Term Care and so would as that the rule require PRTFS to submit these quarterly, not just request. That would help OLTC ensure that all PRTF quality assurance plans share basic QA components, which would promote consistency and quality assurance efforts across their facilities and requiring submission of the QA plans would also allow OLTC staff and any contract providers to regularly assess how the PRTFs are addressing any identified issues that are required in those plans.

Finally, even though the rules require the quarterly assurance plans to go to the residents, it also seems it would be helpful if the rules mandated the QA plans also are shared with parents, guardians, or custodians of the residents. Given that most of the individuals placed in PRTFs are still minors, and that information would help improve communication between the facilities and the parents, guardians, custodians, and empower those who are legally responsible for youth to take action when necessary. And so, I'll stop there. Thank you very much for your time.

Response: Arkansas Medicaid and our Office of Long-Term Care appreciate the thoughtful feedback. We have committed to relooking at the PRTF licensure standards after the permanent rules are in place for six months and will amend if needed. Your feedback will be considered. Thank you.

All visits to a PRTF are unannounced.

Reagan Stanford, Abuse and Neglect Managing Attorney

Disability Rights Arkansas

Comment: Comments submitted on behalf of Disability Rights Arkansas (DRA). DRA is the federally mandated and funded nonprofit organization serving as the Protection and Advocacy System (P&A) for individuals with disabilities in Arkansas. The P&A System is a network of 57 legal advocacy agencies authorized to protect human, civil, and legal rights of all individuals with disabilities, consistent with state and federal laws. DRA's abuse and neglect team provides advocacy services to individuals, monitors facilities, and investigates abuse and neglect. Over the last six years DRA has regularly monitored the Psychiatric Residential Treatment Facilities in the state and conducted numerous abuse investigations.

Facilities should be required to document visual checks, including the location and general activity the child is engaged in, at least every 15 minutes, 24 hours a day. 20 CAR 417-303.

- In the proposed rule the requirement to document visual checks at least every 15 minutes is tied to the times when the 1:8 staff to resident ratio is in effect.

- Under the emergency rule “constant visual on each resident in common areas during waking hours” is required, in addition to 15-minute documentation. The newly proposed rule requires only “supervision and treatment on each child during the 1:4 ratio” with no documentation requirement.

Reporting of physical contact or injuries should not be limited to injuries that require external medical treatment. 20 CAR 417-412 (proposed rule) and 20 CAR 417-411 (Emergency Rule)

- Under the emergency rule one of the events facilities are (or will soon be) required to report is “physical or sexual acts between residents or residents and staff.” In the proposed rule that language has been replaced with “physical injury that requires external medical treatment or sexual acts...”
- These facilities have or should have medical personnel on-site that are not commonly available in other settings, whether they have the ability or choose to treat a resident in-house or send them to an external facility should have no bearing on whether or not the incident is reportable.

The language identifying what must be reported as a serious occurrence should be clarified to clearly include *suspected or reported* abuse and neglect. 20 CAR 417-412

- The proposed rule includes “any incidents of abuse and/or neglect” as a reportable category. Given that serious occurrences must be reported by the close of business the next business day, it is often the case that a determination of whether or not an incident involved abuse or neglect is not able to be made prior to the reporting deadline. Unfortunately, a few PRTFs in Arkansas have in the past opted to read ambiguity into similar language and refused to report incidents unless and until there was a finding of abuse or neglect, which in some cases could be months later.
- Clarifying the language to include “any incidents of suspected or reported abuse and/or neglect” would eliminate this issue.

We are curious what the rationale was for inserting “physical harm or physical injury that caused” into the definition of “serious injury” in a shift from the definition included in the emergency rule.

- The definition in the proposed rule reads - *“Serious injury” means physical harm or a physical injury that caused any significant impairment of the physical condition of the Resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.*
- The significance of this definition is unclear since the only time “serious injury” is referenced outside of the definitions is in the list of events reportable as serious occurrences in 20 CAR 417-412 and that section refers to serious injury as defined in 42 C.F.R. § 483.352 (2001), which as currently written, includes the definition included in the emergency rule.
- If the goal is to attempt to limit or exclude injuries or incidents that are medical in nature, we strongly oppose that goal. Children in these facilities have experienced and been hospitalized for issues that indicate possible lapses in care that do not result from a physical injury including lithium toxicity, fecal compaction, other medication induced conditions, dehydration, and syncope.

Post-Intervention debriefing language should clearly state a requirement for guardians to be offered the opportunity participate.

- 20 CAR 417-504 states that guardians *may* participate in post-intervention debriefings when it is deemed appropriate. This language mirrors 42 CFR 483.370(a) but does not capture the interpretive guidelines that indicate the guardians of minor residents should be given an opportunity to participate in the debriefing. The permissive language in the current rule will maintain the current status quo of guardians being notified of restraints but not offered an opportunity to participate in post-intervention debriefings.

A true finding of child maltreatment should be an automatic bar to employment or cause for termination if already employed. 20 CAR 417-206.

- The proposed rule does not require anything more than “review” by the facility administrator in consultation with OLTC. If the child maltreatment registry is not being used to prevent individuals from working with and having access to some of the most vulnerable children in the state, what is it being used for?
- As an agency that has reviewed hundreds of maltreatment investigations, it is frustratingly rare that allegations against a staff member at a facility result in a true finding. A small portion of reports are almost certainly correctly identified as unfounded allegations, however many more are the result of a lack of evidence or documentation, inability or unwillingness to fully investigate, and inadequate child maltreatment statutes that do not contemplate situations that may be specific to suitability for employment with vulnerable children under psychiatric care. Staff and resident physical altercations, including fist fights, are among the incidents that we have seen not result in a true finding.

The following comments were submitted in reference to the emergency rule but were not incorporated into the currently proposed rule. They remain necessary elements of any attempts to increase and hopefully maintain any baseline of quality care and we hope that their exclusion will be reconsidered.

Staff Training – In addition to what is already included in the proposed rules, DHS should:

- Require standardized training on the function of each oversight agency and how to contact each entity for all facility employees annually.
- Set minimum required hours for initial/orientation training and annual staff training. 20 CAR 417-420 includes a requirement for 15 hours of continuing education yearly for certified dietary managers or food service supervisors and 417-205 requires 12 hours annually for Administrators, however 20 CAR 417-402 does not include a minimum number of hours for initial or annual training.

Definitions Needed -

- “Chemical restraint” and “Sedating PRN” are not defined in 20 CAR 417-501 or in the 20 CAR 417-102 Definitions. “Drug used as a restraint” is defined in 20 CAR 417-102 and 42 C.F.R. 483, Subpart G using the definition commonly used for “chemical restraint,” however since a distinction is being made between chemical restraints and sedating PRNs, both terms should be clearly defined.

- “Scheduled discharge” as used in 20 CAR 417-407 for purposes of requiring 30 days of medication be provided at discharge.

Additional changes that would improve the safety and quality of services and have previously been proposed by DRA.

- Require resident participation in creation of individualized treatment plan and treatment team reviews. If not present during reviews the reason they were not present should be documented. Based on the prevalence of residents not being included in reviews or being able to articulate their treatment goals we do not believe the language in 20 CAR 417-406 indicating treatment plans should be developed “in consultation with the Resident” is strong enough.
- Require information regarding licensing and oversight agencies, Ombudsman offices, and the state Protection and Advocacy Agency and how to report to them be posted in conspicuous locations visible by staff, residents, and visitors.
- Require providers disclose to DHS all states they accept children from *and* provide all inspection, investigation, and corrective or disciplinary action from all placing states. DHS should maintain a public database of this information.
 - A finding related to a deficient practice has the potential to affect all residents of that facility. States operating independently and not sharing information is inefficient and a disservice to current and future residents and their guardians who deserve to have a full picture of what inspections have revealed.
- The use of prone restraints should be banned. Despite overwhelming evidence of the danger inherent in prone restraints, several facilities in the state continue to utilize the practice.
- Limit therapist caseloads to 10 children or less and limit the ability of the Clinical Director to maintain a caseload.
- Require Clinical Director to have at least three years of clinical experience
- Limit the number of hours direct care staff can work consecutively and within a one-week period.
- Require facilities to check and document resident blood pressure, weight, and BMI at least monthly.
- Require indoor recreational space be provided in addition to outdoor space.
- Set maximum number of residents allowed per unit to 8 or less.
- Allow a maximum of two residents per bedroom and require the ability to accommodate single occupancy rooms as needed.

Response: Arkansas Medicaid and our Office of Long-Term Care appreciate the thoughtful feedback. We have committed to relooking at the PRTF licensure standards after the permanent rules are in place for six months and will amend if needed. Your feedback will be considered. Thank you.



From Crisis to Care: Creating Safe and Empowering Environments for Youth

By 11:11 Media Impact

We Look Forward To Working With You!

Please contact Paris Hilton & the 11:11 Media Impact Team at rebecca@1111media.co

Executive Summary

Youth Residential Treatment Facilities (RTFs) in the United States, designed to serve children with complex mental and behavioral health needs, have become environments of pervasive abuse and neglect. Each year, between 120,000 and 200,000 children are placed in these institutions, including therapeutic boarding schools, group homes, wilderness therapy programs, and residential treatment facilities, often through traumatizing interventions by “teen transport” companies.

Despite receiving an estimated \$23 billion in public funding annually, numerous investigations have uncovered systemic failures within RTFs. Understaffed, poorly regulated, and driven on profit rather than the safety and well-being of the children they serve, these facilities frequently subject children to physical, sexual, and emotional abuse, unsafe living conditions, and substandard treatment. The 2024 Senate Finance Committee report, *Warehouses of Neglect*, identified endemic harm within RTFs, including unsafe restraint practices, improper medication use, educational neglect, and insufficient oversight. Alarming, these failures have contributed to hundreds of preventable child deaths over the past two decades.

This crisis disproportionately impacts marginalized youth—those in the child welfare and juvenile justice systems, youth with disabilities, and children of color—exacerbating existing inequities. At a time of unprecedented youth mental health challenges, with over one in three high school students reporting persistent feelings of sadness or hopelessness, it is more important than ever to ensure that young people can access effective, evidence-based treatment that promotes healing, rather than exacerbating their trauma or creating new harm—as is often the case in RTFs.

Comprehensive reform is imperative. This report provides a detailed set of policy recommendations aimed at addressing the failures in the youth residential treatment industry and preventing further harm. These recommendations focus on shifting away from institutional placements and promoting community-based, trauma-informed care that is rooted in evidence-based practices. By prioritizing transparency, oversight, and the safety of children, we can build a system that ensures every young person receives the care they need without the risk of further trauma.

Addressing institutional child abuse and neglect is a necessary step toward resolving the broader youth mental health crisis. This report serves as a call to action for policymakers, advocates, and stakeholders to implement meaningful reforms that protect vulnerable youth and provide pathways for recovery, growth, and resilience.

11:11 Media Impact Policy Recommendations

Youth Safety and Dignity Recommendations

❖ Youth and Family Bill of Rights

- **Policy Recommendation:** Promote and implement a comprehensive Youth and Family Bill of Rights that guarantees fundamental rights and protections for all individuals receiving care in residential treatment facilities or accessing community-based services. This Bill of Rights must prioritize safety, dignity, access to care, and active participation in treatment decisions, ensuring youth and families are informed and empowered throughout their care journey.
 - **Example Legislative Language:**
 - “a. The state shall develop a model Youth and Family Bill of Rights in collaboration with stakeholders, including:
 - i. Youth and families with lived experience in residential care.
 - ii. Advocacy organizations specializing in child welfare and mental health.
 - iii. Residential care providers and community-based service organizations.
 - b. Facilities and service providers must adopt and display the Youth and Family Bill of Rights prominently in common areas and distribute copies to all youth and families at the time of admission.”

❖ Zero Tolerance Policies

- **Policy Recommendation:** Implement zero-tolerance approaches to abuse, with immediate suspension for accused staff pending investigation.
 - **Example Language:**

"Facilities must implement policies mandating immediate suspension of any staff member accused of abuse, with internal reviews conducted within 48 hours. Failure to comply will result in administrative penalties and license suspension."

❖ Individualized Treatment Plans

- **Policy Recommendation:** Require trauma-informed, culturally competent treatment plans that evolve with youth's needs.
 - **Example Language:**

"Each resident shall have a personalized treatment plan reviewed quarterly by a licensed clinician. Treatment plans must include

measurable goals, integrate family involvement, and reflect evidence-based practices."

❖ **Restraints, Involuntary Seclusion, and Behavior Management**

- **Policy Recommendation:** Prohibit prone restraints, or other physical restraints that restrict airflow, or blood flow to the brain.
 - **Example Legislative Language:** "No residential treatment facility serving minors shall use or permit the use of the following physical restraint techniques under any circumstances:
 - a. Prone restraints that involve placing an individual face-down on a surface.
 - b. Chokeholds or any technique that restricts airflow or blood flow to the brain by applying pressure to the neck.
 - c. Restraints that apply pressure to the chest, back, or any other body part in a manner that impairs the ability to breathe or risks asphyxiation."
- **Policy Recommendation:** Prohibit corporal punishment, and mechanical or chemical restraints.
 - **Example Language:**
"Mechanical or chemical restraints are prohibited in all facilities."
- **Policy Recommendation:** Restrict physical restraints to emergency situations, as a last resort, where serious bodily harm to the youth or others is imminent.
 - **Example Legislative Language:**
"Physical restraints may only be used in emergency situations where:
 - i. There is an imminent threat of serious bodily harm to the youth or others.
 - ii. No other de-escalation techniques or alternative interventions are effective or feasible.
 - b. Physical restraints shall not be used:
 - i. As a form of discipline or punishment.
 - ii. For the convenience of staff.
 - iii. As a substitute for treatment, education, or supervision."
- **Policy Recommendation:** All instances of physical restraint and involuntary seclusion must be reported to the state licensing authority, to the youth's parent,

foster parent, guardian, Indian custodian, or other authorized representative, and attorney within 24 hours.

■ **Example Legislative Language:**

"Youth residential treatment facility must report and notify every instance of physical restraint or involuntary seclusion to the following parties within 24 hours: the appropriate state licensing authority, the youth's parent, foster parent, guardian, Indian custodian, or other authorized representative and attorneys.

Notification must include:

- i. A verbal or electronic summary of the incident provided as soon as possible, but no later than 24 hours after the incident.
- ii. A detailed written report, delivered within 24 hours, containing the following:
 - a. A description of the specific behavior or circumstances necessitating the restraint.
 - b. The de-escalation techniques were attempted before the restraint.
 - c. The duration of the restraint, including start and end times.
 - d. The names and certifications of staff involved in the restraint.
 - e. Documentation of any injuries sustained by the youth or others involved, including the provision of medical care or follow-up required."

❖ **Strip Searches**

- **Policy Recommendation:** Prohibit strip searches except in exceptional circumstances where there is probable cause to believe the youth possesses contraband that poses an imminent risk to their safety or the safety of others, and only after all less invasive alternatives have been exhausted. Strip searches must never be conducted as a form of discipline, punishment, or staff convenience.

■ **Example Legislative Language:** "Strip searches of youth are prohibited unless:

- i. There is probable cause to believe the youth possesses contraband that poses an imminent risk to their safety or the safety of others.
- ii. All less invasive alternatives have been exhausted.
- b. No strip search shall be conducted as a form of discipline, punishment, or convenience for staff."

- **Policy Recommendation:** Staff must prioritize verbal interventions and employ detection devices, such as metal detector wands or body scanners, before considering any invasive searches.

- **Example Legislative Language:** “Before conducting a strip search, staff must:
 - i. Exhaust verbal intervention techniques to resolve the situation.
 - ii. Use detection devices, such as metal detector wands or body scanners.”
- **Policy Recommendation:** When a strip search is deemed necessary, strict procedural safeguards must be followed to protect the dignity and well-being of the youth. Searches must be conducted by staff of the same gender as the youth, with a minimum of two staff members present to ensure accountability.
 - **Example Legislative Language:** “If a strip search is conducted, the following safeguards must be in place:
 - i. The search must be conducted by staff of the same gender as the youth.
 - ii. A minimum of two staff members must be present during the search.”
- **Policy Recommendation:** A detailed incident report must be completed immediately, documenting the reasons for the search, de-escalation methods attempted, personnel involved, any contraband found, and any adverse effects experienced by the youth. Facilities must immediately report any strip search to the facility supervisor, the youth’s parent, foster parent, guardian, or Indian custodian, the youth’s attorney or advocate if applicable, and state licensing authority.
 - **Example Legislative Language:** “A detailed incident report must be completed immediately after the search, including:
 - i. The reasons for the search.
 - ii. The de-escalation methods and alternatives attempted.
 - iii. The personnel involved.
 - iv. Any contraband found.
 - v. Any adverse effects reported by the youth.Any strip search must be immediately reported to:
 - i. The facility supervisor.
 - ii. The youth’s parent, foster parent, guardian, or Indian custodian.
 - iii. The youth’s attorney or advocate, if applicable.

iv. and the state licensing authority.”

- **Policy Recommendation:** Facilities must provide access to trauma-informed counseling services for any youth subjected to a strip search.

- **Example Language:**

"Facilities must provide access to trauma-informed counseling services for any youth subjected to a strip search."

Youth Health and Well-Being Recommendations

❖ Comprehensive Medical Care

- **Policy Recommendation:** Provide all youth with access to healthcare, including mental health services, routine check-ups, dental care, and emergency care. In the event that emergency care is needed, the youth's parent, foster parent, guardian, Indian custodian, or other authorized representative and attorneys should be notified immediately.

- **Example Legislative Language:**

"Facilities must contract with licensed healthcare providers to offer residents routine and 24/7 emergency care. Residents may request an independent healthcare provider, with requests fulfilled within five business days. In the event that emergency care is needed, the youth's parent, foster parent, guardian, Indian custodian, or other authorized representative and attorneys should be notified immediately."

- **Policy Recommendation:** Mandate training for all staff on recognizing health issues and responding to medical emergencies.

- **Example Legislative Language:** "All staff employed by youth residential treatment facilities shall complete training on recognizing health issues and responding to medical emergencies as a condition of employment.

b. The training program shall include, at a minimum:

- i. Identifying signs and symptoms of common health issues, including physical illnesses, mental health crises, and substance-related emergencies.
- ii. Basic first aid and CPR certification.
- iii. Responding to medical emergencies, including proper procedures for contacting emergency medical services (EMS).
- iv. Recognizing and responding to signs of abuse, neglect, or self-harm that may require medical intervention."

- **Policy Recommendation:** Establish protocols to ensure the seamless transfer of medical records and effective care coordination for youth in residential facilities. Mandate secure, timely sharing of comprehensive medical records with community healthcare providers to ensure continuity of care during and after placement. Requires residential facilities to designate care coordinators, develop post-placement care plans, and schedule follow-up appointments before discharge.
 - **Example Legislative Language:** “Residential facilities must designate a care coordinator to facilitate communication and coordination between the facility, the youth’s community healthcare providers, and any involved specialists or therapists. Care coordinators must work with community providers to develop a post-placement care plan that includes follow-up appointments, medication management, and referrals to necessary services.
 - i. Prior to a youth’s discharge, residential facilities must:
 - Schedule a follow-up appointment with the youth’s primary care provider or specialist within seven days of discharge.
 - Provide a discharge summary, including updated medical records and any recommended treatment adjustments.
 - ii. Discharge plans must be reviewed and signed by the youth’s care coordinator and shared with the youth, their guardian, and community healthcare providers.”

❖ Medication Management

- Promote safe and informed medication use, ensuring all prescriptions are administered by licensed professionals.
 - **Example Language:**
"All medication shall be prescribed and dispensed by licensed practitioners, with facilities maintaining detailed records of administration."
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Youth Education Recommendations

❖ Quality Academic Education

- **Policy Recommendation:** Provide all youth with access to high-quality, accredited, and culturally responsive education that prepares them for future success. Ensure curriculum and credits are transferable to public schools or higher education institutions, so youth can seamlessly pursue their educational aspirations.

- **Example Legislative Language:**

"All youth in residential facilities shall have access to high-quality, accredited education programs that meet or exceed state curriculum standards.

 - a. Educational programs must prepare youth for future success by providing:
 - i. Core academic instruction aligned with state standards.
 - ii. Career and technical education opportunities.
 - iii. College preparatory courses, where appropriate.
 - iv. Instruction in life skills necessary for independent living and civic engagement.
 - b. All courses offered must align with state curriculum standards to ensure that credits earned:
 - i. Are transferable to mainstream public or private schools.
 - ii. Are recognized by colleges, universities, and vocational institutions.
 - c. Facilities shall develop partnerships with local school districts to facilitate seamless credit transfer and ensure students remain on track academically."
 - **Policy Recommendation:** Develop Individualized Learning Plans (ILPs) tailored to each resident's educational needs and goals.
 - **Example Legislative Language:**

"Each resident shall have an ILP created and reviewed quarterly by certified educators, integrating input from the student, family, and the youth's therapeutic team."
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Youth Communication Recommendations

❖ Unrestricted Communication

- **Policy Recommendation:** Support youth in maintaining vital connections with family and advocates through private, accessible communication.
 - **Example Legislative Language:**

"Residents shall have daily access to telecommunication devices for private communication with legal guardians and advocates."

❖ Incident Reporting Mechanisms

- **Policy Recommendations:** Protect residents and staff by establishing anonymous, accessible reporting systems for concerns or complaints.
 - **Example Language:**
"Facilities must provide a secure platform for anonymous reporting, monitored by the State Licensing Office. Reports must be investigated within __ days."
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Staff Requirements Recommendations

❖ Staff Training

- **Policy Recommendation:** Empower staff to recognize and report abuse through comprehensive, recurring mandatory reporting training, ensuring continuous awareness of their responsibilities to protect youth.
 - **Example Legislative Language:**
"All residential treatment facilities shall require staff to complete ____ hours of annual abuse recognition and reporting training, approved by the state licensing authority. Compliance must be certified annually, and records maintained for a minimum of five years."
- **Policy Recommendation:** Mandate all staff receive annual training in trauma-informed care and de-escalation techniques.
 - **Example Legislative Language:**
"All staff must complete a minimum of __ hours of trauma-informed care and de-escalation training annually. Training records shall be maintained and audited during inspections."

❖ Comprehensive Whistleblower Policies

- **Policy Recommendation:** Encourage all individuals, including staff, volunteers, and residents, to report suspected illegal practices or policy violations to the state licensing authority and/or law enforcement. All individuals reporting concerns in good faith should be protected from retaliation, regardless of the investigation's outcome.
 - **Example Legislative Language:**
"Residential facilities must establish whistleblower policies encouraging staff, volunteers, and residents to report suspected illegal practices or violations of policies to the state licensing authority and/or law enforcement."

- i. No individual may face retaliation, punishment, discrimination, or adverse treatment for reporting concerns in good faith.
- ii. Protections extend to individuals cooperating with investigations or providing testimony.
- iii. Whistleblowers acting without malice are protected even if their claims are ultimately unfounded.

Facilities must implement confidential reporting mechanisms, including:

- i. A whistleblower hotline or intranet reporting system.”

❖ **Extensive Pre-Employment Background Checks**

- **Policy Recommendation:** Require comprehensive background checks for all staff prior to employment, screening for histories of abuse, neglect, or other relevant criminal offenses.

- **Example Legislative Language:**

"All residential treatment facilities shall conduct comprehensive background checks on all potential employees before offering employment. Such checks must include:

- i. State and federal criminal records;
- ii. Child abuse and neglect registries;
- iii. Verification of previous employment in childcare or treatment facilities;
- iv. Reference checks from a minimum of three professional or personal sources.

Facilities shall document the results of background checks and maintain these records for the duration of the individual's employment and for a minimum of seven years thereafter."

Facility Oversight and Accountability Recommendations

❖ **Inspections and Audits**

- **Policy Recommendation:** Require twice-yearly unannounced inspections and independent oversight of residential facilities, including interviews with at least 50% of residents.

- **Example Legislative Language:**

"State licensing bodies shall conduct a minimum of two unannounced

inspections annually, interviewing at least half of the residents privately to assess conditions, practices, and youth safety."

- **Policy Recommendation:** State licensing officials should implement a comprehensive risk assessment framework to evaluate the efficacy of treatment, appropriateness of placement, and quality of care in youth residential treatment facilities. The framework must include direct engagement with youth to gather feedback on their experiences and assess the quality of care provided.

- **Example Legislative Language:**

- "a. Licensing officials shall evaluate the following areas as part of their risk assessment:

- i. Efficacy of treatment programs, including adherence to evidence-based practices and trauma-informed care standards.
 - ii. Appropriateness of placement, including alignment with the youth's individual treatment plan and best interest.
 - iii. Quality of care, including staff qualifications, facility conditions, and youth well-being outcomes.

- b. Direct Engagement with Youth:

- i. Licensing officials shall conduct private, confidential interviews with at least 50% of youth residents during each assessment to gather feedback on their experiences.
 - ii. Youth interviews shall address:
 - Perceptions of safety and well-being.
 - Quality of relationships with staff and peers.
 - Accessibility and effectiveness of treatment programs.
 - Suggestions for improvements in care and services.

- c. Officials shall collect and analyze data from facility records, staff interviews, incident reports, and youth feedback to identify patterns and risks.

- d. Procedures for Youth Interviews

- i. Interviews shall be conducted in a private setting to ensure youth feel safe to speak openly.
 - ii. Responses shall remain confidential unless they reveal an immediate risk to safety or involve mandatory reporting requirements.
 - ii. Interviews shall be conducted in a non-judgmental, youth-centered manner, ensuring questions are age-appropriate and accessible."

- **Policy Recommendation:** Install cameras with audio recording capabilities in common areas of youth residential treatment facilities to monitor interactions, ensure safety, and increase accountability. Footage should be retained for a

specified period and reviewed in the event of reported incidents or allegations of abuse, neglect, or misconduct. Cameras must not be installed in private spaces such as bathrooms or bedrooms to protect the dignity and privacy of residents.

- **Example Legislative Language:**

- “a. Cameras shall be installed in all common areas, including hallways, dining rooms, recreation areas, and other shared spaces where interactions between residents and staff occur.

- b. Cameras shall not be installed in private spaces, including bathrooms, bedrooms, or areas used for changing clothing.

- c. Audio Recording:**

- i. Cameras must include audio recording capabilities to capture conversations and other auditory interactions in common areas.

- ii. Facilities must ensure that audio recordings comply with all applicable state and federal laws regarding privacy and consent.

- d. Retention Period:**

- i. All video and audio recordings must be securely stored for a minimum of 90 days.

- ii. If an incident is reported within the retention period, the relevant footage must be preserved until the investigation and any related proceedings are complete.”

- ❖ **Incident Reporting and Data Sharing**

- **Policy Recommendation:** Mandate public reporting of restraint use and isolation incidents in residential facilities to ensure transparency.

- **Example Legislative Language:**

- “All facilities shall publish quarterly reports on facility performance, restraint use, involuntary seclusion incidents, and investigation outcomes. Data shall exclude personally identifiable information and be made publicly available on the state licensing office’s”

Out-of-State Placement Recommendations

- ❖ **Improve Interstate Coordination**

- **Policy Recommendation:** Streamline interstate placement processes and ensure effective communication between sending and receiving states.

- **Example Legislative Language:**

- “State agencies shall fully implement the National Electronic Interstate Compact Enterprise (NEICE) system to facilitate efficient, transparent,

and expedited interstate placements. Sending and receiving states must establish formal agreements outlining oversight, monitoring responsibilities, and information-sharing protocols."

- **Policy Recommendation:** Each state shall designate an Interstate Placement Liaison to serve as the primary point of contact for coordinating placements and addressing concerns, ensuring timely communication between jurisdictions.

❖ **Enhance Oversight and Accountability**

- **Policy Recommendation:** Strengthen monitoring and ensure high standards for out-of-state placements.
 - **Example Legislative Language:**
"Out-of-state facilities accepting placements must adhere to licensing and accreditation standards equal to or exceeding those of the sending state. Facilities must submit annual performance reports, including data on incident rates, treatment outcomes, and compliance with individualized treatment plans."
- **Policy Recommendation:** States shall conduct quarterly reviews of youth placed out-of-state to assess their progress and conditions. A multi-disciplinary review team shall be responsible for these assessments."

❖ **Focus on Family Engagement and Reunification**

- **Policy Recommendation:** Prioritize family connections for youth placed out-of-state and facilitate their involvement in treatment.
 - **Example Legislative Language:**
"When out-of-state placement is necessary, priority shall be given to placements with relatives or kin. States must allocate funding for transportation and lodging to ensure families can maintain regular contact with youth in out-of-state care. Facilities must provide video conferencing options for families unable to travel."

❖ **Implement Assessment and Approval Processes**

- **Policy Recommendation:** Justify the need for out-of-state placement through rigorous assessment and stakeholder approval.
 - **Example Legislative Language:**
"Before authorizing out-of-state placement, states must conduct a thorough assessment demonstrating that in-state alternatives are unavailable or unsuitable. Approval shall require sign-off from a multi-stakeholder panel, including representatives from child welfare, mental health, and education."

- **Policy Recommendation:** Out-of-state placements must be reassessed every six months to determine ongoing necessity. Recommendations for continued placement or transition must be documented and shared with stakeholders.

❖ **Develop Transition Planning**

- **Policy Recommendation:** Ensure continuity of care and support for youth returning from out-of-state placements.
 - **Example Legislative Language:**
"Facilities and child welfare agencies must develop comprehensive transition plans for youth exiting out-of-state placements. Plans shall include coordination of education, healthcare, and mental health services in the youth's home state."
 - **Policy Recommendation:** Youth must have access to transitional support services, including case management, for at least six months after their return to ensure successful reintegration into their community.
-

Regulation of Youth Transportation Services Recommendations

❖ **Transport Agency Licensure**

- **Policy Recommendation:** Establish strict licensing and oversight requirements to ensure youth transport services operate safely and transparently.
 - **Example Legislative Language:**
"All youth transport service providers must be licensed by the state licensing authority. Licenses shall require annual renewal contingent upon compliance with state regulations, including staff training, documentation, and audit requirements."

❖ **Prohibit Deceptive Practices**

- **Policy Recommendation:** Transportation companies must provide parents or guardians with a detailed description of the transport process, including methods of transport, estimated travel times, and the names of personnel involved. Parental consent forms must clearly outline this information and be signed prior to transport.
- **Policy Recommendation:** Protect youth from deceptive or coercive practices during transport.
 - **Example Legislative Language:**
"Youth transportation services are prohibited from using deceptive practices or force to transport minors. Youth must be informed, in

age-appropriate language, of their destination, the reason for transport, and the expected duration of the trip."

❖ **Mandatory Reporting**

- **Policy Recommendation:** Ensure full accountability through detailed documentation and reporting of incidents.
 - **Example Legislative Language:**

"All transportation incidents, including the use of restraints or any physical intervention, must be documented and reported to the state licensing authority within 24 hours. Reports must include:

 - i. Details of the incident
 - ii. Names of personnel involved
 - iii. Actions taken to resolve the incident"

❖ **Training and Certification**

- **Policy Recommendation:** Mandate comprehensive training and certification for transport personnel.
 - **Example Legislative Language:**

"All transport personnel must complete 20 hours of initial training in trauma-informed care, de-escalation techniques, and youth rights, followed by annual refresher training. Certification is required for all individuals involved in youth transport, to be issued and tracked by the state licensing authority."

❖ **Restraint Practices in Youth Transportation Services**

- **Policy Recommendation:** Prohibit the use of physical, mechanical, or chemical restraint on youth by any youth transportation service.
 - **Example Legislative Language:**

"The use of physical, mechanical, or chemical restraint on youth by any youth transportation service is strictly prohibited, including but not limited to:

 - i. **Chemical Restraint:** The administration of drugs or medication to control behavior that is not prescribed by a licensed healthcare professional and administered for medical or therapeutic purposes.
 - ii. **Mechanical Restraint:** The use of any device or equipment to restrict a youth's movement, including handcuffs, shackles, or other binding devices, except as prescribed for medical or therapeutic purposes by a licensed healthcare professional.
 - iii. **Prone Restraint:** Any restraint that places a youth face-down on the

ground or another surface.

iv. **Supine Restraint:** Any restraint that places a youth face-up on the ground or another surface.

v. **Pressure Restraint:** Any restraint involving the non-incidental use of a solid object, including the ground, wall, or floor, to impede a youth's movement.

Additional Prohibited Practices

a. The following specific restraint practices are prohibited during youth transportation:

i. Any restraint that places, or creates a risk of placing, pressure on a youth's neck, throat, or mouth.

ii. Any restraint that impedes, or creates a risk of impeding, a youth's breathing.

iii. The intentional placement of hands, feet, elbows, knees, or any object on a youth's neck, throat, genitals, or other intimate parts.

iv. Any restraint that places, or creates a risk of placing, pressure on a youth's stomach, chest, joints, throat, or back through the use of a knee, foot, or elbow.

v. Any other restraint, the primary purpose of which is to inflict pain or cause physical harm."

❖ **Age Restrictions**

➤ **Policy Recommendation:** Limit the use of escort services to older youth and prohibit their use for younger children.

■ **Example Legislative Language:**

"Escort services may not be used for children under the age of 12. For youth aged 12 to 18, transport must be conducted with explicit written approval from both parents or legal guardians, and the presence of a trained advocate is required during transport."

❖ **Interstate Cooperation**

➤ **Policy Recommendation:** Develop consistent standards and oversight for youth transport services across state lines.

■ **Example Legislative Language:**

"The state shall enter into an interstate compact for the regulation of youth transport services, ensuring uniform licensing, reporting, and oversight requirements. Compact members shall share data on transport company performance and investigate cross-state complaints jointly."

Preventing Unnecessary Institutionalization

❖ **Community-Based Mental Health Services**

- **Policy Recommendation:** Reduce reliance on institutional placements by expanding community-based mental health services and youth mobile crisis units.
 - **Example Language:**
"The State shall allocate \$__ million annually to fund community-based mental health clinics, prioritizing underserved areas and integrating youth mobile crisis units for emergency interventions."

❖ **Youth and Family Advocacy Programs**

- **Policy Recommendation:** Equip youth and families with knowledge and tools to participate in care decisions and advocate for systemic reform.
 - **Example Language:**
"The State shall fund advocacy programs, providing training in self-advocacy, legal rights, and care system navigation for youth and families."